ABSTRACT

Tort reform has been a hot topic among those interested in assessing whether and how well the tort system aids injured plaintiffs in achieving civil justice. The debate has been especially heated when it comes to medical malpractice liability. Until recently, rhetoric about the liability system and its relationship to insurance markets and physician supply dominated tort reform debates. While claims made by both proponents and opponents can seem intuitive, they are often unsubstantiated. In recent years, however, academics and others have acquired or created datasets to perform analyses to enhance our understanding of the relationship between the tort system and insurance markets. Such studies have helped shift tort reform debates away from rhetoric and toward inferences drawn from facts. While our ability to assess rhetorical claims has been limited given lack of access to private settlement data, recently discovered datasets collected by state insurance departments have provided a window into settlement outcomes, along with a variety of other features of the liability system and insurance markets. Instead of supporting the claims made by those who blame medical malpractice liability system crises for rising insurance premiums, recent results using closed claims data suggest we might instead be facing a potentially worsening patient compensation crisis.

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INTRODUCTION

Tort reform has been a hot topic among those interested in assessing whether and how well the tort system aids injured plaintiffs in achieving civil justice. The debate has been especially heated when it comes to medical malpractice liability. Proponents of malpractice liability reforms—reforms such as damages caps and shifts from joint and several liability to proportionate liability—argue that the broken and out-of-control liability system is error-prone and produces too many jumbo verdicts. The huge and highly variable awards, the argument goes, cause medical malpractice insurers to increase premiums, leading to an increase in the cost of health care and the number of uninsured and a decrease in the number of physicians willing to practice in certain jurisdictions sometimes labeled “judicial hell holes.”

Tort reform opponents, on the other hand, argue that limitations on recovery or access to the tort system violate constitutional rights, that some reforms do more harm than good (e.g., damages caps might make it difficult for a subset of negligently injured plaintiffs to find a lawyer willing to pursue a legal claim on a contingency fee basis), and that the liability system is not the cause of insurance premium spikes and therefore reforms do not stabilize premiums, at least in the long run.\(^1\) Some opponents further argue that the unreformed tort system does not do enough to compensate negligently injured patients.\(^2\)

Until recently, rhetoric about the liability system and its relationship to insurance markets and provider supply dominated tort reform debates. While claims made by both proponents and opponents in some cases seem intuitive, they often are unsubstantiated. In recent years, however, academics and others have acquired or created datasets to perform analyses with the purpose of enhancing our understanding of the relationship between the tort system and insurance markets. Such studies have helped to shift tort reform debates away from rhetoric and toward inferences drawn from facts reported in empirical studies.

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1. We might expect short term decreases in premiums if insurers expect reduced losses. If reforms do not, in fact, reduces losses, however, insurers are forced to increase prices to compensate for short-term under-pricing.

While empirical research has been useful in shifting debates from rhetoric to reality, our ability to observe the impact of the liability system on important outcomes, and the impact of changes to legal rules on the liability system, is substantially limited in many contexts by the inability to observe settlement outcomes. The vast majority of medical malpractice cases are resolved through private settlements between medical malpractice insurers, providers and patients. Recently discovered datasets, however, collected by state insurance departments have provided a window into settlement outcomes, along with a variety of other features of liability systems and insurance markets. Using these datasets we have been able to estimate, for the first time in some cases, comprehensive trends in the number of claims and size of payouts over time, the potential impacts of tort reform on recoveries, the connections between policy limits and payouts, trends in purchases of coverage over time, and trends in defense costs.

The Texas Department of Insurance (TDI) was one of the first to collect and make publically available claims-level data on closed medical malpractice claims. TDI began collecting and reporting data on closed claims in the late 1980s, following a sharp rise in medical malpractice

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insurance premiums. When a Texas insurer closes a medical malpractice claim, it is required to report information about litigation outcomes, timing of litigation procedures and outcomes, payments, patient characteristics, location in which the injury occurred, jurisdiction of the lawsuit, and types of other defendants and payments made by each. During the period 1988-2005, Texas insurers filed roughly 16,000 reports related to closed medical malpractice claims.

Datasets like the one TDI generates and distributes allow us to better assess the liability system’s ability to deliver just outcomes. It also allows us to verify or challenge claims made by proponents and opponents of tort reform, assess the impacts of tort reform on important outcomes, and better understand the relationship between the liability system and insurance markets. Instead of supporting claims made by those who blame medical malpractice liability system crises for rising insurance premiums, results using closed claims data, when taken as a whole, suggest we might instead be facing a patient compensation crisis.

