Medical Malpractice Reform in Three Southern States


Abstract

Louisiana, Alabama, and Mississippi have adopted medical malpractice reform legislation in response to the three crises in medical liability insurance. In 1975, Louisiana adopted damages caps, created a patient compensation fund, and mandated the submission of claims to screening panels. In 1987, Alabama adopted damages caps and modified the collateral source rule, but these reforms were declared unconstitutional in the 1990s. In 2002, Mississippi adopted a damages cap. In this article we review the effect of these reforms on the malpractice environment in each state. We find that based on the total value of paid claims and paid claims per 1,000 physicians, Alabama has the most difficult environment for malpractice plaintiffs while Louisiana has the most plaintiff-friendly environment. Alabama’s medical liability insurance premium rates are also substantially lower than the rates in either Mississippi or Louisiana. We conclude that despite its higher costs, Louisiana has established a stable malpractice system that is supported by providers and insurers, provides compensation for more victims of malpractice than the other states, and provides a more useful model for medical malpractice reform.

Introduction

Three neighboring southern states, Louisiana, Alabama, and Mississippi, have adopted medical malpractice reform legislation with variations among them in the nature and timing of these reforms. The adoption of malpractice reform legislation in these states has coincided with three medical liability insurance crises that have occurred in the United States during the past thirty years. Each of these crises has resulted in a flurry of state legislative activity to counteract problems with the availability and affordability of medical liability insurance. The timing of the adoption of malpractice reform legislation in our three states reflects these national trends.
In 1975, Louisiana adopted comprehensive malpractice reform legislation that placed a cap on damages, created a patient compensation fund, and required the submission of malpractice claims to a pre-trial review panel.\(^1\) The constitutionality of the damages cap has been consistently upheld by the Supreme Court of Louisiana.\(^2\) In 1975, Alabama passed malpractice reform legislation that modified the statute of limitations, eliminated *ad damnum* clauses, defined the standard of care in malpractice actions, authorized post-claim agreements to arbitrate, and provided for the periodic payout of future damages.\(^3\) Subsequently, in 1987, Alabama adopted medical malpractice reform legislation that included damages caps, modification to the collateral source rule, mandatory periodic payout of future damages, and restrictions on expert testimony.\(^4\) In the 1990s, however, the Alabama Supreme Court invalidated the most significant reforms, i.e., the damages caps and the modification of the collateral source rule.\(^5\) In 2002, 2003 and 2004, Mississippi adopted reform legislation that included a damages cap, various procedural reforms (e.g., venue provisions, notice of suit requirements, special pleading rules), the creation of a state run risk pool, and the modification of joint and several liability.\(^6\)

Surprisingly, although it is the state where the most significant tort reforms (i.e., damages caps) were declared unconstitutional in the 1990s, Alabama has the lowest number of paid claims per 1,000 non-federal physicians and the lowest value of total paid claims of these three states. On the other hand, Louisiana, where significant reforms such as a damages cap and screening panel have been in effect since the mid-1970s, has the highest number of paid claims per 1,000 physicians and the highest value of total paid claims. Furthermore, if the surcharges paid to the Louisiana Patient

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\(^1\) See discussion, *infra* at III. A.

\(^2\) See discussion, *infra* at III. A.

\(^3\) See discussion, *infra* at III. B.

\(^4\) See discussion, *infra* at III. B.

\(^5\) See discussion, *infra* at III. B.

\(^6\) See discussion, *infra* at III.C.
Compensation Fund Medical are included, then liability insurance premiums are significantly lower in Alabama than in either Louisiana or Mississippi.  

In order to better understand the nuances and subtleties of the relationship between malpractice reform legislation and the malpractice environment of each state, we begin in Part I with an introduction to the three malpractice insurance crises, including a review of the controversy over the causes of these crises. We then briefly survey nationwide trends in the enactment of malpractice reform legislation and court decisions on its constitutionality. In Part II, we review the literature on the effectiveness of malpractice reforms. In Part III, we discuss the adoption of malpractice reform legislation in each state, reviewing the background of the reforms, describing the reforms enacted, and briefly discussing court decisions on the constitutionality of the reforms. In Part IV, we assess the effects of malpractice reforms on the malpractice environments in these states, focusing primarily on the effects of these reforms on physicians rather than on the effects on institutional providers.

