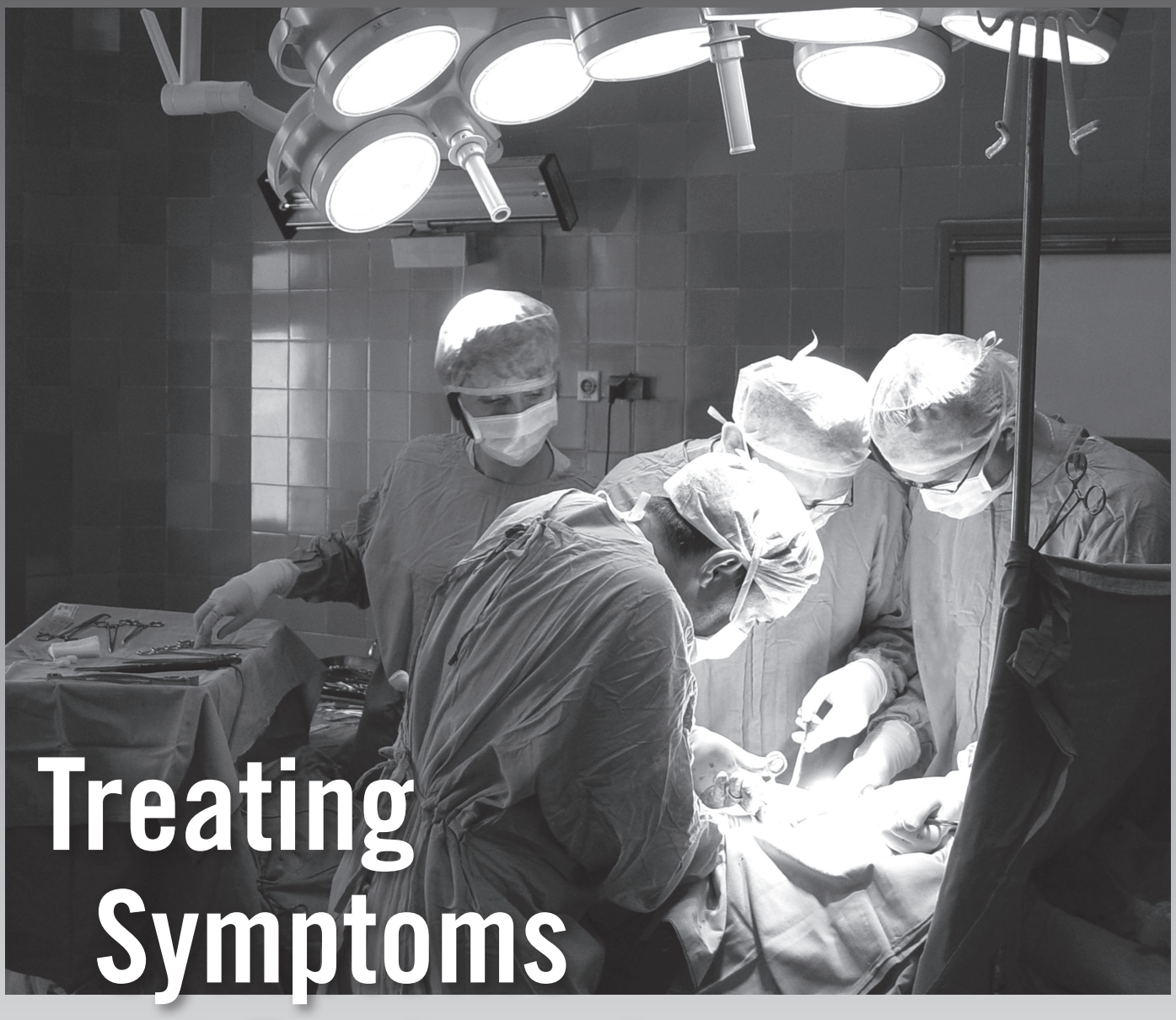
Medical Malpractice Tort Reform in Texas



Treating Symptoms Rather than Seeking a Cure

By Roger Sherman and
Geraldine Szott Moohr*

Over the last thirty years, persistent efforts to limit tort damage awards for medical malpractice in Texas have made the state one of the most physician-friendly in the country. In particular, in 2003, the Texas legislature made it more difficult to bring malpractice claims to court and limited the amount of money juries could award to injured patients for non-economic damages. In order to understand these and other elements of medical malpractice tort reform, we review recent empirical research on tort reform's effects. In brief, the data do not support claims made about benefits of reform. And the problem of negligence by physicians, other providers, and institutions is still largely ignored.

We begin by reviewing traditional tort law and summarizing Texas medical malpractice tort reforms in Part I. In Part II, we identify the claims made for, and the main effects of, malpractice tort reform and consider whether the reform improves medical service for Texans. We are aided in this by several empirical studies that provide data on the consequences of the limits on non-economic damage awards. Analysis of these studies leads us to conclude that malpractice tort reform has reduced insurance rates for doctors but at the price of reducing compensation to those most seriously injured. There is little evidence that the number of doctors per capita practicing in Texas has increased or that the quality of medical care has improved. Moreover, while limiting non-economic damage awards eases insurance costs for doctors and other providers, it does not treat the root cause of the problem, the negligent practice of medicine. Indeed, medical malpractice tort reform tends to minimize the malpractice problem because limiting damage awards makes malpractice appear less costly than it really is, understates the true cost of malpractice insurance, and distorts medical providers' incentives. Medical malpractice tort reform has thus distorted incentives that would, if left undisturbed, tend to penalize malpractice more heavily and thereby possibly reduce it. In Part III, we address how medical malpractice might be controlled. We note that patients are often unable to obtain relevant information about the quality of medical care offered by providers and we present alternative ways to deal with this information disparity, such as relying on gatekeepers, medical review boards, and experience rating by insurers. When applied in combination, these alternatives would be more effective than malpractice tort reform for improving medical service in Texas.

Damage awards perform two functions; they compensate those who are harmed and they impose costs on negligent medical service providers.

