Appendix G: Summary of State Studies on Tort Reforms

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Study	Data and methodology	Major reported findings	Comments
U.S. General Accounting Office, Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms, HRD-87-21 (Washington, DC U S Government Printing Office, December 1986)	**Data:** Claim frequency, payment per paid claim Insurance premiums, and the cost of resolving claims in Arkansas, California, Florida Indiana New York and North Carolina from 1980 to 1986 **Method:** Comparison of trends among states	▪ Despite the implementation of tort reforms, every state continued to experience increases in claim frequency, payment per paid claim, and insurance premiums. ▪ Indiana, the only state with a cap on both economic and noneconomic damages, experienced smaller insurance premium increases relative to other states.	▪ The study was unable to determine whether tort reforms had slowed the growth in claim frequency, payment per paid claim, or insurance premiums because no data were collected on trends prior to the reforms ▪ The methodology did not control for other factors that might affect malpractice claim activity
W.P. Gronfein, and E. Kinney, Controlling Large Malpractice Claims The Unexpected Impact of Damage Caps, *Journal of Health Politics, Policy and Law* 16(3) 441-483, 1991	**Data:** 1,282 closed claims in Indiana, Michigan and Ohio from the period 1977 through 1988 in which $100,000 or more in total damages were awarded. **Method:** Statistical regression analysis to determine whether Indiana's $500,000 cap on total malpractice damages lowered the average payment per paid claim for large claims The analysis controlled for the effects of plaintiff's age and sex, year of settlement, severity of injury, and allegations of negligence (e g diagnosis, anesthesia surgery medication patient monitoring, etc.)	▪ Mean and median payments per paid claim with damages $100,000 or more were approximately 18 and 42 percent higher in Indiana compared with Michigan and Ohio, respectively. The regression analysis suggested that the higher average award in Indiana is attributable to Indiana's tort reform. ▪ In Michigan and Ohio, payments of $1 million or more were made in 3.1 and 2.6 percent of claims, respectively. Payments for these claims accounted for 21 percent of all payments in Michigan and 14 percent in Ohio. There were no payments above $1 million in Indiana.	▪ There was no pre-reform and post-reform comparison of payment levels for malpractice claims ▪ The higher mean and median payment per claim may be a result of the operation of Indiana's Patient Compensation Fund, which was passed at the same point as the cap on damages and not the result of the cap on damages ▪ Although the average payment per paid claim was higher in Indiana the study could not determine whether Indianas tort reforms resulted in an overall savings in malpractice claims payments
California Medical Association, Actuarial Study of Professional Liability Insurance prepared by Future Cost Analysts Newport Beach CA May 31 1985	**Data:** Malpractice claims costs* from 1966 to 1985 n California. **Method:** Actuarial methods used to assess the impact of California's 1975 package of tort reforms. Medical Insurance Compensation Reform Act (MICRA) on malpractice claims costs (see chapter 4 for a description of these reforms). *Claims costs include payments made to plaintiffs (including the payments by plaintiffs to their attorneys) and the malpractice insurers' direct costs attributable to the claim (fees for investigative work, expert witnesses, and legal defense work).	▪ Prior to MICRA (1966-75), claims costs were increased at an annual rate of 15 percent in California. After MICRA (1976-85), claims costs increased 7 percent annually.	▪ According to data gathered by the U S Health Care Financing Administration national average premiums increased at a compound annual rate of approximately 12 percent between 1976 and 1985 (51 F R 28772, 28774 57 F R 5903) Therefore California claims costs (a proxy for premiums) Increased at a slower rate after MICRA than national malpractice insurance premiums ▪ The reductions in claim costs may be unrelated to MICRA especially since MICRA was not upheld by the courts until 1985, which may have limited its impact There may be alternative explanations for the findings for exam,ple after 1975 most commercial Insurers were replaced by physlclan-owned companies