I. Malpractice Crises and Reform Legislation 1975- Present

A. The Three Crises and Their Causes

There have been three national malpractice insurance crises since 1974 with periods of relative stability and moderate premium increases intervening between them. The first crisis of the mid-1970s involved both a spike in premiums and the lack of availability of malpractice insurance coverage. Premiums rose as much as 500 percent in some states, and several commercial insurers withdrew from the medical liability line of business. It was during this period that physician mutual insurers were formed in several states. Several states responded by passing tort reform legislation focusing specifically on malpractice claims.

The malpractice insurance crisis subsided by the late 1970s, but by 1985, the general liability insurance market as well as the malpractice insurance market was again

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7 See discussion, infra at IV. D.
9 DANZON, supra note 8.
10 DANZON, supra note 8.
11 Sloan, supra note 8, at 629.
in crisis. In the mid-1980s, "to bring premiums into line with incurred losses," medical liability insurance premiums had to be increased by 20 to 40 percent across the country and by 50 to 100 percent in some areas. The crisis of the mid-1980s was primarily a crisis of affordability across several lines of insurance and in several jurisdictions. The legislative response in many states was to pass tort reform legislation that applied in all personal injury actions, including malpractice actions.

A third crisis occurred in the early 2000s. Premiums for all physicians nationwide rose by 15 percent between 2000 and 2002—nearly twice as fast as total health care spending per person." Increases were even higher for some specialties: "22 percent for obstetricians/gynecologists and 33 percent for internists and general surgeons." In addition, in December of 2001, St. Paul, a malpractice insurer operating in forty-five states, announced its decision to withdraw from the medical malpractice liability insurance market due to heavy losses in that line of business. Two other major insurers—PHICO and Frontier Insurance Group—also withdrew from the medical liability insurance market.

There has been little agreement among various interest groups as to the causes of the three malpractice insurance crises. Consumer groups and trial lawyers typically reject the notion that these crises are the result of increased loss payouts and instead blame insurer losses on investments and the insurance cycle. On the other hand, providers and insurers typically point to increases in loss payouts and litigation costs as

17 Id.
the root causes of the crises. Recent studies support the view that the crises have not been caused by spikes in loss payouts. In a 2005 book, Professor Tom Baker contends that the recurrent crises in the malpractice insurance market have been caused by the insurance underwriting cycle rather than from increases in loss payouts. He attributes most of the volatility in malpractice premiums to a phenomenon in which loss estimates are periodically underestimated until actual loss experience results in firms overestimating predicted losses and increasing reserves, thereby causing a spike in premiums. This problem is exacerbated by the time it takes for actual losses to become known. Professor Baker also notes that medical inflation is the most important factor influencing rate of growth in loss payouts in medical malpractice cases.

In a 2005 article, Chandra et al. examine the link between rising malpractice loss payments and increasing malpractice liability insurance premiums using evidence from the National Practitioner Data Bank. They note that proponents of damages caps have argued that rising malpractice loss payouts have been the primary reason for substantial increases in malpractice premiums. But they further observe that while “the average payment grew... .52 percent between 1991 and 2003... the growth of the top 10 percent of payments is smaller than that of the average payment.” On this basis, they conclude that “large jury awards have not been the key drivers of malpractice growth.” Moreover, they note that “(s)tates where payments grew dramatically between the early 1990s and the early 2000s were not states where premiums grew rapidly.” They also find that the growth in loss payouts is consistent with increases in

22 Id.
23 Id.
24 Id. at 55.
26 Id. at W5-240.
27 Id. at W5-247.
28 Id.
health care spending. They believe that premium increases may largely be explained by rising medical costs and the concomitant increases in compensatory damages, increased administrative costs and declining investment income.