I. Tort Reform in Texas

The law of tort developed common law principles through hundreds of years of judicial and jury decisions that dealt with actual events,[1] and today it provides a system of redress for injuries caused by negligence. In Texas, as in other states, "victims of medical negligence have a well-defined common law cause of action to sue for injuries negligently inflicted upon them."[2] Patients who have sustained injuries because of negligent medical practice seek compensation from those responsible. The general goal of compensation is to make injured patients "whole," that is, to restore them to the position they would have enjoyed if the tort had not occurred. In malpractice cases involving severe injuries, that goal of "wholeness" may not be realized, even when the lawsuit is won. Notwithstanding this reality, the award of non-economic damages expresses the community's appreciation of the harm imposed by serious nonpecuniary losses.

Generally, to win a malpractice tort award, the injured patient, as plaintiff, must show that a harm-causing event occurred, that the provider caused the harm, and that the provider was negligent. The plaintiff must also prove the amount of damages necessary to compensate for the injury, and juries are given wide latitude to decide this issue. Damage awards are justified by evidence of economic loss and non-economic harm. Economic damages include past and future medical expenses, lost past and future income, and other costs that can be converted into dollars. Non-economic damages are those that are not so easily quantified but are nonetheless real, such as physical pain and mental anguish, physical impairment, disfigurement, loss of consortium of spouse, child, or parent. Damage awards perform two functions; they compensate those who are harmed and they impose costs on negligent medical service providers. These costs should, in turn, motivate greater care and reduce instances of malpractice.

A. Unintended Consequences of Litigating Malpractice Claims

The tort system does not operate perfectly; it is costly to administer and juries may make mistakes. Redress is limited to those who can prove that the providers were negligent, and compensation is not available for those whose injuries were caused by the non-negligent practice of medicine. The tort system is useful in other ways, in part because it identifies the magnitudes of harms and, over time, fashions a standard for quality of care. Nevertheless, the high cost of tort cases surely has contributed to malpractice tort reform movements.[3] Because an injured party is often unable to afford a lawsuit to pursue damages, lawyers agree to work under contingency arrangements. Essentially, they receive part of the award, but only if they win the suit. These arrangements might encourage too many lawsuits, although lawyers are unlikely to undertake cases that promise a low award even if won or that have little chance of success, for in such cases they are unlikely to recover their costs. Studies show, however, that the costs of the justice system are not wastefully high.[4] So although litigation is costly and thus may prevent some harmed parties from pursuing compensation for their harms, it also produces otherwise favorable incentives and allows many to seek compensation when no other means is offered.

In addition to the cost of litigation, the medical profession fears its unpredictability, although evidence suggests that outcomes of Texas medical malpractice claims have been stable and reasonable.[5] To the extent that litigation results are unpredictable, dealing directly with litigation issues seems preferable to reducing incentives to sue by reducing damage awards. One proposal recommends special health courts that would deal only with medical malpractice cases, much as certain courts now specialize in patent cases.[6] A dedicated court could utilize the special knowledge needed in malpractice cases, and decisions would systematically accumulate a set of principles to govern them, resulting in more predictable outcomes. They may also lower cost and improve medical care more effectively than tort reform. Undoubtedly, other ways to deal with the problems of litigation should be explored.

To protect themselves against claims of negligence, providers do more than purchase malpractice insurance. They may also order many medical tests in an effort to avoid error, a

step that is made particularly easy when private third-party health insurers pay for the tests.[7] Pursuing excessive protection from negligence claims by unnecessarily testing is known as defensive medicine.

Research by Daniel Kessler and Mark McClellan shows that defensive medicine adds considerably to the cost of health care,[8] and it is reasonable to object, as tort reform supporters do, to costs of defensive medicine. The cost of defensive medicine is used to justify limits on non-economic damages for medical malpractice on the theory that lowered damage awards would reduce the incentive for health providers to order more tests than necessary.[9] Indeed, Kessler and McClellan provide some evidence that lower awards have that effect. But there are other more direct ways to reduce the waste of unnecessary tests. Patients' health insurer's reimbursement schemes encourage testing, and changing the existing basis for health insurance payments would also reduce the practice of defensive medicine. We note here only that the costs of tort litigation and a perversion of medical practice that arises largely from existing health insurance arrangements partly motivated malpractice tort reform.

B. The Political Movement for Malpractice Tort Reform

Medical service providers (doctors, other professional practitioners, and health facilities) purchase medical malpractice insurance to reimburse them for damages awarded because of malpractice.[10] Sharp increases in malpractice insurance fees during the 1970s burdened doctors even though they were able to pass much of this increased cost on to their patients.[11] Physicians, other providers, and their insurance companies joined together to seek lower damage awards. In 1975 the Texas Medical Professional Liability Study, chaired by W. Page Keeton, former Dean of the University of Texas Law School and coauthor of the leading hornbook on torts, reported that insurance rates had indeed risen and offered recommendations to lower them.[12] A main recommendation of the Report was to place an upper limit, or cap, on damage awards.[13] Acting on the report, the Texas legislature passed the Medical Liability and Insurance Improvement Act of 1977 (MLIIA).[14] Among other goals, the MLIIA was enacted to decrease the cost of malpractice insurance by reducing the number and severity of health care liability claims. Accordingly, the MLIIA limited the amounts of civil damage awards for non-economic damages and economic damages other than medical expenses to $500,000, a limit that was to be adjusted for inflation.[15] Although the Report also recommended the creation of a patient compensation fund that would serve as a statutory substitute for the cap on non-economic damages,[16] legislators did not include this in the bill. In the end, the MLIIA's damage caps failed to survive a constitutional challenge and, in 1988, the Texas Supreme Court struck down the liability caps because they violated the "open-court" provisions of the Texas Constitution.[17]

Supporters of malpractice tort reform continued to press for legislative changes.[18] In 2003, buoyed by a redistricting of the state that resulted in a Republican legislative majority,[19] tort reform advocates succeeded in passing a massive bill that altered many aspects of the tort system in Texas. As to malpractice torts, the legislation limited non-economic damage awards and made such cases more difficult to bring to court.[20] The bill also proposed a constitutional amendment, passed by voters as Proposition 12, that overcame the objections of the Texas Supreme Court.[21] We focus on the non-economic damage limitations, but the effect of the procedural hurdles that make it harder to win a malpractice claim should not be underestimated.[22]

The Medical Malpractice and Tort Reform Act of 2003, which Governor Rick Perry called the "most sweeping and comprehensive lawsuit-reform in the nation,"[23] capped total non-economic damages at $250,000 for all providers who are proved negligent. A further cap of $250,000 for each facility, with a limit of two facilities, was included. Thus, the maximum award for non-economic damages ranges from $250,000 to $750,000.

