

Which Tort Reform Options?

Some solutions work much better with the nature of tort law.

By Michael I. Krauss

It is not disputed that, since 1930, growth in litigation costs has been four times the growth of the overall economy. The estimated aggregate cost of the tort system in 2002 was \$233 billion, or roughly \$1,000 for every man, woman, and child in America, according to Tillinghast-Towers Perrin, the respected actuarial firm. In 1950, the cost was \$12 per person. Even adjusting for inflation, this represents an increase of more than 900 percent over 50 years.

But while tort reform is necessary, the exact form must be considered carefully. In general, six forms of tort reform have been adopted by the states: requiring alternative dispute resolution, limiting contingent fees, modifying the collateral source rule, imposing damage caps, adopting no-fault compensation schemes, and using stop-loss funds. Each of these options has advantages and drawbacks, which are discussed below.

COMPULSORY ADR

Compulsory alternative dispute resolution typically mandates that, before a suit can be brought, potential medical malpractice plaintiffs seek relief through some alternative adjudication process, such as nonbinding arbitration of the claim by an expert panel of medical professionals. The panel can recommend for or against compensation, but its sentence does not prevent the losing party from filing a tort suit *de novo*.

The goal, presumably, is to nip frivolous lawsuits in the bud by showing the plaintiff's lawyer that he has no hope of success, and to do this at low cost to innocent physician defendants. If the arbitration result is relatively certain and relatively cheap, the defendant's insurer will be less likely to offer the generous "nuisance settlements" that drive up premiums. With little prospect of a nuisance settlement, the plaintiff's attorney will probably drop a losing claim rather than invest hundreds of hours of labor in it.

Most versions of this reform, however, have proved ineffective. Plaintiffs who lose before a medical panel do not typically feel disadvantaged when the panel's report is produced at trial,

so long as they are able to find an expert who agrees with their assessment of the defendant's behavior. Plaintiffs often feel comfortable going forward with this hired expert, since juries arguably are increasingly inclined to see tort law as a form of health insurance that should compensate plaintiffs for significant medical costs resulting from surgery regardless of whether any medical negligence actually exists. Binding arbitration through tort reform has of course not been possible, as 49 states' constitutions guarantee their citizens the right to a jury trial of all justiciable civil disputes.

One proposal from North Carolina has particular interest. It would allow judges to order mandatory nonbinding arbitration at their discretion. After reviewing the med-mal case, the arbitration panel would recommend either that the defendant settle or that the suit be dropped.

The proposal states that if a party loses before the arbitration panel *and again* at trial, that party must pay the winning side's costs, including attorney fees. This provision would arguably dissuade the plaintiff's lawyer from pursuing a dubious suit after an adverse arbitration sentence. Because settlements could not easily be subjected to the loser-pays rule, plaintiffs would be more likely to accept low-ball settlements after an adverse ruling.

LIMITS ON CONTINGENT FEES

Some jurisdictions cap med-mal contingent fees of plaintiffs lawyers at 33 percent, or some lesser figure on a sliding scale based on the amount eventually obtained. Typically, the maximum marginal "commission" for the plaintiff's attorney drops as the award or settlement amount increases. In general, such modifications have been upheld by state courts applying their own constitutions (as, for example, in the 1974 case of *American Trial Lawyers' Association v. New Jersey Supreme Court*)—and the U.S. Supreme Court has never found any federal right to freedom of contract in matters of lawyers' fees.

Some researchers believe fee caps in fact lead attorneys to inflate the quantum of hard-to-quantify noneconomic damages

claimed, in the hope that they will emerge with the same fee previously received for similar work.

There is not sufficient academic research to evaluate whether lawyers have such pricing power. And the Manhattan Institute proposed more than a decade ago that early settlement offers, if declined, would set a baseline for assessing the reasonableness of the contingent fee: Trial awards at or below the offer would not have been “contingent,” so no fee would be earned.

Even under current law, contingent fees may in many cases constitute violations of states’ ethics codes. Most states require that contingent fees be “reasonable” (i.e., that there be a real risk of nonrecovery for the attorney, and a relationship between the fee and the effort expended) and “subsidiary” (i.e., that a client preferring to pay an hourly or fixed fee be given that option). Many contingent fees fail one or both of those tests and are vulnerable to challenge; see, for example, the 1988 West Virginia ruling in *Committee on Legal Ethics of West Virginia v. Gallaher*.

COLLATERAL SOURCE

Another option is to modify the “collateral source” rule. The common law traditionally does not allow defendants to deduct from their amount of liability any sums provided to plaintiffs by third parties. This was meant to ensure that gratuities made to, or insurance purchased by, the victim accrued to the victim and not ultimately to the tortfeasor.

For example, under the common law rule, if an injury causes a plaintiff to miss a day’s work, but the plaintiff’s employer decides to pay his salary for that day anyway, the plaintiff is able to recover that salary again by suing the tortfeasor.

The recent proliferation of third-party payments has arguably transformed the collateral source rule. For example, injured plaintiffs have been allowed to sue a tortfeasor for the very high “list price” of a medical procedure, even though charge for the procedure might have been 90 percent below “list” because the plaintiff’s health insurer obtained discount rates. In such cases, the common law rule seems to be little more than a way to increase payments from tortfeasors.

Abrogation of the collateral source rule, such as has occurred in Connecticut, reduces payouts from tortfeasors—in the short run. Over the long run, insurers and other businesses likely modify their contracts with plaintiffs to require reimbursement if a solvent tortfeasor becomes available. On the other hand, reform of the collateral source rule could have lasting effects in cases such as the “no one pays list price” operations discussed above.