This Essay is organized as follows. Part I summarizes the rhetoric common in tort reform debates that places blame for rising premiums on the liability system and touts tort reform as the cure-all for ailing insurance markets. It then summarizes results produced using Texas

7 See Black et al., supra note 4 (describing the data collected by the Texas Department of Insurance (TDI)). Description of the data in the text is attributed to Black, et al. unless otherwise indicated. A “claim” in this context is a request by an insured provider for indemnification for a loss incurred (or expected loss) from an insured peril. See Texas Department of Insurance, Texas Closed Claim Reporting Guide (2004) [hereinafter Reporting Guide] (on file with author). Claims filed by the insured are not always accompanied by the filing of a lawsuit. A claim is considered closed when the insurer has made all indemnity and expense payments on the claim. See id. TDI has audited the data for completeness and accuracy (but only for some variables) since 1990. Black et al. exclude 1988-89 when reporting number of claims due to potential incompleteness.
8 See Reporting Guide. TDI does some work to audit reports. See Black et al., supra note 4, for details.
9 The data TDI collects varies according to the size of the total known payment to the claimant by all defendants. For claims with payments between $0 and $24,999, insurers are not required to report the cause of the injury; therefore, separating medical malpractice claims from other types of claims is impossible. For this reason, most results are produced using only “large” claims—those with total payments of at least $25,000.

In addition, TDI does not adjust the reporting threshold from year to year. Therefore, the number of claims reported as large claims will increase over time in part due to inflation. To control for this, we exclude claims with payouts measured in 1988 dollars that fall between $25,000 (nominal) and $25,000 (1988 dollars). For example, we excluded all claims closed in 1989 with payouts between $25,000 and $26,205 (buying power of $25,000 in 1988 dollars).
closed claims data (and other data), which suggest not only that Texas tort reform advocates wrongly placed blame on the liability system but also that non-economic damages caps passed in 2003 cause more harm than good. Part II describes results that suggest that the widely utilized tactic of pointing to jumbo jury verdicts to justify tort reform is misguided. While verdicts and payouts are positively correlated, patients (and their lawyers) recover only 56 cents of each dollar awarded on average. In addition, the larger the verdict, the lower the fraction paid. While judicial oversight and damages caps explain about a third of the difference between verdicts and payouts, the largest chunk of the difference is explained by the fact that patients rarely recover more than the provider’s insurance policy limits. This, coupled with the fact that coverage purchased by Texas physicians is lower than conventional wisdom would predict and is on the decline, is cause for concern. The data paint a picture not of a liability system crisis but of a patient compensation crisis—one that might severely limit the ability of the liability system to deliver civil justice to negligently injured patients.

I. THE TORT REFORM DEBATE

In 1999, Texas medical malpractice insurers started to sharply increase insurance premiums.\textsuperscript{10} Some insurers continued to increase rates through 2003.\textsuperscript{11} Proponents of tort reform argued that an out-of-control liability system was causing the sudden and sharp premium increase.\textsuperscript{12} Specifically, they maintained that the number of claims and size of payments were on the rise, that juries were increasingly handing down outrageously large verdicts that necessitated giant payments by medical malpractice insurers, who had no choice but to increase premiums. They also claimed that the broken liability system regularly and handsomely rewarded sympathetic plaintiffs who brought frivolous claims.

In 2003, the Texas legislature passed a tort reform package, including caps on non-economic damages, in an effort to address the

\textsuperscript{10} Black et al., \textit{supra} note 4, at 224 (Figure 1).
\textsuperscript{11} \textit{Id.}
\textsuperscript{12} Texas Urgently Need Tort Reform to Avert Further Damage to Health Care System, \url{http://www.tortreform.com/node/173} (last visited July 13, 2009); Eric Torbenson and Jason Roberson, Are Texas’ Malpractice Damage Limits Healthy?, \textit{The Dallas Morning News}, \url{http://www.dallasnews.com/sharedcontent/dws/bus/stories/061707dnbusmedmal.3ce4922.html} (last visited July 13, 2009).
perceived insurance and tort system crisis. During the run-up to passage, supporters claimed, “[c]apping non-economic damages at reasonable limits would encourage insurers to do business in Texas by ensuring that they would not incur massive losses because of large damage awards.” Some went further to argue that public resources were at stake. Texas Senator Deuell argued during floor debate that “[w]hen noneconomic damages are excessive, it’s really not the defendant . . . that pays. It’s the other people who pay into the insurance plans.” Deuell went on to assert that taxpayers ultimately pay for excessive awards.

While rhetoric often takes center stage in tort reform debates, recent compilation and dissemination of comprehensive datasets on closed medical malpractice insurance claims has allowed us to observe actual trends in medical malpractice litigation and get a better handle on the relationship between the liability system and insurance markets. Empirical analyses of Texas closed claim data have helped to evaluate whether trends in the liability system actually justified the non-economic damages cap passed in Texas and whether and how the cap might impact litigation outcomes. The studies suggest that much of the rhetoric missed the mark.

A. Did Conditions Warrant Caps and Other Reforms?

The Texas closed claims data have been used to test multiple claims made by tort reform proponents. With respect to the number of claims, the data do not support rhetoric regarding steep upward trends in the number of medical malpractice claims prior to the passage of the statutory non-economic damages cap. Instead, the data demonstrate that the per capita claims rate was stable from 1990-2002. Whether growth rates are measured using total number of claims per year, number of large paid claims, or percentage of claims that resulted in large payouts, the conclusion is the same: no increase in the number of large paid claims

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13 2003 Tex. Sess. Law. Serv., 78th Leg., ch. 204, § 10.01, eff. Sept. 1, 2003. In addition to caps on non-economic damages, the tort reform package included other provisions meant to reduce expected liability (e.g., modifications to joint and several liability rules and possibility of periodic payments). See Ronen Avraham, Database of State Law Tort Reforms (DSTLR 2nd) 116-18 (Northwestern Univ. Sch. of Law, Law & Econ. Research Paper No. 06-08, 2006).