Unlike the damage award caps in the overturned 1977 legislation, the caps of 2003 are set in nominal terms and do not increase to reflect the effects of inflation, so as time passes damage awards will be limited more severely. Compared with $250,000 in 2003, for example, a damage award of $250,000 in 2009 is worth only $216,800 because inflation has reduced the value of $250,000 by more than 15 per cent.[24] Tort reform legislation thus reduces malpractice insurance premiums for doctors, but it does so by reducing damage awards to the patients who are harmed by malpractice, and as there is no adjustment for inflation the value of the maximum damage award will steadily decline over time. The greater point is that the focus on reducing malpractice insurance premiums treats only a symptom of malpractice and does not address the underlying problem of negligent medical treatment.

C. The Limited Scope of Malpractice Tort Reform – Treating Symptoms

The medical malpractice reform movement focused on lowering malpractice insurance rates for health care providers and claimed that lower rates would increase the number of doctors in the state and thus improve medical care. But limits on medical malpractice damage awards do nothing to discourage medical malpractice in the first place. Indeed, by reducing the cost borne by negligent doctors for malpractice, damage award limits might even encourage it.[25] This effect occurs because tort reform reduces the incentive that is created when providers must fully compensate patients for the harms they cause. Capping damage awards for malpractice has the opposite effect, saving doctors from facing the full costs of their negligent actions. This effect is exacerbated because the upper limits of malpractice insurance usually influence the award made, generally by reducing it.[26]

Advocates for malpractice tort reform argue that large damage awards raise malpractice insurance rates. This argument fails to recognize that large awards tend to go to those who are most seriously harmed. Indeed, in rejecting limits on damage awards the Supreme Court of New Hampshire put the trade-off this way: "It is simply unfair and unreasonable to impose the burden of supporting the medical care industry solely upon those persons who are most severely injured and therefore most in need of compensation."[27]

In sum, tort reform was adopted in Texas to pursue a symptom of medical malpractice – high malpractice insurance rates – by reducing compensation to the severely injured. But the reform does nothing to treat the underlying problem of medical malpractice. On the other hand, even advocates for traditional damage awards do not claim such awards are ideal, largely because the litigation and medical care systems, in tandem, foreclose ideal solutions and motivate practices like defensive medicine. Notwithstanding these unintended consequences, the tort system provides a considered estimate of actual harms in specific circumstances and is thus more reliable than an arbitrarily fixed upper limit.

II. Effects of Tort Reform in Texas

Evaluating claims made about the benefits of tort reform is complicated. First, studies that support reform tend to deal with broad tort reforms and their evidence may not apply to malpractice cases, which are our main concern. Second, in the area of medical malpractice, an accurate evaluation requires an

assessment of claimed benefits against the lost compensation to those injured by malpractice. That is, an accurate evaluation requires a comprehensive benefit-cost analysis that has so far not been undertaken.[28] Here, we begin that evaluation by analyzing recent research about the consequence of malpractice tort reform. We separate the research into three categories, (1) effects on costs, (2) effects on the number of doctors in Texas, and (3) effects on insurance payouts.

A. General Claims about Costs

Supporters of general tort reform in Texas have interests well beyond medicine, including for example product liability, so their evaluations include factors that are not related to medical cases. Supporters rely on general studies emphasizing the costs of our tort system, which is more expensive than similar legal procedures in many other countries.[29] They also point out that many public companies have lost substantial sums as a result of tort awards, but they offer no evaluation of the companies' harmful conduct or its effects. Instead, they make general claims about increased productivity, enhanced product innovation, and faster economic growth because of cost savings due to tort reform. The costs of tort cases and their attendant liability are said to hold back the development of risk-reducing products and may even raise accidental death rates that exclude vehicle accidents. Emphasizing these types of costs in the medical malpractice area is misleading, however, because supporters ignore their main use in medical cases of compensating injured patients. Injured patients suffer under medical malpractice tort reform because their compensation is reduced and made harder to obtain, but no account of the lost compensation is included in evaluations of tort reform by its supporters. This point is illustrated by analyzing studies that focus on the overall benefits from tort reform.

It is inappropriate and misleading to focus on such benefits for doctors and insurance companies while ignoring the cost of lost compensation for those harmed by malpractice.

For example, the Perryman study analyzes national studies that found patterns among these many variables and applies the patterns to Texas in order to estimate effects of reductions in litigation costs and other claimed benefits.[30] Outcomes of two simulated conditions are compared for the year 2008, one with and the other without tort reform. Economic benefits of tort reform are claimed through those comparisons, but such claims are misleading for the health area. For medical cases in particular, the claimed reductions in tort costs cannot simply be classed as benefits because their sources are reductions in compensation for injured parties, which are costs to those parties. Counting cost reductions as benefits while ignoring loss in compensation is inherently one-sided. It may be accurate to say that limiting non-economic damages reduced medical malpractice insurance premiums by as much as 50 percent,[31] or that the declines in premiums averaged 21.3 percent.[32] It may also be true that, since malpractice tort reform of 1995, the number of legal cases has dropped substantially.[33] But it is inappropriate and misleading to focus on such benefits for doctors and insurance companies while ignoring the cost of lost compensation for those harmed by malpractice.

In sum, supporters of tort reform focus on limiting damage awards rather than finding an ideal balance between harm and award. Although that ideal balance is mentioned in the Perryman study, along with the goal of efficiency,[34] it consistently treats damage awards as if they were solely costs that do not benefit patients or the economy by fully compensating the injured. To put the issue in the starkest terms, capping non-economic damages in order to lower malpractice insurance rates essentially redistributes money from those harmed by medical malpractice – who under traditional tort rules are entitled to compensation – to medical service providers.