In 2005, Black et al. examined closed malpractice claims in Texas from 1988-2002, finding that "no crisis involving malpractice claims outcomes occurred." They also found a "weak connection between claims-related costs and short-to-medium term fluctuations in insurance premiums." They concluded that malpractice reforms may not prevent future crises, but acknowledged that "it is theoretically possible that the spike in insurance premiums was driven by a spike in the number of new claims or expected cost per claim that is not yet reflected in the closed market that we study."

B. Malpractice Reform Legislation

Malpractice reforms have been adopted in three waves of reform in response to these periodic insurance crises, with occasional enactments between crises. The malpractice crisis of the mid-1970s involved both a spike in premiums and the lack of availability of malpractice insurance coverage. It resulted in a flurry of state legislative activity that began in 1975, but the conditions of the market and the nature of the response varied greatly from state to state. In 1975, at least forty-one states authorized the creation of medical malpractice study commissions. A number of states passed legislation to authorize the creation of joint underwriting associations to force insurers to provide malpractice coverage. A few states authorized the creation of physician mutual insurers. Other popular reforms during the 1970s included: damages caps, mandatory screening panels, tightened up statute of limitations, restrictions on ad

30 Id. at W5-243.
31 Id. at W5-247.
33 Id.
34 Id.
35 Sloan, supra note 8, at 629.
37 Id. at 4.
38 Id. at 4. “Joint underwriting associations (JUAs) serve as residual market mechanisms for physicians who are unable to obtain coverage in the voluntary market.” Danzon et al., supra note 18, at 2. Typically it is funded by assessments on malpractice insurers doing business in the jurisdiction.
damnum clauses, collateral source rule modification or abrogation, restrictions on
contingency fees, and clarification or limitation of the doctrine of informed consent. Additionally, some states created patient compensation funds (PCFs) that were coupled with caps on provider liability and total damages.

In 1975, California enacted the Medical Injury Compensation Reform Act [MICRA], a package of bills that incorporated a number of provisions, including a damages cap that has become the "gold standard" for proponents of malpractice reform. MICRA capped non-economic damages at $250,000. The lack of an inflation adjustment in the MICRA cap has resulted in a ratcheting down of the cap over time. In fact, "(i)f adjusted for inflation, the cap would have reached $877,000 in 2002." Other MICRA provisions included collateral source offset, periodic payout

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40 Grossman, supra note 36, at 8-10.
41 See e.g., IND. CODE ANN. § 34-18-14-3 (2007) (PCF coupled with cap on total damages of $500,000); LA. REV. ST. ANN. § 40:1299.42 (2007) (PCF coupled with cap on total damages of $500,000); see generally Lister Hill Center, University of Alabama at Birmingham School of Public Health, Malpractice Damages Caps Table, available at http://images.main.uab.edu/isoph/LHC/DamagesCapsTable.pdf.
43 CAL. CIV. CODE § 3333.2 (West 2007) states:
(a) In any action for injury against a health care provider based on professional negligence, the injured plaintiff shall be entitled to recover noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage.
(b) In no action shall the amount of damages for noneconomic losses exceed two hundred fifty thousand dollars ($250,000).

Damages in a malpractice action may include compensatory and punitive elements. Compensatory damages (compensation for losses) include both economic (e.g., lost earnings and medical expenses) and non-economic components (e.g., pain and suffering). DANZON, supra note 8.
45 CAL. CIV. CODE § 3333.1 (West 2007). At common law, plaintiffs were permitted to recover damages even though the plaintiff has been reimbursed for those damages by a collateral source unrelated to the defendant. For example, a plaintiff could recover for medical expenses even if those expenses were covered by plaintiff's health insurer. The California statute modifies this common law rule by permitting the defendant to introduce evidence that the plaintiff was reimbursed for expenses by a collateral source. Since the mid-1970s many jurisdictions have adopted statutes requiring the judge to offset the moneys from the collateral source or permitting evidence of reimbursement to be presented to the jury with evidence of the payment of premiums by the plaintiff. Randall R. Bovbjerg, Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card, 22 U.C. DAVIS L. REV. 499, 526 (1989).
of future damages, limits on the contingency fees that may be charged by plaintiff's attorney, a statute of repose, mandatory advance notice of a claim, and binding arbitration.