16 Id.

17 Bernard Black et al., supra note 4, at 231 (Figure 4).
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over time. In fact, the number of large paid claims appears to decrease when we control for changes in the number of practicing physicians or growth in inflation-adjusted health care spending. Both the number of claims with payments of less than $10,000 and with payments between $10,000 and $25,000 appear stable over time.

How about claims related to payment size prior to the passage of the 2003 damages cap? Do the data support claims that payment size was skyrocketing during the late 1990s and early 2000s? Again, the empirical results suggest these claims were greatly exaggerated. Despite the variability and possible increase in the average pro-plaintiff verdict from 1988-2002, payouts per claim were either relatively stable or increased only slightly. After controlling for the increase in health care costs (a significant component of amounts paid to injured patients), average payouts are either stable or declining over time. Defense costs per large paid claim increased over the period, but did so gradually. In addition, defense costs comprise only a small fraction of payout dollars. Total cost (including inflation-adjusted indemnified amounts and defense costs) for all large paid claims as a percentage of Texas gross state product was roughly flat over 1990-2002. Thus, the gradual increase in total costs during the late 90s likely is explained by a predictable increase in medical costs, not an out-of-control liability system.

These results, taken together, suggest that the data do not support claims made about the state of the medical malpractice liability system in Texas used to justify tort reform. Closed claims data suggest little

18 Id. Adjusting for population growth, number of physicians and health care spending allows us to control for changes in claims rates due to changes in the number of Texas residents. Id. It’s important to control for changes in these variables because, if we find that claim rates increase because (for example) the population increased, we would not characterize the claims rate increase as a crisis. It’s something we would expect.

19 Id. (Figures 4 and 8).

20 Bernard Black et al., supra note 4, at 234 (Figure 5).

21 Id. at 249-51.

22 Id. at 238 (Figure 9). Note that, while median payouts remained stable from 1996 to 2000, the mean payout increased from roughly $280,000 to $360,000 (29%). Insurance premium increases, however, far out paced this increase.

23 Bernard Black et al., supra note 4, at 237-41.

24 Id. at 243 (Figure 11).

25 Id. at 245. Data on zero payout and small payout claims is unavailable; therefore, it is impossible to estimate the change in total defense costs over time. The authors, however, cast doubt on the possibility that defense costs caused the sharp premium increases. Id.

26 Id. at 248 (Figure 13).

27 Id. at 248.
connection between the liability system and premium fluctuations contrary to tort reform proponents’ assertions.\(^{28}\)

If a broken liability system was not behind the sharp increase in insurance premiums during the late 90s and early 2000s, what was? One possibility is that increases were the unintended consequence of price regulations imposed from 1995-1998. When Texas passed its 1995 tort reform package, it also imposed a three-year mandatory insurance premium reduction to ensure that predicted savings insurers would enjoy would be passed on to health care providers.\(^{29}\) Sharp price increases began in 1998, the same year Texas lifted price reduction mandates. The timing is consistent with the theory that tort reform did not work as well as expected to reduce losses, and insurers were forced to increase rates substantially to replenish their reserves hit hard by below-cost pricing following tort reform.\(^{30}\) Black et al. posit additional alternative explanations, including contemporaneous shocks to reinsurance markets and the long-tail nature of medical malpractice claims.\(^{31}\) Further study is required to uncover the cause of price increases in Texas.

While data limitations might hinder our ability to draw definitive conclusions regarding whether the liability system is responsible for the sharp increase in premiums (e.g., unobservable defense costs and/or the impacts of the liability system on certain specialists might justify tort reform\(^ {32}\)), empirical studies are helpful in shifting the debate away from rhetoric and toward reality. Analyses of this kind can help to shift the burden of proof to tort reform proponents, compelling them to back up their claims with empirics when possible. As the next section demonstrates, empirical studies can also help to determine whether tort reforms succeed.

\(^{28}\) Black et al. note that, because data on open claims is unavailable, premium increases might in fact be due to an increase in the number of claims or an increase in expected payouts on open claims. See id. at 210. While the data employed in their study cannot rule out this possibility, the authors argue it is unlikely. Id. at 210, 218-19. In any event, this hypothesis will be testable as open claims close and reports are filed with TDI.

In addition, TDI does not collect data on physician specialty. Therefore, the data cannot be used to study connections between the liability system and insurance markets for subsets of physicians that are particularly hard hit by insurance price increases (e.g., obstetricians). Despite this limitation, the data are useful for debunking more general rhetorical claims.

\(^{29}\) Texas Insurance Code, Article 5.131 (effective Sept 1. 1995; repealed April 1, 2007).

\(^{30}\) Bernard Black et al., supra note 4, at 254. I am currently constructing a multi-state dataset to investigate this conjecture.

\(^{31}\) Bernard Black et al., supra note 4, at 253-54.

\(^{32}\) Texas does not require reporting of defense costs when small payouts are made. It also does not require insurers to report the provider’s specialty.
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B. Have Reforms Met Their Intended Goals?