B. The Number of Doctors in Texas

Supporters of malpractice tort reform also claim that the number of doctors practicing in Texas increased markedly after non-economic damage awards were capped in 2003.[35] The evidence, however, is not so clear. Charles Silver, David Hyman, and Bernard Black found no increase in physicians per capita in Texas when they examined effects of the 2003 reforms on the supply of physicians.[36] Data showed a substantial increase in license applications to the Texas Medical Board, but the authors point out that applications for new credentials or even awards of new licenses fail to reveal the number of doctors directly dealing with patients. In particular, if some physicians retired or moved out of Texas, their numbers could offset the number of new physician licenses, and the total number of practicing physicians might even decline.

Silver, Hyman and Black obtained data from the Texas Department of State Health Services that show the number of physicians who provide direct care to patients in Texas.[37] They calculated the number of direct care physicians per capita per year, and found that although that number increased steadily from 1990 to 2003, it remained flat, or constant, between 2003 – the year the legislature adopted damage caps – and 2007. It is possible that the caps on non-economic damages will yet bring an increase in direct care physicians per capita, but so far the data show it has not had any such effect.

To further enrich their analysis, Silver, Hyman, and Black estimated a predictive model for the twenty-two years from 1981 to 2002.[38] They found that Year and Real Texas Gross State Product provided an excellent forecast of physicians, or of physicians per capita. The successful model was then applied to the 2003 to 2007 period, to obtain predictions of physicians and physicians per capita. Actual physicians fell 1,650 *short* of the predicted total for 2007, and 9 physicians per 100,000 population *below* the predicted per capita level. This result indicates that if the same forces that accurately predicted physician numbers through the twenty-two years from 1981 to 2002 had continued into the period from 2003 to 2007, *more* physicians would work in Texas than the number actually observed. Simply stated, it cannot be claimed that the 2003 reforms caused an increase in physicians per capita in Texas.

Supporters of malpractice tort reform also claim large increases in doctors who practice in specialties where malpractice lawsuits are more common, such as orthopedic surgery, obstetrics, or neurosurgery.[39] But Silver, Hyman, and Black show that the sources of data cloud such claims.[40] First, recall that supporters rely for their data on the Texas Medical Board, which counts all doctors in Texas, whereas Silver, Hyman, and Black use the Texas Department of State Health Services data which include only those doctors who are directly involved in patient care. Second,

a change in physician reporting in 2001 allowed physicians to register online, where it is easier to declare specialties, resulting in a general increase in reported specialties that may have had nothing to do with malpractice tort reform.[41] But even when they used the higher numbers of the Texas Medical Board, which probably overstates medical specialists after 2003 due to online reporting, Silver, Hyman, and Black found that the number of doctors in the three high-risk specialties grew no faster than the Texas population from 2003 to 2007.

In 2003, Texas was ranked 40th among the states by the American Medical Association for direct care physicians per capita; in 2006 its rank had fallen to 43rd.[42] Silver, Hyman, and Black suggest that the relative dearth of physicians in Texas may be due in part to the large fraction of the population that is uninsured. At 24.2 percent, Texas has a larger fraction of uninsured citizens than any other state.[43] This fact might even lead to more malpractice lawsuits, if uninsured victims of malpractice lack other means with which to cover their medical expenses. Expanding health insurance coverage might be more effective than malpractice tort reform in improving health care and attracting doctors to Texas.

C. Effects on Insurance Payouts in Texas

Although not examined by supporters of tort reform, nationwide evidence from tort verdicts demonstrates that caps on non-economic damages have markedly reduced medical malpractice insurance payouts.[44] It is not possible to observe directly the Texas experience under award caps because insurance payout data are available only through 2005. Insurance cases can take many years to complete, so there are not enough data after 2003 to compare payouts before and after caps were imposed. Yet we know that award caps can have two kinds of effects: (1) fewer cases are brought because, under capped awards, some cases are not worth bringing, and (2) for cases brought, awards are lower because of the caps.

As to the first effect – a decline in the number of cases brought – a full comparison of the before and after regimes is not yet possible, so it is not possible to assess directly the decline's effect on total payouts. That such a decline has occurred is beyond dispute. The reduction in cases after 1995 is cited by the Perryman study as a benefit of tort reform,[45] and reasons for reductions after the 2003 tort reform are carefully described by Nixon[46] and by Sweeney and Perdue.[47]

David A. Hyman, Bernard Black, Charles Silver, and William M. Sage were able to deal with the second effect by reducing actual damage awards in completed Texas jury trials from 1988 to 2004 to comply with the award caps. By comparing consequent payouts with and without caps, all in 1988 dollars, they estimated tort reform's effect on insurance payouts in Texas.[48] We focus on effects of non-economic damage caps and note, as a starting point, that jury awards for non-economic damages in the period totaled $185,842,000. The authors first applied all other caps to these damage awards (such as limits on punitive damages) and found the total non-economic damage awards were reduced to $162,481,000. Then they applied the non-economic damage award caps. The allowed total of non-economic damage awards then dropped to $43,066,000. Limits on non-economic damage awards thus reduced damage awards by 73 percent.

Actual insurer payouts are even lower than damage awards, however, because successful plaintiffs receive less than adjusted jury verdicts would indicate.[49] The Hyman, Black, Silver, and Sage research shows that actual insurer payouts for non-economic damages over the 1988 to 2004 period, after other caps were imposed, totaled $92,267,000.[50] This insurer payout amount is considerably less than the total damage awards after other caps were imposed of $162,481,000. Indeed, the total payout of $92,267,000 is only 50 percent of the $185,842,000 that juries had originally awarded. After the 2003 non-economic damage award limits were applied, the payouts for non-economic damages fell 62 percent, from $92,267,000 to $35,117,000. This much-reduced payout is only 19 percent of the $185,842,000 that juries originally had awarded. Thus, the reduction in insurer payouts that can be traced solely to the 2003 damage award caps is quite large, especially when compared with original jury awards. If the effects on payouts caused by declines in the number of cases brought could also be analyzed, the total of the lost insurance payouts would almost certainly be even greater.