MICRA has been in effect for more than three decades, and malpractice reform advocates frequently point to its success in moderating malpractice premium increases. On the other hand, tort reform opponents have argued that it is not the damages cap that has kept premium increases in California at moderate levels, but rather the passage in 1988 of Proposition 103, which included a twenty percent rollback on premiums for all property casualty insurers, a one year moratorium on increases, and a right of consumers to challenge premium increases of more than fifteen percent. Proponents of tort reform, however, have continued to insist that it is the MICRA, rather than Proposition 103, that accounts for the relatively modest increases in malpractice liability.

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46 CAL. CIV. PROC. CODE § 667.7 (West 2007). At common law, plaintiffs were entitled to receive a damages award as a lump sum including past damages and future damages discounted to present value. The California statute modifies this common law rule by mandating, upon the request of any party, the periodic payout of future damages that exceed $50,000. Under this law these future damages are to be paid out as they accrue. Since the mid-1970s, several jurisdictions have passed statutes mandating or permitting periodic payout. Bovbjerg, supra note 45, at 527.

47 CAL. BUS. & PROF. CODE § 6146 (West 2007). This statute was adopted in 1975 and amended in 1987. Its current version provides for limits of 40% of the first $50,000 recovered; 33% and 1/3 of the next $50,000; 25% of the next $500,000, and 15% of any amount exceeding $600,000. Since the mid-1970s, a number of jurisdictions have passed statutes imposing specific percentage limitations or providing for reasonableness review. Bovbjerg, supra note 45, 522-23.

48 CAL. CIV. PROC. CODE § 340.5 (West 2007). A statute of repose places an absolute time limit on when an action must be filed regardless of whether plaintiff has discovered the injury. The California statute has a one year discovery rule coupled with a three year statute of repose than runs from the date of the injury with certain exceptions including fraud, intentional concealment, and presence of a foreign body with no therapeutic or diagnostic purpose in the plaintiff's body. Several states have adopted this type of legislation typically with a three or four year statute of repose. Bovbjerg, supra note 45, at 524.

49 CAL. CIV. PROC. CODE § 364 (West 2007) requires 90 days advance notice of intent to file a medical malpractice claim.

50 CAL. CIV. PROC. CODE § 1295 (West 2007) provides for the enforcement of pre-claim agreements to arbitrate that follow a specified format. Beginning in the mid-1970s, several states passed legislation endorsing voluntary pre-claim agreements to arbitrate. This legislation sometimes imposes special requirements to ensure that the plaintiff is aware that the right to jury trial is being given up. Bovbjerg, supra note 45, at 522.


insurance premiums in California since 1988.\textsuperscript{53}

When, in the mid-1980s, the general liability insurance market and the malpractice insurance market experienced another spike in premiums, insurers and their customers turned to state legislatures for relief in the hope that tort reform legislation would stabilize insurance markets. In 1986, as a result of their efforts, tort reform measures were adopted in forty-one states.\textsuperscript{54} Many of these reforms were the same as those enacted in the 1970s (e.g., damages caps, collateral source offset, periodic payout, etc.).\textsuperscript{55} In the early 2000s, several states again passed traditional malpractice reform as a reaction to a crisis of affordability and availability.\textsuperscript{56}

Traditional malpractice reform measures are not intended to reduce the costs of medical liability insurance premiums by reducing the rate of injuries, but rather are intended "to alter the probability of winning an award, the size of the award, and the costs of litigation."\textsuperscript{57} Indeed, most traditional reform measures are designed to reduce claim frequency and severity.\textsuperscript{58} However, Professor Sage has argued that these traditional malpractice reforms were not an appropriate response to the early 2000s crisis.\textsuperscript{59} He contended that the crisis of the early 2000s was different than earlier crises because it was connected to "overall health policy."\textsuperscript{60} In this regard, he identified "four key areas" in which health care system changes uniquely impacted malpractice reform in the early 2000s: "patient safety, medical progress, industrialization, and cost containment."\textsuperscript{61}