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Californians Allied for Patient Protection, The Coalition to Preserve MICRA, MICRA Information, January 1 1993	**Data for various years between 1976 and 1991:** ▪ Physician fees—American Medical Association survey ▪ Malpractice premiums in California—Physlclan Insurance Association of America ▪ Malpractice premiums in New York Florida Michigan—Medical Liability Monitor ▪ National Malpractice Premiums—Tlllinghast **Method:** Comparison of trends in California with those in other states and the nation to assess the impact of MICRA reforms	▪ No pre-reform, post-reform comparisons between states. ▪ Physician fees declined physician fees in California increased by 9 2% compared with 13.1% nationally. ▪ Average California malpractice insurance premiums, after adjusting for inflation, declined from $18,000 in 1976 to $7,000 in 1991. ▪ 1992 average malpractice Insurance premiums were lower in California than in New York, Florida, or Michigan	▪ The magnitude of the decline may have been overstated by comparing a peak in premium levels (1 976) to a relative trough in premiums (1991) [a] In addition comparisons of single-year premiums can be misleading because premiums are based on expected revenue needs and are often adjusted upward or downward when better Information is available ▪ The study did not control for any other factors in California that may have led to lower insurance premiums or physician fees e g changes in the malpractice insurance market or health care delivery market
Harvey **Rosenfeld,** California MICRA Profile of a Failed Experiment in Tort Law Restrictions , Voter Revolt, Los Angeles CA (no date)	**Data:** ▪ National per capita health care spending data—U S Health Care Financing Administration and the Center for National Health Statistics U S Public Health Service ▪ Estimate of California's personal health care expenditures—California Almanac (5th Ed 1991) ▪ Average medical consumer price index from Los Angeles, San Francisco, and San Diego ▪ Malpractice Insurance premiums, profits, and losses—National Association of Insurance Commissioners **Methods:** Comparison of trends in the measures listed above from 1975 to 1991, and comparison of these measures among states in various years	▪ In 1990 the average California malpractice insurance premium was $7,741 as compared with a national average premium cost of $8,327 ▪ Incurred malpractice Insurance losses as a percent of health care costs declined in California between 1987 and 1990 at a greater rate than in the nation	▪ In 1985 California's average premium was 65 percent above the national average, therefore, the decline to less than the national average is noteworthy [b] ▪ The study did not control for other factors that contribute to changes in malpractice and health costs therefore, one cannot conclude that MICRA was solely responsible for lower premiums or moderate growth in health care costs

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Academic Task Force for Review of the insurance and Tort Systems, Preliminary Fact-Finding Report on Medical Malpractice, Gainesville, FL, August 14, 1987. #	**Data:** Florida insurance company data on claims closed between 1975 to 1986. **Method:** Analysis of trends in malpractice cost indicators. **Tort reforms:** Florida passed three malpractice reform acts: The 1976 act implemented:* ▪ limitation on *res ipsa loquitur* doctrine, ▪ abolishment of collateral source rule, ▪ periodic payment of future damages, and ▪ standard of care determined by reference to same or similar locality. 1985 and 1986 acts included: ▪ pretrial screening, ▪ patient compensation fund, ▪ cap on noneconomic damages, ▪ attorney fee limits, and ▪ certificate of merit. * For a definition of these reforms, see chapter 4, box 4-2 or appendix K.	▪ The rate of closed claims per 100 physicians remained stable from 1975 to 1986 ▪ The average payment per paid claim increased 14.8% per year from 1975 to 1986 ▪ Claims with million dollar plus awards accounted for **4.9%** of total paid claims in 1981 but 29 1% in 1986 ▪ The average cost of defending a claim increased at an annual rate of 17% from 1975 to 1986, ▪ Increases in payment per paid claim were the primary factor driving Increases in premiums in Florida	▪ The study did not do a pre-post reform comparison of trends The 1985-86 reforms were unlikely to have had an effect on the data analyzed because most claims were closed prior to implementation of reforms. ▪ The study looked at gross trends in malpractice cost indicators, but made no attempt to assess the individual impact of particular reforms on those Indicators
Pretrial screening studies			
P.E., Carlin, Medical Malpractice Pre-trial Screening Panels: A Review of the Evidence, Intergovernmental Health Policy Project, The George Washington University, Washington, DC, October 30, 1980.	**Data:** Various statistics on the operations of 15 pretrial screening panels in Arizona (Maricopa County), Delaware, Hawaii. Indiana Louisiana, Massachusetts, Montana, Nevada, New Jersey, New Mexico, New York, Pennsylvania, Tennessee, Virginia, and Wisconsin **Method:** ▪ Analysis of data ▪ Review of the empirical literature ▪ Interviews with pretrial panel administrators and members of state medical societies and state bar associations	▪ Majority of panel decisions found no liability; physicians won an average of 73% of panel decisions. ▪ Plaintiffs only appealed approximately 5% to 22% of adverse decisions in Delaware, Hawaii, Massachusetts, Arizona (Maricopa County), and Wisconsin, indicating that pretrial screening panels may lead some claims to be settled earlier. ▪ Nearly every state had failed to convene a panel within the statutory time limit and there were long delays and backlogs of cases.	▪ There were no comparisons of claim disposition prior to the implementation of the panel ▪ Because pretrial panels offer plaintiffs a relatively inexpensive mechanism for screening the merits of a case, their existence may have encouraged plaintiffs with nonmeritorious suits to file This could explain the high rate of decisions for defendants and the low rate of plaintiff appeals ▪ The long delays in panel hearings may lead some plaintiffs to drop claims or settle after proceeding through the pretrial screening process