Hyman, Black, Silver, and Sage also examined settled cases, which are more numerous and involve more dollars than juried cases, although less information is available for them. By applying patterns found for juried cases, the authors estimate that damage caps lower payouts for non-economic damages in settled cases by 38 percent. Their analysis provides much more information, and readers interested in methods and results of the analysis are urged to consult the original paper.[51] The point made here is that damage award limits clearly reduce payouts for settled cases as well as juried cases.

Who bears the greatest burden of these lost insurance payouts? The caps on non-economic damage awards imposed by malpractice tort reform caused a decline in payouts for completed cases of 62 percent, and that is effectively the decline in the *average* payout. Hyman, Black, Silver, and Sage also report that the reduction in the *median* court award for those cases is only 2 percent, which means those in the lower half of awards by size would not have suffered greatly.[52] The burden of lost compensation due to the damage caps is thus borne almost entirely by those who otherwise would have received the largest non-economic damage awards – those in the upper half of jury awards by size. Assuming that juries make reasonably accurate findings, these patients would tend to be the most seriously harmed.[53] The limits on

non-economic damage awards thus have a greater negative effect on those most in need of assistance.

The authors were able to show that greater reductions are experienced by victims in cases that involve death or unemployment, and the elderly and children, although comparisons for these latter two groups were not statistically significant.[54] The data did not include the sex of plaintiffs, so it was not possible for the authors to determine whether women suffer larger losses than men. Other studies have shown that caps on non-economic damages have greater effects on women, children, infants, and the elderly.[55]

In sum, malpractice tort reform may have lowered some apparent costs of the tort system if compensation to those harmed is ignored, which of course it should not be. Nor is there evidence that tort reform has brought a surge of doctors into the state to raise the ratio of doctors per capita, even in specialties that experience more lawsuits. Much of the savings claimed for malpractice tort reform comes from damage award limits that reduce compensation to the most seriously injured. While it lowers apparent costs, reducing compensation to those harmed by malpractice is surely an unfair source of benefit for doctors and hospitals. And malpractice tort reform does nothing to curtail medical malpractice itself.

If patients were well informed, they could choose good doctors and shun bad ones, and their choices would tend to weed poorly performing doctors out of the medical profession.

III. Going for a Cure

High malpractice insurance rates prompted medical professionals to join the malpractice tort reform movement, which won legislated limits on damage awards for malpractice. But how effectively has the medical profession controlled medical negligence, the major reason for its high medical malpractice insurance rates? Bear in mind that narrow self interest can lead generally to tight control within professional groups, as incomes of existing members rise when there are fewer of them. This has historically been accomplished, from the age of medieval guilds, by limiting the number of providers and making entry into the profession difficult.[56] Nevertheless, research shows that although control by professional groups may bear down more on older doctors with larger practices,[57] it does not appear to be harsh and certainly is not excessive.[58] The role of the medical profession in controlling quality in medical service markets is important in large part because information in the market for medical care is so poor.

A. The Problem of Information Disparity

Whether the medical profession should provide more information and guidance to patients is an appropriate question, largely because it is very difficult for patients to obtain relevant information about the quality of care offered by providers. If patients were well informed, they could choose good doctors and shun bad ones, and their choices would tend to weed poorly performing doctors out of the medical profession. In the case of medical care, however, patients do not have adequate information with which to make those decisions. Internet sources mainly provide access information like name, specialty, and addresses, although online sources may provide more information about medical care in the future. At this time, there is only limited publicly available information about doctors who have been subject to lawsuits,[59] and a non-negligent standard of care is not readily available. Indeed, information about doctor quality is so poor that Zagat, a leading guide to restaurants, has teamed with Wellpoint, a medical insurer, to provide such information.[60] Like those it supplies for restaurants, Zagat's review of doctors will be based on customer-patient evaluations. Doctors complain, with some justification, that patient evaluations may not properly assess doctor quality. To the extent doctors are correct in this judgment, however, it only underscores the point that market mechanisms – such as market responses to negative information – do not work in this context because of the absence of evaluative information about the quality of medical care. Thus, we must turn to indirect substitutes for such information.

B. Gate-Keeping by Physicians

Research reveals that one substitute for patient information results from the design of fee-for-service health insurance plans.[61] Included originally to certify the need for a specialist, physician gate-keepers in these plans are better able than patients to evaluate qualified specialists. Gate-keepers are likely to know which doctors have troubling records, and they are unlikely to recommend them to their patients. Referring physicians' incentives to find good solutions for their patients reward high quality specialists by sending them more referrals. So even without other remedies, the insurance mechanism under fee-for-service principles can move patients toward higher quality medical service providers.

In their study of medical referrals, Gary Fournier and Melayne McInnes also noted that HMO managed-care systems do not allocate patients to doctors as effectively as traditional fee-for-service systems.[62] Perhaps because HMOs have stronger incentives to cut costs, they do not shun doctors who have had malpractice claims as thoroughly as fee-for-service systems do, with the result that lower quality doctors may still obtain HMO referrals.

C. Medical Licensing Boards

A second substitute for information is action by a state medical board, which is responsible for regulating the standard of care, to provide the public with accurate evaluations of medical service providers. The medical boards should make their evaluations public. They should also increase disciplinary actions against negligent doctors and curtail their practices if necessary to preserve the quality of physician services.[63] Professionally disciplining poorly performing doctors directly attacks the problem of medical malpractice. Discipline by a state medical board also has indirect effects that may reduce incidences of malpractice. Disciplinary actions can raise the costs faced by poorly performing physicians by reducing the number of patients they attract, thereby lowering their incomes. The threat of medical board sanctions and lower income provides incentives to doctors and other providers to take more care, which in turn benefits all patients.

The record shows, however, that medical licensing boards, across the states and over time, have only weakly regulated physician effectiveness. Based on a large sample of medical board disciplinary actions in Florida, Gary M. Fournier and Melayne Morgan McInnes found few instances of Medical Board censure.[64] In the most egregious cases, where awards exceeded one million dollars, only 16 percent of the involved physicians were penalized by the Florida Medical Board, and those penalties were seldom severe. The Texas Medical Board

ranks 33rd in the country for the number of disciplinary actions per doctor.[65] This record is slightly better than Florida's but is still well below the average number of disciplinary actions for all states, which itself has declined 22 percent since 2004. One possible explanation for so few disciplinary actions is a view that all doctors face the same risk of negligently practicing medicine, and it therefore seems arbitrary for individual doctors to be sanctioned for a malpractice event. But the evidence indicates otherwise, and shows that, given doctors' records, experience rating of malpractice insurance is entirely feasible.[66] Experience rating by insurers is thus a promising alternative that merits further discussion.