In debates over whether to reform the liability system in an effort to stem the rise of medical malpractice insurance premiums, rhetoric about the potential impacts of tort reform is as common as rhetoric about the out-of-control liability system. Proponents of tort reform point to evidence (often produced by industry players with an interest in the outcome of the debate) suggesting that damages caps, limitations on joint and several liability, collateral source rule reform, tightening of statutes of limitations and other reforms have a substantial impact on medical malpractice insurance premiums.

Recent studies, however, have demonstrated fairly convincingly that tort reforms do not work well to substantially reduce insurance premiums. Empiricists have investigated the impacts of various tort reforms on claim rates, average payouts and insurance premiums. The results, some of which are summarized below, suggest that reforms have little to no impact on outcomes, with the most restrictive damages caps having the greatest impact. 33

While some evidence suggests that joint and several liability limitations are associated with lower premiums, 34 other results suggest they do not decrease payouts. 35 Although, to my knowledge, we do not have evidence about this reform’s impact on the claim rate, the evidence related to premiums and payouts in Texas is consistent with the conjecture that price regulations passed in conjunction with tort reforms might have led to price decreases in the absence of an effect of joint and several liability reform on average payouts.

33 All studies cited in this section use sophisticated methods to estimate effects and control for alternative explanations.


Findings related to the impacts of statutes of limitations and repose reforms also are mixed. Some studies suggest that these reforms reduce average payouts; some suggest they do not. Some suggest they reduce claim frequency; some find they do not. Similarly, some conclude they reduce premiums, but others find no association between statute reforms and premiums. Further investigation of the impacts of statutes of limitations and repose reform is required to more confidently assess how these reforms affect outcomes.

On the other hand, the literature does signal consensus on the impacts of a number of reforms including attorney contingency fee limits, collateral source offsets, pretrial screening panels and periodic payments. The majority of published studies find that these reforms do not decrease claim frequency, payment severity and premiums. The general rhetoric prevalent in tort reform debates might account for the continued popularity of these reforms despite the strong evidence that they do not achieve their intended goals.

The evidence on the effectiveness of damages caps, the most popular tort reform, is mixed. Some have found that caps on non-economic damages do not significantly lower premiums, while others have found that states capping both economic and non-economic damages and those with more restrictive caps have enjoyed premium reductions. Some have

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38 Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 LAW & CONTEMP. PROB. 57 (1986); Zuckerman et al., supra note 34.
39 Danzon, supra note 36.
40 Zuckerman et al., supra note 37.
43 See id. at 9-11.
44 Zuckerman et al., supra note 37; Bhat, supra note 3.
45 Zuckerman et al., supra note 37; Bhat, supra note 3; Thorpe, supra note 34; Danzon et al., supra note 34; Meredith L. Kilgore, Michael A. Morrissey &
found that caps lead to small decreases in defensive medicine, but others have found no effect. Morrisey et al. find no impact of caps on health insurance premiums for employer-sponsored insurance, while Avraham and Schanzenbach find (1) a positive association between caps on total damages and rates of private health care coverage for price-sensitive buyers and (2) no association between health care coverage and punitive and non-economic damages caps. In sum, while damages caps have been found in some cases to achieve their intended goals—albeit having small impacts on outcomes—much evidence supports the claim that caps fail to stabilize medical malpractice insurance markets.

While the Texas closed claims data is not well suited to estimate the impacts of tort reform due to the small number of claims closed post-cap, David Hyman and co-authors used it to estimate the hypothetical impact of the 2003 non-economic damages cap on payouts related to claims closed from 1988-2004. Hyman et al. first estimate the impact the cap would have had on jury verdicts. They then use this analysis to consider how the cap might have affected settlements. The results comport with prior findings. While caps would have had a substantial impact on jury verdicts, the impact on actual payouts would have been much smaller, although substantial given the restrictive cap ($250,000). Most importantly, their findings provide clues as to why caps might not impact medical malpractice insurance premiums in predicted ways. Using insights from previous research finding that payouts in Texas rarely exceed the provider’s insurance policy limits, Hyman et al. note that we

51 Id. ("We find that this cap will have economically significant effects. For tried cases, holding case mix constant, the cap will reduce allowed non-econ damages by an estimated 73%, allowed verdicts by 38%, and payouts by 27%. In settled cases, the estimated decline in payouts is 18%.").
would not expect damages caps that exceed average policy limits to have a substantial impact. So, while the “simulation” certainly cannot provide a completely accurate picture of how the cap would have impacted outcomes (e.g., some claims would not have been brought at all had caps been imposed), it does help explain, at least in part, why caps might not impact payouts and premiums in predicted ways.

Empirical studies have not only demonstrated the general ineffectiveness of tort reform, but they have also exposed some potentially harmful impacts tort reforms can have on subsets of the injured patient population. Using Texas closed claims data, Hyman et al. predict a disparate impact across plaintiff groups, with the deceased, unemployed, and (likely) elderly plaintiffs enduring much larger reductions in recoveries. Mello reports results demonstrating similar effects for the most severely injured. The literature addressing this question is thin, however; more research is needed to get a better handle on whether and how caps affect outcomes differently for various subsets of claimants. It should be noted, however, that lower recoveries are not the sole concern here. We also need to consider the difficulty these types of patients will have in finding lawyers working under contingency fee arrangements to agree to pursue their claims. This is something that is very difficult to estimate, but it remains an important part of the big picture.

