Resolving Malpractice Claims after Tort Reform: Experience in a Self-Insured Texas Public Academic Health System

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UT System’s Malpractice Closed Claims

- Under its Professional Medical Liability Benefit Plan, established in 1977, the University of Texas System self-insures medical liability claims against over 6,000 faculty physicians, dentists, residents, and fellows, as well as approximately 3,500 medical students.

- UT System’s Office of General Counsel works with risk managers at the health campuses to resolve claims and with the Texas Attorney General’s Office to defend lawsuits.

- Our study included six health campuses around the state: UT Southwestern Medical Center in Dallas, UT Health Science Center at San Antonio, UT Health Science Center at Houston, UT Medical Branch at Galveston, UT MD Anderson Cancer Center, and UT Health Science Center at Tyler.

- The UT System also self-insures malpractice risk for six hospitals owned or operated by certain campuses, but most hospital and clinic care provided by covered physicians occurs at independent but affiliated facilities.
Types of Cases Giving Rise to Claims

- Treatment (316 cases; 38 percent)
- Surgery (252 cases; 31 percent)
- Diagnosis/diagnostic procedures (89 cases; 11 percent)
- Labor and delivery (42 cases; 5 percent)
- Medication (29 cases; 4 percent)
- Emergency care (27 cases; 3 percent)
- Anesthesia (17 cases, 2 percent)
- Falls (14 cases; 2 percent)
- **Wrongful death was alleged in 148 claims (18 percent)**
A Better Approach to Medical Error: Communication and Resolution Programs (CRPs)

• **Transparency**: Tell patients what happened to them
• **Assistance**: Try to make things easier for injured patients and their families
• **Learning**: Improve safety for future patients
• **Empathy**: Empower and support caregivers

Legal environment matters -- biggest challenges at **extremes** (e.g., NY and TX).
Malpractice Tort Reform in Texas

• For claims filed on or after September 1, 2003, noneconomic damages are limited to $250,000 against physicians and $250,000 against up to two hospitals, for maximum damages of $750,000 (Tex. Civ. Prac. & Rem. Code. § 74.301).

• The statute of limitations is reduced to 2 years from the act or omission (Tex. Civ. Prac. & Rem. Code § 74.251 (a)). Claims involving emergency care are barred unless “willful and wanton” (Tex. Civ. Prac. & Rem. Code § 74.151).

• The legislation increased the disciplinary authority of the Texas Medical Board.

• Public entities are subject to additional rules. For example, a nexus must exist between injury and the “use or misuse of tangible personal property” (Dallas Area Rapid Transit v. Whitley 2002). Total damages against state agencies are effectively capped at $250,000 (Tex. Civ. Prac. & Rem. Code Ann. § 101.023).

• However, general liability rules applied to public academic physicians until the Texas Supreme Court ruled that government workers acting within the scope of their employment may not be sued as individuals (Franka v. Velasquez 2011).
We Studied UT System’s Malpractice Closed Claims Before and After Tort Reform

• We studied malpractice claims covered by UT System’s plan (N = 822) that were closed in fiscal year 2001–02 (244 claims/60 settlements), 2009–10 (99 claims with 16 settlements), 2010–11 (111 claims/22 settlements), 2011–12 (113 claims/22 settlements), 2012–13 (102 claims/30 settlements), 2013–14 (80 claims/12 settlements), and 2014–15 (73 claims/16 settlements).

• Only one payment in the years we reviewed resulted from a judgment at trial rather than a voluntary settlement between the parties. Even that case was subsequent resolved by mediation pending appeal.

• The first year we studied predates tort reform in Texas. Of six post-tort reform years, the first three predate the *Franka* decision.