D. Experience-Rated Malpractice Insurance

Malpractice insurance serves two functions: (1) it provides compensation to those harmed by malpractice, and (2) it discourages malpractice by penalizing service providers who are negligent and cause harm. Under experience rating, doctors with more malpractice claims against them pay more for insurance, just as motor vehicle drivers with more accidents do, and this added cost will discourage medical negligence. Fournier and McInnes show from Florida data that a doctor's past record of malpractice events is a good predictor of that doctor's future events, because from a malpractice standpoint some doctors are simply better than others.[67] This makes it possible to base insurance premiums on doctor experience so doctors with poorer records pay more for insurance. In states where malpractice insurance is not experience rated, insurance premiums are quite uniform across all doctors, so high-quality doctors pay high premiums even though they have fewer malpractice events. Doctors who have better records effectively subsidize those who perform poorly. It is unfortunate that malpractice tort reform focused on lowering malpractice insurance premiums, because damage award limits only make malpractice appear less costly than it really is. The resulting distortions in insurance costs lower premiums for negligent doctors and thereby reduce their incentive to avoid malpractice.

Many insurance companies in Texas use experience rating, but their premiums to negligent physicians do not rise as sharply as they should because, in limiting the damage awards that go to those harmed, tort reform has made insuring negligent doctors less costly. By making malpractice seem less costly, damage limits distort the application of experience rating. How can this distortion of medical malpractice insurance rates – caused by malpractice reform – be overcome? Raising the level of damage award caps would reduce the distortion in rates, and the higher the caps the less the distortion. But note that with no adjustment for inflation, the value of present damage award limits will decline as time passes, and insurance rate distortions under experience rating will have ever larger effects.

A more direct way to avoid distorting experience rating is to eliminate caps on damages, which would make experience rating a more effective tool in pricing malpractice insurance and thus penalize negligent doctors. Of course this step would undercut the aim of the reform movement, which was to reduce malpractice insurance rates. But insurance rates that reflect the true costs of negligent doctors would impose greater penalties on them and motivate a reduction in malpractice, while premiums for high-quality doctors might not change much at all. By lowering *all* insurance rates of all doctors, damage caps and other reforms prevent negligent doctors and their insurers from facing the full costs of the harms they cause, and that circumstance has to be remedied if medical malpractice is to be discouraged. The main point is that tort reform seriously distorts experience-rated malpractice insurance rates. To return incentives to their proper levels, especially for negligent doctors, the rates should reflect the full costs of harms caused.

Conclusion

Lowering medical malpractice insurance premiums for doctors and other service providers through tort reform has not benefitted patients in Texas. The reforms attack malpractice insurance costs, which are a symptom of medical malpractice, by limiting damage award payments to those patients who are harmed by malpractice. But the reform ignores the genuine, and more fundamental problem of medical malpractice, and can even be said to encourage it by reducing the cost to doctors of negligence. Full experience rating of malpractice insurance – without any award limits – is a more effective way to reduce malpractice. By imposing damage award limits, tort reform distorts experience-rated insurance premiums, lowering them especially for more negligent doctors. Corrections to experience-rated malpractice insurance premiums and stronger Medical Board actions are both urgently needed now that tort reform has weakened control over medical malpractice in Texas. Medical boards should provide information to the public about provider quality and take action against problem doctors. In addition to medical board action and effective experience rating of insurance, a special medical court might also improve the handling of medical malpractice cases.

In considering such improvements, it is important to use results of research on the consequences of malpractice tort reform and their possible remedies, so we can reject political solutions that are not as effective as options for treating medical malpractice that are based on evidence. Currently, research points not to a single solution, but to a combination of alternatives. At a modest level, the non-economic damage cap should be adjusted upward from $250,000, and inflation adjustment is certainly in order to prevent the cap from constantly growing smaller. More importantly, attention should move beyond malpractice insurance fees and focus on malpractice itself.

* Roger Sherman is Emeritus Professor of Economics at the University of Houston and the University of Virginia. Geraldine Szott Moohr is Alumnae Law Professor at the University of Houston Law Center. The authors gratefully acknowledge the thoughtful comments of Seth Chandler, Gary Fournier, and Rich Saver, the help of Mon Yin Lung, Associate Director of the University of Houston Law Center Library, and the help of our student research assistant, Aaron Reis. Professor Moohr thanks the Law Center Foundation for continued support of her research.

1 *See* W. Page Keeton, et al., Prosser & Keeton on the Law of Torts (5th ed. 1984).

2 Lucas v. United States, 575 S.W.2d 687, 690 (Tex. 1988).

3 *See* Joseph M. Nixon, *The Purpose, History and Five Year Effect of Recent Lawsuit Reform in Texas*, 44 Advoc. 9, 9-10 (2008).

4 See Charles Silver, *Does Civil Justice Cost Too Much?*, 80 Tex. L. Rev. 2073 (2002) (concluding that the civil justice system is reasonably efficient).

5 *See* Bernard S. Black, et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002*, 2 J. of Empirical Legal Stud. 207 (2006); David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 Vand. L. Rev. 1085 (2006).

6 *See* Philip K. Howard, *Just Medicine*, N.Y. Times, April 2, 2009, at A27. There is no shortage of suggestions for reform. *See, e.g.*, Patricia M. Danson, *Tort Reform: The Case of Medical Malpractice*, 10 Oxford Rev. of Econ. Pol'y 84 (1994).

7 For instance, testing can increase the income of providers because insurance companies reimburse doctors at a higher rate for medical tests than for some medical procedures. For an analysis of health providers' financial incentives, see Richard S. Saver, *Squandering the Gain: Gainsharing and the Continuing*

Dilemma of Physician Financial Incentives, 98 Nw.U.L. Rev. 145, 157 (2003) (noting that Medicare's reimbursement scheme "has tended to increase fees for evaluation/management services at the expense of procedure-based services").