The recent sophisticated empirical studies of the impacts of tort reform on the liability system and insurance markets make it difficult for proponents of tort reforms to claim reforms will substantially quell rising insurance premiums, unless we impose severe caps that are likely to have negative impacts on the ability of some of the neediest to recover. Data have certainly allowed more objective assessments of the trade-offs we face in exchange for potential marginal benefits obtained from implementing the most effective tort reforms.

II. DRAWING INFERENCES FROM LARGE VERDICT AWARDS

In addition to rhetoric on the connection between the liability system and insurance markets, tort reform debates are also often influenced by

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52 See Part II for a discussion of the impact of policy limits on payouts.
53 In addition, the authors must make a number of assumptions about how caps impact verdicts because they lack important information (e.g., portion of economic damages attributed to medical expenses, to which the death cap does not apply). See Hyman et al., supra note 50, at 8.
54 See Hyman et al., supra note 50, at 2.
55 See Mello, supra note 42, at 13.
unsubstantiated claims related to trends in jury verdicts resulting from medical malpractice trials and how these verdicts impact eventual insurer payouts and premiums. Proponents of tort reform argue that out-of-control juries hold health care providers liable for medical malpractice more often than they should and have been awarding plaintiffs larger and larger amounts, forcing insurers to substantially increase premiums or drop out of the market.57

A recent empirical study by David Studdert and others provides one of the first assessments of tort reform proponents’ claims of excessively high medical liability system error rates.58 They find that error rates are lower than tort reform proponents often claim. In roughly 73% of claims in which physicians concluded that medical error caused the plaintiff’s injury, the plaintiff received compensation. In addition, in roughly 72% of claims in which no medical error was found, plaintiffs received no compensation. The authors also found that payment size is positively correlated with whether a medical error occurred. These findings suggest that the liability system’s error rate, while substantial and a cause for concern, is not as high as some have claimed.59

Recent empirical findings also allow us to assess claims about trends in Texas medical malpractice verdicts and how verdicts impact payouts and premiums. Part II.A summarizes recent findings that suggest that, despite an increase in Texas medical malpractice jury awards, payouts have remained stable over time. Part II.B describes evidence that might

56 See e.g., P. Baker, Bush Campaigns to Curb Lawsuits, WASH. POST, January 6, 2005, at A6 ("Bush surrounded himself with doctors in white coats to argue that ‘junk lawsuits’ were driving physicians out of places such as Collinsville, ranked by advocates as the friendliest place in the United States for trial lawyers chasing big awards. ‘You see firsthand what happens when the system gets out of control,’ he told a crowd of supporters.").
57 See e.g., James Dao, A Push in States to Curb Malpractice Costs, N.Y. TIMES, January 14, 2005, at A21 ("…many insurance companies had stopped issuing policies, reducing competition and causing premiums to rise."); Sheryl Gay Stolberg, Senate Rejects Award Limits in Malpractice, N.Y. TIMES, May 9, 2005, at A25 ("Mr. Frist and other supporters of revamping malpractice law, including the American Medical Association, have argued for years that rising insurance rates, fueled by skyrocketing jury awards, are driving doctors out of business and compromising patient care.")
58 David Studdert et al., Claims, Errors, and Compensation Payments in Medical Malpractice Litigation, 354 NEW ENG. J. MED. 2024 (2006).
59 Id. at 2031 ("[P]ortraits of a malpractice system that is stricken with frivolous litigation are overblown."). It is important to note that physicians reviewing the medical records had access to the litigation outcome, which might have influenced their medical error determinations. See id. at 2032 (cautioning reader about several limitations of the study). Additional research is required to confirm conclusions drawn from the study about the liability system error rate.
help us explain this counterintuitive finding: insurance policy limits tend to limit payouts regardless of verdict size. Patients rarely recover more than the provider’s policy limit, even when juries award large verdicts. Finally, Part II.C presents findings consistent with the claim that Texas physicians are strategically decreasing their insurance coverage, which might eventually further limit amounts injured patients receive. While additional research is necessary to more fully understand the relationship between the liability system and insurance markets, the current evidence gives us reason to believe that Texas might be experiencing a patient compensation crisis rather than a medical malpractice liability crisis.

A. Verdicts v. Payouts

Tort reform proponents often point to large verdict awards as evidence of a broken medical malpractice liability system. They argue that unjustified blockbuster awards encourage plaintiff attorneys, who work on a contingency fee basis, to play the “lawsuit lottery.” In addition, they claim that awards impact not only claim rates but also settlement behavior of claimants and insurers. Fear of out-of-control juries, the argument goes, compels insurers to settle even non-meritorious claims with large payments.