Damages caps have been the "most controversial and important aspect of tort reform,"\textsuperscript{62} and as seen from the survey of empirical studies, \textit{infra}, the only reform that

\begin{itemize}
  \item \textsuperscript{53} William Hamm, H.E. Frech, III & C. Paul Wazzan, \textit{MICRA, Not Proposition 103, Accounts for the Relatively Low Growth in Medical Malpractice Insurance Costs in California} (2005), \textit{available at} \url{http://www.micra.org/healthcare-costs/docs/proposition_103_report.pdf}.
  \item \textsuperscript{54} Glenn Blackmon & Richard Zeckhauser, \textit{The Effect of State Tort Reform Legislation on Liability Insurance Losses and Premiums} 1 (1990).
  \item \textsuperscript{55} Bovbjerg, \textit{supra} note 45, at 538.
  \item \textsuperscript{56} William N. Sage, \textit{Understanding the First Malpractice Crisis of the 21st Century, in Health Law Handbook} 1, 29 (Alice Gosfield ed., 2003).
  \item \textsuperscript{58} Id.
  \item \textsuperscript{59} Sage, \textit{supra} note 56, at 29.
  \item \textsuperscript{60} Sage, \textit{supra} note 56, at 2.
  \item \textsuperscript{61} Sage, \textit{supra} note 56, at 3.
  \item \textsuperscript{62} Michael J. Saks, Lisa A. Hollinger, Roselle S. Wissler, David Lee Evans & Allen J. Hart,
has consistently been shown to have a significant impact on malpractice insurance premiums. The authors have developed a table on damages caps that is available at the Lister Hill Center website, which provides a comprehensive review of the states' adoption of damages caps applicable in malpractice cases and decisions on their constitutionality.63 As seen from this table, damages caps have been popular reforms that have been adopted during all three crises and sometimes in the interludes between crises.

During the most recent crisis, there have been unsuccessful attempts to adopt damages caps at the federal level.64 On several occasions, President Bush has asked Congress to adopt a national cap patterned after the MICRA cap, and the House has on several occasions passed such a cap only to have it blocked in the Senate.65 A 2003 study issued by the Joint Economic Committee of the U.S. Congress estimated that comprehensive malpractice reform at the federal level including a cap of $250,000 on non-economic damages would result in “budgetary savings of more than $19 billion per year, reduce the number of Americans without health coverage by up to 3.9 million, and lead to an environment that is significantly more receptive to efforts to improve patient safety and reduce medical errors.”66

The United States Supreme Court has never ruled on the constitutionality of malpractice reform measures under the United States Constitution, and state courts are divided on the constitutionality of tort reform measures as analyzed under various provisions in their state constitutions.67 Damages caps are the tort reform measure that has most frequently been held to be unconstitutional.68 Although damages caps are susceptible to attack under both the federal and state constitutions, state courts have typically focused on provisions in their own state constitutions.69 This approach

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64 Finley, supra note 42, at 1263-64.
65 Finley, supra note 42, at 1263-64.
68 Id.
insulates the state court’s decision from review by the United States Supreme Court because there is no federal question. As seen from the LHC table, courts in several states have struck down damages caps as unconstitutional while other state courts have rejected these challenges.\(^{70}\)

II. Review of Published Empirical Research on the Effects of Malpractice Reforms

The arguments advanced by tort reform advocates and their opponents have changed very little over the past four decades.\(^{71}\) Proponents of MICRA-style reforms have argued that the reforms will reduce the volatility of malpractice liability insurance markets and eventually result in premiums being kept at manageable levels for physicians.\(^{72}\) They cite to studies indicating that reforms will enhance access to care and keep health care costs down by reducing defensive medicine.\(^{73}\) They further argue that physicians will relocate to, and continue to practice in, states that adopt malpractice reforms because of reduced fear of litigation and lower malpractice insurance premiums.\(^{74}\) In calling for a nationwide cap on damages, President Bush has also contended that reforms are necessary because health care cost inflation is attributable in part to the costs of defensive medicine driven by the fear of frivolous malpractice claims.\(^{75}\)