8 *See* Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q. J. of Econ. 353 (1996).

9 *See id.* at p. 388.

10 For a classic description of malpractice insurance see Frank A. Sloan, Randall R. Bovbjerg, & Penny B. Githens, Insuring Medical Malpractice (1991).

11 *See* Patricia M. Danzon, Mark V. Pauley, & Raynard S. Kington, *The Effect of Malpractice Litigation on Physician's Fees and Incomes*, 80 Am. Econ. Rev. 122 (1990).

12 Tex. Med. Prof. Liability Study Com., Final Report of the Texas Medical Professional Liability Study Commission to the 65th Texas Legislature (1976).

13 *See* Lucas v. United States, 575 S.W.2d 687, 691 (Tex. 1988) (commenting on the Keeton Report). For commentary on the legislative efforts, see the supplemental issue of the Texas Tech Law Review, Michael S. Hull, et al., *House Bill 4 and Proposition 12: An Analysis with Legislative History*, 36 Tex. Tech L. Rev. 2 (2005) [hereinafter *House Bill 4 and Proposition 12*]. For an excellent collection of recent, conflicting commentary on the effects of that legislation, see *Symposium: Five Year Retrospective on House Bill 4*, 44 Advoc. 1 (2008).

14 *See* Act of May 30, 1977, 65th Leg., R.S., Ch. 817, 1977 Tex. Gen. Laws 2039.

15 *See House Bill 4 and Proposition 12*, *supra* note 13, at p 4.

16 *See* Lucas, 757 S.W. 2d at 691 (noting that Indiana and Louisiana had created such funds when they adopted damage limitations).

17 *See id.* at 690 (holding that limitations on non-economic damages were "unreasonable *and* arbitrary" and unconstitutionally limited plaintiff's right of access to the courts for a "remedy by the due course of law" under Article I, Section 13 of the Texas Constitution).

18 For instance, legislation enacted in 1995 provided several procedural rules whose aim was to reduce the number of cases filed. *See* 65th Leg., R.S., ch. 817, 1.02, 1977 Tex. Gen. Laws 2040, 2041 (codified at Tex. Rev. Civ. Stat. Ann. Art. 4590i) (currently at Tex. Civ. Prac. & Rem. Code Ann. §§ 74.001 et seq.).

19 *See* A. Craig Eiland, *A Word from the Opponents*, 44 Advoc. 22, 22 (2008) (emphasizing the political agenda of supporters of reform).

20 The 2003 legislation requires plaintiffs to submit the report of an expert, defined as a practicing physician in the same or similar field as the defendant, within 120 days of filing suit that clearly states the provider violated the standard of care. Failing to do so results in dismissal with prejudice. *See* Nixon, *supra* note 3, at 15 (recounting imposition of numerous controls).

21 *See The Medical Malpractice and Tort Reform Act of 2003: Hearings on Tex. H.R.J. **3** Before the Senate Affairs Comm.*, 78th Leg., R.S. (May 13, 2003). The amendment passed both houses of the Texas legislature in June, 2003, and the constitutional amendment was approved by voters in September, 2003. *See* Janet Elliot, *To Amend? The Propositions: Lawsuit Caps Win in a Squeaker*, Hous. Chron., Sept. 14, 2003, at A1.

22 *See generally* Paula Sweeney & Jim M. Perdue, Jr., *HB4 – Medical Malpractice – Plaintiff's Perspective*, 44 Advoc. 42 (2008) (providing judicial interpretations of procedural limitations that generally favor defendants).

23 *See* Seyfarth Shaw, *Texas Tort Reform – Highlights of the Omnibus Civil Justice Reform Act*, July 11, 2003, http://www.seyfarth.com/dir_docs/news_item.

24 *See* Bureau of Labor Statistics, Price Calculator, http://www.bls.gov/data/inflation_calculator.htm.

25 There is some evidence that better health care is associated with greater risks of being sued, although the relation is weak across a large sample of cases. *See* David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the United States: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 Cornell L. Rev. 893 (2005). Nevertheless, evidence from specialized areas, like anesthesia, shows that the threat of damage awards induces changes in practices that lead to significant improvements in health outcomes. *Id.* Indeed, medical errors may be due to faults in systems that are beyond the control of individual providers. But, analogous to the anesthesia example, the incentive of malpractice awards can motivate solutions to systemic flaws. For discussion of system complexities, see the important Institute of Medicine report, *To Err is Human: Building a Safer Health System*, Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds., http://www.nap.edu/openbook.php?isbn=0309068371.

26 *See* Kathryn Zeiler, et al., *Physicians Insurance Limits and Malpractice Payments: Evidence from Texas Closed Claims, 1990-2003*, 36 J. of Legal Stud. S9 (2007); *see also* Charles Silver, et al., *Malpractice Payouts and Malpractice Insurance: Evidence from Texas Closed Claims, 1990-2003*, *in* 33 Geneva Papers on Risk and Insurance 177 (2008).

27 *See* Carson v. Maurer, 424 A.2nd 825, 837 (N.H. 1980), *overruled on other grounds*, Community Resources for Justice v. Manchester, 917 A.2d 707 (N.H. 2007).

28 For the basics of benefit-cost analysis, see E.J. Mishan, Cost-Benefit Analysis: An Introduction (1971).

29 *See* The Perryman Group, Texas Turnaround: The Impact of Lawsuit Reform on Business Activity in the Lone Star State (2008) (reporting that administrative costs and attorneys' fees have been estimated at about 40 percent of our tort system costs).

30 *See id.*

31 *See* Am. Tort Reform Found., Judicial Hellholes, 2006 (2006), http://www.atra.org/reports/hellholes/.

32 *See* David Hendricks, *Insurance Companies, Doctors Flock to Texas*, San Antonio Express News, June 1, 2007, at D1.

33 *See* Perryman, *supra* note 29.

34 *See id.*.

35 *See* Hugh Rice Kelly, *House Bill Four After Five Years: Business Perspective*, 44 Advoc. 35, 39 (2008) (quoting the executive director of the Texas Medical Board); Hendricks, *supra* note 32. An element of the savings from tort reform cited by Perryman, *supra* note 29, at 25, depends on an increase in the number of doctors.