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J.K. Mardfin, Medical Malpractice in the State of Hawaii, Department of Commerce and Consumer Affairs, Honolulu Hl, January 1986	**Data:** 453 pretrial screening panel decisions between 1979 and 1984 in Hawaii Method: Comparison of disposition of pretrial screening panel decision and subsequent disposition of claim	• The majority of claims were settled or dropped after a panel hearing ▪ Of the 109 cases in which the panel found the physician liable, 18 claims (16%) were subsequently settled, and 53 claims (49%) were apparently dropped. ▪ In the **328** cases in which no liability was found, 3% settled without filing suit and 221 claimants (67%) apparently took no further action ▪ A majority of plaintiffs who filed suit after a panel decision of no-liability received a payment ▪ Data was available on 71 suits filed following a panel finding of no-liability Only 51 were closed by the time the study was completed In 28 cases (55%), plaintiffs received a payment In 10 of these cases, the amount paid to the plaintiff exceeded $100,000 ▪ The average time from filing a claim to the panel's decision was 7'/$_2$ months, with 55% Of claims beinq settled within 1 month	The majority of claimants took no further action following the pretrial screening panel hearing This indicates that the panel promoted early settlement However, the researchers were not completely confident about the status of the cases they reported as taking no further action They did not know whether plaintiffs were still considering a suit or engaged in settlement negotiations The relatively large number of no-liability panel decisions that resulted in payment to the plaintiff raises a question about the accuracy of the panels' decisions
Howard, D.A An Evaluation of Medical Liability Review Panels in Arizona *State Courts Journal* 519-25, 1981	**Data:** ▪ Aggregate data for malpractice claims filed in Maricopa County (Phoenix), Arizona, 1975 to 1979 ▪ Individual case data for cases in Maricopa County from primary malpractice Insurers in Arizona, 1975 to 1979 ▪ Insurance claim data for Arizona, 1975 to 1979 • Interviews with judges and attorneys in Arizona (circa 1980) **Method:** Analysis of trends before and after implemnentation of pretrial screening panels in 1976	**Court data:** • The percentage of malpractice cases that went to trial dropped from 15°/0 in 1975 to 6°A in 1978 ▪ The percentage of stipulated dismissals (indicating settlement prior to trial) Increased after 1975 ▪ Median time for resolution of claims Increased after panels were Instituted Cases that went through the panel process were slowest • There were significant delays in convening panels and scheduling hearings. **Insurance claims data:** • Probability of payment remained stable • Average payment per paid claim similar for screened and nonscreened claims • Average cost to the insurer to defend a claim increas°d • Average time to resolve a claim Increased • Claim frequency increased after the implementation of the panel (1 978 1979)	▪ The data set only Included 1 year of data for claims filed prior to the enactment of pretrial screening, and 3 years of claims data postpanel The use of only a slngle year of prepanel data is inadequate for comparison of trends The decline in the number of trials may result from delay in claim resolution, 27% of claims filed in 1977 and 56% of those filed in 1978 had not been closed by the time the study was completed in May 1980 Changes in patterns of disposition of claims may be a result of changes in the malpractice Insurance market A major shift from commercial to physician-owned Insurance companies occurred at the same time panels were implemented