• Although it still lacks a formal CRP, UT System made a commitment to transparency with patients in 2008, and in 2010 UT System hired a consultant to work with the health campuses to implement that commitment.
Overall Claims, Lawsuits, and Payments

- Lawsuits had been filed by plaintiffs in 303 of the 822 cases closed during the years we studied (37 percent).
- The remainder of the closed claim files (519/822, 63 percent) had been opened as a result of internal incident reports, complaints, or correspondence from patients, family members, and/or attorneys without formal litigation being commenced.
- Whether a lawsuit was filed was strongly correlated with the likelihood of payment (53 percent vs. 33 percent; p < .001) and with the settlement amount ($505,813 vs. $168,482; p < .035). This is an expected finding, given the incentives of plaintiffs’ lawyers to select cases based on those parameters.
Fewer Claims, Lawsuits, and Payments After Tort Reform

• Closed claims dropped from 244 in 2001–02 to an annual mean of 96 in 2009–15
• Closures following lawsuits dropped from 136 in 2001–02 to an annual mean of 28 in 2009–15
• Paid claims dropped from 60 in 2001-02 to an annual mean of 20 in 2009–15.
Settlement Amounts Declined After Tort Reform

• The mean amount paid by UT System for all study years was $168,084 (median $100,000; range $119–1,450,000).
  • In 10 cases (6%), alternative or additional payments were made by a hospital not owned by UT System, with mean total compensation of $1,043,435 (median $48,750; range $4,353–10,000,000).
• Mean payment amounts dropped sharply from $279,851 in 2001–02 to $92,661 in 2009–12 and $98,067 in 2012–15 (p < .001 between the earlier and either later period).
## Settlement Amounts by Quartile

### Table 1: Settlement Amounts

| Variable                        | First                          | Second                       | Third                        | Fourth                       |
|---------------------------------|动|动|动|动|
| Settlement amount, $            | 46,543 (901–95,000) (n = 14)  | 167,726 (100,000–290,000) (n = 15) | 448,867 (300,000–600,000) (n = 15) | 1,695,267 (620,000–8,000,000) (n = 15) |
| Plan liability paid, $          | 18,829 (0–67,000) (n = 15)    | 105,230 (75,000–165,000) (n = 15) | 310,100 (190,000–449,000) (n = 15) | 614,667 (450,000–1,250,000) (n = 15) |
| UT System paid, $               | 31,218 (0–75,444) (n = 14)    | 127,167 (80,000–200,000) (n = 15) | 318,500 (200,000–495,000) (n = 15) | 644,600 (495,000–1,450,000) (n = 15) |

*Note:* This table excludes one case categorized by UT System as a case with payment but with a $0 settlement amount.
Decline and Shift to Payment Without Suit
Some Payments Without Lawsuits or Lawyers After Tort Reform

• Following tort reform, most patients and families were represented by an attorney even without formal litigation.

• In 2009–12, payments were made in 20 cases (33 percent of payments) without lawsuits but with attorney representation.

• In 2012–15, payments were made in 17 cases (29 percent of payments) without lawsuits but with attorney representation.

• Unrepresented patients received payment in 13 cases closed in 2009–12 (22 percent of payments; mean amount $60,566) and in 24 cases closed in 2012–15 (41 percent of payments; mean amount $109,410).
Resolution Remains Slow After Tort Reform

• Overall time from event to closure dropped following the enactment of tort reform, likely because the statute of limitations was reduced, but time from claim to closure did not change significantly.

• For all cases (adult and minor) closed without payment, mean time from event to closure was 1,312 days in 2001–02, 1,254 days in 2009–12, and 1,193 days in 2012–15.