DAMAGE CAPS

Damage caps are the most typical type of tort reform. Caps come in different flavors. Here are two of the most popular:

Caps can be placed on noneconomic damages. More than half of all tort awards these days pay for general damages or pain and suffering.

Pain and suffering are real phenomena that a wrongdoer has no *carte blanche* to inflict upon an innocent victim. But pain and suffering are intrinsically tough to quantify: Is the pain caused by the loss of a hand “worth” \$5,000, or \$500,000, or \$5 million? Is the suffering occasioned by a patient’s knowledge that he or she is disfigured “worth” \$10,000, \$100,000, or \$1 million?

Despite ingenious attempts by economists to quantify pain and suffering, juries are not instructed on economic theories, and jury awards for noneconomic damages vary tremendously.

Only a cap—either judicial (as has been imposed by Canada’s Supreme Court) or legislative (as in Maryland, for example)—can chop off the tail of the high end of the distribution curve of noneconomic awards. Because the wide range of awards encourages settlements to avoid the risk of a very high verdict against defendants and insurers, caps on noneconomic damages are meaningful.

But the cap shouldn’t be too low. A cap of \$250,000, currently in place in California, is severe. Cases of extreme and long-lasting pain are arguably worth more than that amount, and, practically speaking, the lower the legislative cap, the greater the likelihood a state court will find the cap to violate the right in many state constitutions to redress grievances.

A second type of cap limits total damages. Virginia, for instance, has a comprehensive cap on total med-mal damages.

No judgment can exceed \$1.75 million, even if, say, a negligent physician caused a patient to require 10 remedial operations costing \$3 million. The plaintiff, his first-party insurer, and the state are on the hook for the difference.

A comprehensive med-mal cap surely reduces the average award, but only by making victims of the most egregious injuries bear part, or most, of the damage wrongfully inflicted on them. This is simply not compatible with corrective justice.

NO-FAULT COMPENSATION

One effort to stem the retirements of obstetrical-gynecological doctors consists of removing ob-gyn injuries from tort and creating a no-fault system for them, as is done for workplace injuries. Virginia implemented this solution in 1987 with its Birth-Related Neurological Injury Compensation Act.

Obstetricians who wish to participate pay \$5,000 into the BRNIC Fund each year, while other physicians licensed in the state, including those who do not practice obstetrics, are assessed \$250 per year. Participating hospitals pay \$50 for each delivery made during the prior year, with a cap of \$150,000 per year.

If a participating hospital or physician is sued for a neurological birth-related injury, the hospital or physician refers the case to the fund. If the state Workers’ Compensation Commission determines that an infant comes within the terms of the act, the commission awards a remedy limited to net economic loss (that is, deducting amounts received from collateral sources). The award is paid out



as it accrues, rather than in a lump sum. In addition to medical costs, the award compensates for modest attorney fees and loss of earnings from the age of 18 onward.

No noneconomic damages are allowed, nor is any recourse to a court. If a baby dies soon after birth, the commission may award up to \$100,000 even if there were no economic damages. On the other hand, if economic damages are substantial, there is no ceiling on recovery: Virginia's med-mal cap does not apply to amounts awarded under the act.

Interestingly, the fund has not proven universally popular among ob-gyns. Many have opted not to pay the \$5,000 annual assessment, perhaps because they assume their hospital is already covered, or because med-mal awards are limited by the med-mal cap.

In addition, much litigation has centered on whether a given baby's injury qualifies as a birth-related neurological injury. A skillful plaintiff's attorney intent on obtaining tort relief can characterize a child's injury in ways that maximize the chance the commission (which is intent on minimizing payoffs to ensure solvency of the fund) will turn down the claim because it supposedly does not fall within this definition.

And, since a mother may sue her ob-gyn for the mother's own injuries, even if the physician is a participant in the fund, the statute has not thwarted access to the courts. Only a half-dozen claims per year, on average, are resolved through the fund. Those tend to be mammoth suits where the plaintiff is trying to evade the cap. As a result, the fund is in danger of insolvency, which would result in a substantial increase in assessments.

STOP-LOSS FUNDS

One reform recently adopted in Maryland is the insurance

stabilization fund, often referred to as a stop-loss fund. The fund (created by a new tax on HMO premiums) provides that government will absorb all liability insurers' costs in excess of a relatively low malpractice premium threshold.

This concept is disconcerting in several ways. From a political standpoint, it suits the physicians' lobby (it caps their liability insurance premiums) and the plaintiffs lawyers' lobby (it allows them to continue obtaining lofty judgments).

But from a torts perspective, this is most regrettable. If the problem is one of excessive verdicts, it would be better to adopt more-stringent caps than to have those who will provide revenue for the fund—HMO customers under the Maryland law—shoulder the burden of these excesses.

If the problem is that certain losses deserve payment from the public weal even though no one is at fault, then exiting tort and establishing no-fault insurance, as Virginia has done for birth-related injuries, would be appropriate. If the problem is that Maryland doctors are for some reason prone to excessive negligence, then the fund shifts some of the cost of that error from culpable physicians to innocent insurers and insureds.

Ultimately, establishing a stop-loss fund retains torts and places state government in the inappropriate role of über-insurer. Socialism is simply not the way to contain medical costs.

In sum, though tort reform is desirable, state legislatures need to think carefully about their options. Some solutions are simply better adapted to the nature of tort law than are others.

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