Using verdicts to predict settlement behavior, however, might lead to substantial errors if payouts and verdicts tend to diverge. Payouts can be lower than verdicts for several reasons: adjustments made through remittitur, appellate court reversals, imposition of statutory damages caps, and post-verdict settlement negotiations. On the other hand, we expect payouts to exceed verdicts in some cases (e.g., plaintiffs regularly accept payments in exchange for foregoing appeals following pro-defendant verdicts). Therefore, data on verdicts might lead to false impressions about the more telling measure of how much money ends up changing hands. The latter has been notoriously difficult to estimate given lack of available data on settlements.

I, along with co-authors, used the Texas data on claims closed from 1988-2003 to estimate differences between verdicts and payout. We found that payouts fall far short of verdicts in the vast majority of cases with total payouts of at least $25,000 (in 1988 dollars) (“large claims”). While jury verdicts and payouts are positively correlated, 75 percent of post-verdict payments were lower than the adjusted verdict (jury award

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60 Hyman et al., supra note 5. Of 13,269 incidents of alleged malpractice that resulted in payouts of at least $25,000 (in 1988 dollars), 690 (5.1%) went to trial and 315 resulted in a verdict (2.7%). Id. Fifteen cases involving bench trials were excluded from the analysis. Id.
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plus pre- and post-judgment interest). Across the 306 verdicts handed down in large claims closed from 1988-2003, plaintiffs received only 56 percent of total adjusted verdicts ($212 million total payouts following adjusted verdicts totaling $482 million). The mean per-case “haircut” was 29 percent of the adjusted verdict (median = 19 percent).

In addition, the study found that haircuts and adjusted verdicts are positively correlated. Forty-seven percent of plaintiffs awarded adjusted verdicts of less than $100,000 experienced a haircut averaging 8 percent per case. In contrast, 98% of plaintiffs awarded adjusted verdicts in excess of $2.5 million experienced a haircut averaging 56 percent. As the adjusted verdict increases, both the percentage of cases taking a haircut and the average per-case haircut increase.

These findings underscore the difficulties inherent in justifying tort reform by pointing to verdicts, often widely reported by the press, and ignoring eventual payouts, which the press almost never report. While accounting for differences between verdicts and payouts is important, understanding what accounts for these differences is also helpful in better understanding the tort system’s inner workings. The following section summarizes findings that illuminate factors that drive the verdict-payout discrepancy.

B. Explaining the Discrepancy

As mentioned, remittitur, appellate court reversals, imposition of damages caps, and post-verdict settlement negotiations account for a portion of the $270 million Texas plaintiffs were awarded from 1988-2003 but never received. The information TDI collects allows us to estimate the impact of various mechanisms that limit amounts plaintiffs collect post-verdict.

Judicial oversight in the form of remittitur, JNOV and appellate reversals had a small direct impact on haircuts. Judges reduced verdicts through remittitur in roughly five percent of cases, for a total reduction of

61 Id. at 5. Five percent of payouts following verdicts exceeded adjusted verdicts. Id. at 6.
62 Id. at 6.
63 See id. at 13-14 for details on how pre- and post-judgment interest were computed.
64 Id. at 6.
65 Id.
66 Id. at 32 (Table 10).
67 It should be noted that judicial oversight might indirectly impact post-verdict settlement negotiations. This indirect impact is impossible to measure; therefore, we likely underestimate the influence of judicial oversight on haircuts.
approximately $9 million (3.3% of the total haircut). JNOV and appellate reversals also account for a small portion of the total haircut in large payout claims, accounting for roughly $2.5 million of the $270 million total haircut (about 1 percent).

Texas courts were required to impose statutory caps on punitive damages and damages awarded in death cases during the period we studied. The punitive damages cap reduced allowed damages in five of the 22 cases in which they were awarded. The total reduction was roughly $44 million, 62 percent of the awarded punitive damages and 16 percent of the total haircut. A cap on recovery in wrongful death cases applied in 66 cases. The cap does not apply to medical expenses, and TDI does not report these expenses separately; so, the impact of this cap is a rough estimate. As an upper bound, we estimated that the wrongful death cap accounted for roughly $38 million of the $270 million total haircut (roughly 14 percent). Therefore, together, statutory caps accounted for approximately 30 percent of the total haircut. This estimate, plus the estimated impact of judicial oversight, leaves roughly two-thirds of the total haircut to be explained.

It turns out that the largest portion of the total haircut is due to the fact that plaintiffs rarely collect more than the provider’s insurance policy limit, even when the adjusted verdict greatly exceeds the limit. Figure 1 displays payout-to-policy-limit ratios for single-payer cases in which the policy limit was at least as large as the adjusted verdict and cases in which the adjusted verdict exceeded the policy limit (“above-limits cases”). For cases in which the payout-to-policy-limit ratio was 100%, the payout was exactly equal to the policy limit. As the figure reflects, 31 percent (24/77) of above-limits single-payer cases had payouts between 95-105 percent of policy limits. A majority (53 percent) of above-limits cases