36 *See* Charles Silver, David A. Hyman, & Bernard S. Black, *The Impact of the 2003 Texas Medical Malpractce Damages Cap on Physician Supply and Insurer Payouts: Separating Fact from Rhetoric*, 44 Advoc. 25 (2008); *see also* David A. Hyman, Bernard S. Black, Charles Silver, & William Sage, *Estimating the Effect of Damage Caps in Medical Malpractice Cases: Evidence from Texas*, 1 J. of Legal Analysis 355 (2009).

37 *See* Silver, Hyman & Black, *supra* note 36. The count of physicians who give direct care excludes fellows, teachers, administrators, researchers, federal, military, retired or those otherwise not available to the general population.

38 *See id.*

39 *See* Howard Marcus & Bruce Malone, *2003 Reforms Helping Doctors Do Their Work*, Austin American Statesman, April 10, 2006, http://www.tortreform.com/node/220; Perryman, *supra* note 29.

40 *See* Silver, Hyman, & Black, *supra* note 36, at p. 28.

41 *See id.* Silver, Hyman and Black show that doctors declaring no specialty averaged 2 percent from 1997 to 2003, when it began to decline, and then fell to 1 percent in 2004 and close to ½ percent after that, an indication that more specialties were being claimed, probably as a result of the change to on-line reporting. *Id.*

42 *See id.*

43 *See id.*; Sweeney & Perdue, *supra* note 22, at 52 (over 5.5 million Texans do not have health insurance, placing Texas "dead last" among the states).

44 *See* Patricia Born, W. Kip Viscusi, & Tom Baker, *The Effects of Tort Reform on Medical Malpractice Insurers' Ultimate Loses*, 76 J. Risk & Ins. 197 (2009).

45 *See* Perryman, *supra* note 29.

46 *See* Nixon, *supra* note 3.

47 *See generally*, Sweeney & Perdue, *supra* note 22.

48 *See* David A. Hyman, Bernard Black, Charles Silver, & William M. Sage, *Estimating the Effect of Damage Caps in Medical Malpractice Cases: Evidence from Texas*, 1 J. of Legal Analysis S9 (2009) (analyzing cases with payouts of more than $25,000 in 1988 dollars).

49 *See* David A. Hyman, et al., *Do Defendants Pay What Juries Award? Post-Verdict Haircuts in Texas Medical Malpractice Cases*, 4 J. of Empirical Legal Stud. 3 (2007) (showing that actual insurance payouts are considerably smaller than damage awards).

50 *See* Hyman, Black, Silver, & Sage, *supra* note 48.

51 *See id.*

52 *See id.*

53 *See* Black, et al., *supra* note 5.

54 *See id.*; *see also* Jeff Watters, Comment, *Better to Kill than to Maim: The Current State of Medical Malpractice Wrongful Death Cases in Texas*, 60 Baylor L. Rev. 749 (2008) (reviewing effects of tort reforms in wrongful death cases).

55 *See*, *e.g.*, Lucinda M. Finley, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 Emory L.J. 1263, 1280-1312 (2004) (analyzing data from Maryland, California, and Florida). Women, children, and the elderly, whose estimated lost future wages may be low or hard to determine, depend more heavily on non-economic awards to make them whole. *Id.*

56 *See* Avner Shaked & John Sutton, *The Self-Regulating Profession*, 48 Rev. of Econ. Stud. 217 (1981).

57 *See* Gary M. Fournier & Melayne Morgan McInnes, *Medical Board Regulation of Physician Licensure: Is Excessive Malpractice Sanctioned?* 12 J. of Reg. Econ.113 (1997) (providing evidence of the effectiveness of medical boards).

58 *See* Harris County Medical Society, *HCMS Advocacy: Texas Medical Board* (2008), http://www.hcms.org/Template.aspx?id=131; *see also* Roberto Cardarelli & John C. Licciardone, *Factors Associated with High Severity Disciplinary Action by a State Medical Board*, 106 J. Am. Osteopath Assoc. 153 (2006), http://www.jaoa.org/cgi/content/full/106/3/153.

59 *See e.g.* http://www.ratemds.com. (providing simple one-dimensional information rating system). Advice on searching for doctors' malpractice records is increasingly available. *See e.g.*, Trisha Torrey, *How to Find a Doctor's Medical Malpractice Track Record*, About.com. Dec. 30, 2008, http://patients.about.com/od/doctorinformationwebsites. Unfortunately, a National Practitioner Data Bank that contains information about malpractice claims is not available to the public. *See* http://www.npdb-hipdb.hrsa.gov/npdb.html.

60 *See* Milt Freudenheim, *Noted Rater of Restaurants Brings Its Touch to Medicine*, New York Times, Feb. 16, 2009, at B1.

61 *See* Gary M. Fournier & Melayne Morgan McInnes, *The Effects of Managed Care on Medical Referrals and the Quality of Specialist Care*, 50 J. of Indus. Org. 457 (2002).

62 *See id.*

63 The Texas Medical Board has been the subject of criticism. *See* AAPS, *Doctors Sue Medical Board for Misconduct*, Assoc. of Am. Physicians and Surgeons, Inc., News of the Day, Dec. 21, 2007, http://www.aapsonline.org/newsoftheday/004.

64 *See* Fournier & McInnes, *supra* note 57 (providing evidence of the effectiveness of medical boards).

65 *See* Sidney M. Wolfe & Kate Resnevic, *Public Citizen's Health Research Group Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2006-2008*, http://www.citizen.org/publications/print_release.cfm?ID=7652; Cheryl W. Thompson, *Jurisdictions Rated on Doctor Discipline*, Wash. Post, April 21, 2009, at B3; Cardarelli & Licciardone, *supra* note 58.

66 *See* Gary M. Fournier & Melayne Morgan McInnes, *The Case for Experience Rating in Medical Malpractice Insurance: An Empirical Evaluation*, 68 J. of Risk & Ins. 255 (2001); *see also* Frank A. Sloan, *Experience Rating: Does It Make Sense for Medical Malpractice Insurance?*, 80 Am. Econ. Rev. 128 (1990).

67 *See* Fournier & McInnes, *supra* note 66