• For adult cases with payment, mean time from event to closure was 1,064 days in 2001–02, 937 days in 2009–12, and 878 days in 2012–15.
# Resolution Times By Quartile

## Table 2: Time to Resolution

<table>
<thead>
<tr>
<th>Variable</th>
<th>First (Mean, Range)</th>
<th>Second (Mean, Range)</th>
<th>Third (Mean, Range)</th>
<th>Fourth (Mean, Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case resolution time</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2001–2002 ($n = 60$)</td>
<td></td>
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</tr>
<tr>
<td>Time from event to claim</td>
<td>116 (1–191) ($n = 15$)</td>
<td>266 (191–407) ($n = 15$)</td>
<td>536 (420–677) ($n = 15$)</td>
<td>822 (680–2,252) ($n = 15$)</td>
</tr>
<tr>
<td>Time from claim to closure</td>
<td>253 (15–495) ($n = 15$)</td>
<td>572 (501–643) ($n = 15$)</td>
<td>771 (653–961) ($n = 15$)</td>
<td>1,326 (979–2,125) ($n = 15$)</td>
</tr>
<tr>
<td>Time from event to closure</td>
<td>628 (16–843) ($n = 15$)</td>
<td>992 (853–1,184) ($n = 15$)</td>
<td>1,267 (1,201–1,330) ($n = 15$)</td>
<td>1,778 (1,353–3,231) ($n = 15$)</td>
</tr>
<tr>
<td>2009–2012 ($n = 60$)</td>
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</tr>
<tr>
<td>Time from event to claim</td>
<td>86 (9–120) ($n = 15$)</td>
<td>159 (121–187) ($n = 15$)</td>
<td>275 (190–388) ($n = 15$)</td>
<td>917 (389–2,819) ($n = 15$)</td>
</tr>
<tr>
<td>Time from claim to closure</td>
<td>201 (101–304) ($n = 15$)</td>
<td>412 (319–576) ($n = 15$)</td>
<td>761 (591–900) ($n = 15$)</td>
<td>1,528 (923–2,570) ($n = 15$)</td>
</tr>
<tr>
<td>Time from event to closure</td>
<td>335 (173–472) ($n = 15$)</td>
<td>640 (504–799) ($n = 15$)</td>
<td>1,126 (805–1,420) ($n = 15$)</td>
<td>2,238 (1,553–5,336) ($n = 15$)</td>
</tr>
<tr>
<td>2012–2015 ($n = 58$)</td>
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</tr>
<tr>
<td>Time from event to claim</td>
<td>50 (5–105) ($n = 15$)</td>
<td>148 (109–184) ($n = 15$)</td>
<td>310 (187–449) ($n = 14$)</td>
<td>974 (465–2,721) ($n = 14$)</td>
</tr>
<tr>
<td>Time from claim to closure</td>
<td>93 (33–129) ($n = 15$)</td>
<td>279 (168–408) ($n = 15$)</td>
<td>527 (423–650) ($n = 14$)</td>
<td>1,338 (696–2,191) ($n = 14$)</td>
</tr>
<tr>
<td>Time from event to closure</td>
<td>238 (124–384) ($n = 15$)</td>
<td>555 (411–689) ($n = 15$)</td>
<td>896 (701–1,094) ($n = 14$)</td>
<td>1,988 (1,122–3,371) ($n = 14$)</td>
</tr>
</tbody>
</table>
Many Delays Result From Medicare Liens

• In recent years, the federal Medicare program has vigorously asserted its statutory right of repayment from tort settlements and other third-party funds under the ‘Medicare as Secondary Payer” regulations.

• In 2012–15, 15 of the 58 settlements (26 percent) could not be finalized until the amount of a Medicare lien had been identified and negotiated.

• Mean time from claim to resolution was greater for claims with than for claims without Medicare liens (856 vs. 438 days; p < .011).

• For the 15 cases with Medicare liens, a median of 153 days elapsed between signing a settlement agreement and formally closing the case file (mean 449 days, range 1–1,574 days).
Non-Disclosure Conditions to Settlement Became Stronger After Tort Reform

• Omitting 5 cases without a UT System payment, 88% of settlement agreements (152/173) included nondisclosure agreements selectively binding the claimant.

• All clauses prohibited disclosing the amount and terms of the settlement agreement.