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68 Id. at 35. If reversed remittiturs are excluded, the total reduction is approximately $5.5 million (2 percent of the total haircut). Id.
69 Id. at 36.
70 See id. at 12-13 for a description of the caps.
71 Id. at 36-37.
72 Id. at 38.
73 Id. We assumed that none of the economic damages were for medical expenses; therefore, we overestimated the impact of the wrongful death cap.
74 Id. at 39-47.
75 We included only single-payer cases in this analysis because we do not have full information about excess coverage in multi-payer cases. Of the 315 cases that went to verdict, 214 were single-payer cases with information on policy limits sufficient to analyze the impact of limits on payouts. Id. at 39. Caution should be used when drawing inferences from single-payer cases, however. For example, payouts related to single-payer cases are smaller than those for multi-payer cases. Id. at 15.
settled at or below policy limits, with the limits effectively capping recovery. Depending on the assumptions adopted to estimate the impact of policy limits on recoveries, policy limits account for 73-87 percent of total haircuts in single-payer cases. For this subset of cases, judicial oversight and caps explain only 1.5-15 percent of the total haircut (depending on estimation assumptions).

Figure 1: The impact of limits on payouts

In a separate study, we analyzed the impact of policy limits on payouts in all claims against physicians with payouts of at least $25,000 (1988 dollars), including those that settle prior to verdict. We found that policy limits act as de facto caps in these cases as well; only 1.5 percent of large payout claims had above-limit payments. Interestingly, primary carriers funded most of these payments. Physicians made out-of-pocket payments in only 62 cases of the 9,525 closed from 1990-2003.

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76 Id. at 41.
77 Id. at 44-45. One estimate assumes that caps and remittiturs are applied first and then policy limits bind. The other assumes policy limits bind before caps and remittiturs have an impact.
78 Id. at 44.
79 Kathryn Zeiler et al., supra note 5.
80 Id. at S11.
81 Id. While we did not explore the reasons why insurers pay amounts above the limits, we conjecture that insurers make payments in some cases to avoid bad faith settlement claims by providers who wish to settle when the insurer wishes to defend the provider against the claim. Id. at S31.
82 Id. at S26.
addition, although we might expect more out-of-pocket payments in cases in which policy limits are low, we found that low policy limits did not trigger a flood of out-of-pocket payments by physicians.\textsuperscript{83} Physicians with $250,000 per-occurrence policies made an out-of-pocket payment in only 32 of 2,488 claims (1.3 percent).\textsuperscript{84}

While additional unobservable factors likely explain a portion of the total haircut (e.g., high-low agreements, plaintiffs’ willingness to take less to avoid an appeal, etc.), policy limits clearly play a substantial role in reducing amounts plaintiffs receive, even when they win large verdicts. This alone is cause for concern given the primary goals of the tort system: to compensate negligently injured patients for their losses and to deter negligence. Concern might extend beyond this, however, if we consider how physicians might react over time to learning that they face limited personal exposure even when injured patients might perceive them as being underinsured.

Although the reasons behind why policy limits act as de facto caps on recoveries are not well understood,\textsuperscript{85} the Texas closed claim data provide some insights into coverage trends.\textsuperscript{86} The following section discusses findings related to policies purchased by Texas physicians involved in large paid claims.

C. Trends in Medical Malpractice Coverage and Implications for Tort Recoveries

The conventional wisdom seems to be that physicians hold medical malpractice insurance with $1 million per-occurrence limits.\textsuperscript{87} The Texas closed claims data suggest otherwise, at least for policies covering large paid claims closed from 1990-2003. The median policy limit for the subset of policies covering these claims was $500,000 (nominal).\textsuperscript{88} Only 31 percent of policies in the sample had limits of $1 million.\textsuperscript{89} Six percent

\begin{thebibliography}{89}
\bibitem{footnote10} \textit{Id.} at S27.
\bibitem{footnote11} \textit{Id.}
\bibitem{footnote12} \textit{Id.} at S39.
\bibitem{footnote13} \textit{Id.} at S32-S34.
\bibitem{footnote15} Zeiler et al., \textit{supra} note 79, at S32.
\bibitem{footnote16} \textit{Id.}
\end{thebibliography}
had limits of more than $1 million, and 32 percent had limits of $200,000 or less.  

Insurers in Texas are required to report the year in which the policy covering the paid claim was purchased. This allows us to estimate time trends in physician purchasing habits for policies covering large paid claims. Sample sizes for purchase years 1988-1999 were sufficient to estimate average limits. Figure 2 displays time trends in policy size by purchase year for perinatal and nonperinatal physicians.  

Real mean and medium limits on policies purchased by both perinatal and nonperinatal physicians eventually involved in large paid claims fell by roughly 30 percent from 1988-1999.  

**Figure 2: Perinatal and nonperinatal physician policy size by purchase year**

Source: Zeiler et al. at S34 (Figure 9).
Note: Policies relate to single-payer cases resolved with a payment of at least $25,000 (1988 dollars).