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S. Shmanske, and T. Stevens, The Performance of Medical Malpractice Review Panels, *Journal of Health Politics, Policy and Law* 11 (3) 525-535, 1986	**Data:** Claims data from two Insurance companies in Arizona prior to (1 972-75) and after (1 976-79) pretrial screening panels were implemented The data set Included only claims that closed within 2 years of filing and claims that were filed within 1 year of the incident **Method:** Pre-post comparison of differences in claims disposition before and after 1976.	▪ Claim frequency Increased ▪ Claims took longer to resolve ▪ Probability of payment remained the same ▪ There was no overall Increase in average indemnity payment, but claims that closed quickly had higher average payment	• There were no controls for other factors that may have led to changes in malpractice claim activity for example, the change from commercial insurer to a physician-owned mutual company, changes in demographics, and national trends in malpractice claims activity
J. Goldschmidt, Where have All the Panels Gone? A History of the Arizona Medical Liability Review Panel, *Arizona State Law Journal* 23:1013-1109, 1991.	**Data:** Interviews with 69 Superior Court judges, 47 defense attorneys, 41 plaintiff attorneys, 250 physicians, and 73 malpractice plaintiffs.	▪ Participants tended to believe that pretrial screening panels did not promote settlement ▪ Pretrial screening Increased the cost of litigation ▪ General dissatisfaction with the operation of the pretrial screening panel system ▪ About one-third of plaintiff attorneys said there was no reason to enter settlement negotiations prior to the panel decision	▪ No empirical data ▪ Response rates to surveys were as follows Defense attorneys—60% Plaintiff attorneys—42% Physicians—50% Plaintiffs—24% Superior court judges—68% Thus, there was potential for response bias in results
arbitration studies			
U.S. Department of Health, Education and Welfare, Public Health Service, Health Resources Administration, National Center for Health Services Research, An Analysis of the Southern California Arbitration Project, January 1966 Through June 1975, prepared by D H Heintz, HHEW Pub 77-3159 (Washington DC: U.S. Government Printing Office, 1975)	**Data:** 1,353 malpractice claims brought between 1966 and 1975 against Southern California hospitals One group of 8 hospitals had Implemented an arbitration project in which patients were presented with an arbitration agreement upon entering the hospital (the 'arbitration hospitals") The other group of 8 hospitals did not promote arbitration (the "nonarbitration hospitals") **Method:** Comparison of claims experience in arbitration and nonarbitration hospitals before and after implementation of the arbitration program in 1970	▪ Fewer claims were filed in arbitration hospitals as compared with nonarbitration hospitals ▪ The amount paid per closed claim was lower in arbitration hospitals ▪ There was a statistically significant decline in the defense cost per claim in the arbitration hospitals over the period of the study ▪ The average length of time to resolve a claim was shorter For arbitration hospitals the time period was measured from the filing of the claim Prior to the initiation of the arbitration project the arbitration hospitals had taken longer to resolve a claim than the nonarbitration hospitals	• Hypotheses were stated in terms of differences between arbitration hospitals and nonarbitration hospitals in the levels of certain variables (e. g. , the number of malpractice claims) but the test statilstic measures the difference between the two groups of hospitals in the rates of change in those variables A number of hypotheses were tested using a test statistic that appears to be Incorrectly specified. Consequently, the statistical significance-though not necessarily the direction-of the findings must be questioned ▪ There was evidence that arbitration hospitals were using "more intensive efforts to resolve claims earner in the process "

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Ladimer, I., Solomon, J.C., Mulvihill, M., Experience in Medical Malpractice Arbitration. *The Journal of Legal Medicine*, 2(4) 433-469. 1981	**Data:** ▪ 130 California medical malpractice arbitration cases filed between 1971 and 1980. These cases arose in hospitals from the Southern California Arbitration Project (see previous study reviewed in this table). ▪ 500 to 3,200 California malpractice claims that were filed in a court between 1975 and 1978. (The number of litigated cases used for comparison varied depending on the data available.) **Method:** Comparison of trends in arbitration cases and litigated malpractice cases.	▪ Fewer defendants per arbitration claim. The percent of claims involving a single defendant were as follows: arbitration—62% litigation—23% ▪ Plaintiffs' injuries were less serious in arbitrated cases: arbitrated cases less frequently involved death and more frequently involved temporary injuries. ▪ There were no statistically significant differences in the probability of payment between arbitration and litigation cases. ▪ Arbitration claims were filed more quickly following the incident than were claims filed for litigation. ▪ The average time to resolve an arbitrated claim was 28 weeks less than for a litigated claim.	▪ Exact methods used to control for confounding factors were not clearly specified. ▪ Arbitration claims may be filed more quickly because claimants with temporary injuries may be able to file their claims sooner. ▪ The quicker settlement time for arbitration claims may be a result of fewer defendants in arbitration claims or the plaintiffs with less serious injuries choosing arbitration. ▪ Since arbitration is voluntary, the patients who select arbitration may differ from the patients that chose litigation. Moreover, patients were permitted to revoke the arbitration agreement within 30 days after being discharged. Therefore, plaintiffs with obvious, serious injuries upon discharge may have decided to proceed to trial.

[a] U.S. Congress, Office of Technology Assessment, *Impact of Legal Reforms on Medical Malpractice Costs*, OTA-BP-H-119 (Washington, DC: U.S. Government Printing Office, 1993).
[b] S. Zuckerman, S. Norton, and B. Wadler, *A State-Based Survey of Malpractice Premiums: Implications for Medicare Physicians Payment Policy*, Report 6090-02 (Washington, DC: The Urban Institute, March 1993).

SOURCE: Office of Technology Assessment, 1994.