• Settlements in 2009–13 were more likely than settlements in 2001–02 to prohibit disclosing the event of settlement (55% vs. 33%; p < .018), to prohibit disclosing the underlying facts of the claims (57% vs. 28%; p < .002), and to prohibit complaints to regulatory bodies (43% vs. 7%; p < .001). However, explicit language imposing confidentiality on the attorney as well as the claimant decreased (22% vs. 75%; p < .001).
But UT System Improved Its Non-Disclosure Practices After 2013

• In 2015, we published data on confidentiality clauses in the cases we reviewed through FY 2011–12 (Sage, Jablonski, and Thomas, JAMA Internal Medicine).

• We concluded that tightly restricting patients from disclosing information as a condition of settlement seemed incompatible with emerging understandings of patient safety, transparency, and compassionate care following unanticipated injury.

• As a result of that research, UT System changed its practices regarding restrictions on patients’ disclosing underlying facts and on complaining to regulatory bodies.

• Settlements in 2013–15 were less likely than settlements in 2009–13 to prohibit disclosing the underlying facts of the claims (23% vs. 59%; p < .003), and to prohibit complaints to regulatory bodies (14% vs. 45%; p < .007). The overall use of nondisclosure clauses also decreased (79% vs. 99%; p < .001). Clauses where they existed were more likely to explicitly prohibit disparagement of the physicians or health system (23% vs. 3%; p < .002).
Changes in Non-Disclosure Provisions

Table 3: Restrictions in Nondisclosure Agreements

<table>
<thead>
<tr>
<th></th>
<th>Clauses Prohibiting</th>
<th>Clauses Prohibiting</th>
<th>Clauses Prohibiting</th>
<th>Clauses Prohibiting</th>
<th>Clauses Prohibiting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Settlements</td>
<td>Number of Confidentiality</td>
<td>Disclosure of Settlement</td>
<td>Disclosure</td>
<td>Disclosure to Disparagement of</td>
</tr>
<tr>
<td></td>
<td>(%)</td>
<td>Clauses (%)</td>
<td>Amount (%)</td>
<td>Terms (%)</td>
<td>of Facts (%)</td>
</tr>
<tr>
<td>2001–2002</td>
<td>57 (33)</td>
<td>43 (28)</td>
<td>43/43 (100)</td>
<td>43/43 (100)</td>
<td>12/43 (28)</td>
</tr>
<tr>
<td>2009–2011*</td>
<td>36 (21)</td>
<td>35 (23)</td>
<td>35/35 (100)</td>
<td>35/35 (100)</td>
<td>19/35 (54)</td>
</tr>
<tr>
<td>2011–2013*</td>
<td>52 (30)</td>
<td>52 (34)</td>
<td>52/52 (100)</td>
<td>52/52 (100)</td>
<td>32/52 (62)</td>
</tr>
<tr>
<td>2013–2015*</td>
<td>28 (16)</td>
<td>22 (15)</td>
<td>22/22 (100)</td>
<td>22/22 (100)</td>
<td>5/22 (23)</td>
</tr>
<tr>
<td></td>
<td>173</td>
<td>151</td>
<td>151/151 (100)</td>
<td>151/151 (100)</td>
<td>68/151 (45)</td>
</tr>
</tbody>
</table>
Conclusions

• In a large, self-insured public academic health system in Texas, malpractice claims and payments decreased sharply following legal changes that reduced rights to sue and available damages.

• Patterns of resolution suggest efforts by UT System to provide some compensation to injured patients in cases that were no longer economically viable for plaintiffs’ lawyers to litigate.

• A higher percentage of settlements were reached without formal litigation, although most claimants were represented by attorneys.

• Even after tort reform, claims that resulted in payment remained slow to resolve, which was worsened for claimants subject to Medicare secondary payer rules.

• Strict confidentiality became a more common condition of settlement, although restrictions were subsequently relaxed in order to further transparency and improve patient safety.

• Based on this experience, health systems operating in a low-tort environment should work with policy makers, plaintiffs’ attorneys, and patient groups to assist unrepresented patients, facilitate early mediation, limit nondisclosure obligations following settlement, and expedite the resolution of Medicare liens.