Although our study did not investigate what might be driving the decline in real coverage, we offered a few conjectures. One theory consistent with observed trends suggests that physicians, realizing over time that exposure is minute even when coverage is low, might have

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90 Id.  
91 While TDI does not require insurers to report the specialty of the physician against which a claim is made, it does require reporting of the patient’s age. We characterize all claims for injury to patients aged one month or younger at the time of the injury as perinatal claims. This allows us to estimate trends for a group of physicians thought to be hardest hit by the out-of-control liability system. *See id.* at S18.  
92 Id. at S33-34. Declines over time were statistically significant at the 1% significance level. *Id.*  
93 Id. at S38-39.
benefited from purchasing smaller (and cheaper) policies. While most managed care organizations and hospitals require their physicians to hold liability insurance, physicians likely are able to influence decisions over required coverage levels. Whether declining coverage is explained by something as simple as an increase in premiums or relatively cheaper alternatives (e.g., asset protection strategies) or a more complex story of strategic behavior on the part of providers, declining coverage implies fewer dollars available to fuel the liability system, which might limit the ability of the system to deliver just outcomes for injured patients.

**CONCLUSION**

These findings, together with other published findings, help us evaluate whether and how well the medical malpractice liability system meets its intended primary goals: just compensation and deterrence. Contrary to the common rhetoric heard during tort reform debates, evidence suggests that the connection between the liability system and insurance markets is tenuous, which makes it unsurprising that tort reform has little to no impact on insurance markets. In addition, Texas closed claims data suggests that large jury awards, which get ample press, are often followed by much smaller payouts, a fact almost never accompanying news of jumbo verdicts. A large portion of the difference is attributable to the finding that patients rarely receive more than the provider’s policy limits. This, coupled with the fact that Texas physicians are purchasing less real coverage over time, suggests that we might be facing a patient compensation crisis rather than a medical malpractice liability crisis.

While the data collected by the Texas Department of Insurance have proven extremely useful for establishing a set of facts from which debates about how best to handle crises can begin, data on closed medical malpractice claims are rare. Either the data are not collected or they are collected but not made publically available. Academic researchers have

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94 Id. 95 Florida and Missouri collect similar datasets and make them publically available. Michigan collects closed claims data, but they are available only in paper form. Illinois, New York, Minnesota, Massachusetts, Nevada and Washington collect closed claims data but do not allow the public access to them, to my knowledge. Most states do not collect such data. The National Practitioner Data Bank also collects and distributes to the public data on paid medical malpractice claims, although the data are not audited for completeness and accuracy. See Lawrence Smarr, *A Comparative Assessment of the PIAA Data*
a substantial role to play in the endeavor to increase the volume of data available to establish factual baselines and to study important questions. Involvement comes in many forms, from generating datasets using legal rules\(^9\) to gathering data from market players\(^7\) to teaming up with organizations working to increase the stores of data that can be used to fashion more efficacious policy.

To this end, I and others have been working with the National Association of Insurance Commissioners to draft a model law requiring the collection of medical malpractice closed claims data from insurance companies and self-insured market actors.\(^8\) The hope is that a substantial number of states will adopt the model law and that uniform multi-state data will be available to the public. Multi-state data is necessary to conduct more sophisticated analyses of causes of medical malpractice insurance crises (assuming they exist), causes of medical error, impacts of tort reform on premiums, payments and claims rates, just to name a few. Involvement by academics can mitigate, at least to some extent, the influence of industry actors, who have strong incentives to keep the data private.

It should be noted that we do not know much about the generalizability of the results from the Texas studies. This is a cause for concern if the state is different in important ways from other states that experience severe fluctuations in medical malpractice insurance

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*Sharing Project and the National Practitioner Data Bank: Policy, Purpose, and Application, 60 LAW & CONTEMP. PROBS. 59, 60 (1997); Joseph Hallinan, *Attempt to Track Malpractice Cases is Often Thwarted*, WALL ST. J., Aug. 27, 2004, at 1. Despite these shortcomings, some have used the NPDB data to analyze medical malpractice liability trends. See, e.g., Avraham, *supra note 35.*

*96 See, e.g., Ronen Avraham, *supra note 13* (constructing dataset of tort reforms passed by state and by year, including results of judicial determinations of constitutional challenges to reforms).*

*97 See, e.g., Tom Baker, *Blood Money, New Money and the Moral Economy of Tort Law in Action, 35 LAW & SOC. REV. 275 (2001) (employing qualitative data gathered from interviews of practicing medical malpractice attorneys to study why physicians tend not to pay out of their own pockets on claims with payments in excess of the policy limits); Albert Yoon, *Damage Caps and Civil Litigation: An Empirical Study of Medical Malpractice Litigation in the South, 3 AM. LAW & ECON. REV. 199 (2001) (using data obtained from a medical malpractice insurer to study the impacts of damage caps on payment severity).*

*98 National Association of Insurance Commissioners (NAIC), *www.naic.org.* A draft of the model law, guidelines for companion regulations and opinion letters from interested parties including physician groups, insurance companies and academics are posted to the NAIC’s website. *http://www.naic.org/documents/committees_c_sitf_080221_Med_Mal_SITF_Request_closed-claim_reporting_model_law.pdf*
In addition, all empirical studies come with limitations (e.g., missing observations, limited time period, etc.). Studies produced using the Texas data, however, demonstrate the value of observation in understanding whether the liability system enhances or limits civil justice for injured patients. Policy makers are more likely to implement effective solutions if debates stand on firm foundations established by facts rather than rhetoric.

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99 For example, Texas has one of the nation’s largest homestead exemptions, which might make it relatively easy for doctors to protect at least some of their assets from attachment.