The debates between proponents and opponents of proposed federal MICRA-style reforms have focused on the effects of reforms on malpractice premiums, defensive medicine, and access to care. In his 2003 testimony before Congress, Donald Palmisano, a former President of the American Medical Association (AMA) and a physician from Louisiana, called for the enactment of federal legislation patterned after MICRA, including a $250,000 cap on non-economic damages.\(^{76}\) He testified that this


\(^{71}\) See generally Sage, supra note 56.

\(^{72}\) AMA, supra note 20, at 11-15.

\(^{73}\) AMA, supra note 20, at 11-15.

\(^{74}\) AMA, supra note 20, at 11-15.


legislation was necessary because many physicians could either no longer find or were unable to afford liability insurance and thus were closing their practices, retiring or reducing services.\textsuperscript{77}

In his testimony, Doctor Palmisano referred to two reports prepared by the United States Department of Health and Human Services (HHS) in support of his claim that states with caps on non-economic damages had experienced only moderate increases in rates while states without such caps had experienced much larger increases.\textsuperscript{78} He argued that federal MICRA-style reforms were necessary because state courts had struck down many reforms as unconstitutional. He contended that the adoption of MICRA was responsible for keeping premium increases on medical liability insurance in California at moderate levels. Doctor Palmisano urged congressional passage of legislation patterned after the MICRA because of its effectiveness "especially at controlling non-economic damages."\textsuperscript{79}

On the other hand, opponents of reforms have asserted that reforms have not been successful in stabilizing the insurance market and moderating the increases in premium levels. In this regard, they have pointed to the insurance cycle as the cause of the periodic crises in liability insurance. They have argued that, during times when returns on investment are higher, premium rate increases have been moderate because insurers want to attract capital, but when investment income decreases, insurers have raised rates to make up for lower investment income and sought to shed marginal risks or less profitable lines of insurance.\textsuperscript{80}

Trial lawyers and consumer groups attack malpractice reforms as being ineffective in controlling liability insurance costs, expanding access to care, and reducing defensive medicine. For example, a 2007 press release by the American Association of

\textsuperscript{77} Id. at 122.


\textsuperscript{79} Palmisano Statement, supra note 76, at 127.

Justice (formerly known as the Association of Trial Lawyers of America or ATLA) claimed that caps do not work and that premiums continued to go up in several states after the enactment of caps. 81 In response to claims that doctors have been forced out of practice by the increased cost of malpractice liability insurance, a 2006 ATLA backgrounder, relying on a 2003 report from the General Accounting Office (GAO), contended that many of the anecdotes about doctor’s retiring, relocating, or closing practices could not be substantiated. 82 The 2006 ATLA backgrounder also cited a 2003 GAO report in support of its argument that the cost of defensive medicine had not been “reliably measured.” 83 Additionally, it relied on data from a 2005 report prepared by Jay Angoff, the former Insurance Commissioner of Missouri, to support its assertion that loss payouts for malpractice claims have been stable or even decreasing. 84

Thus, proponents and opponents of tort reform typically disagree on the effectiveness of malpractice reforms. There are now a number of empirical research studies looking at the potential effects of malpractice liability reform. In the remainder of this section, we will review studies on the effect of malpractice reforms on

malpractice insurance premiums, defensive medicine, access to care, health insurance premiums, patient safety and the compensation of victims of malpractice.

A. The Effect of Malpractice Reforms on Medical Liability Insurance Premiums

Supporters of malpractice reform contend that the spike in malpractice insurance premiums during the periodic crises have been caused by increases in large judgments that have also increased settlement amounts. 85 While there is evidence that

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85 Chandra et al., supra note 25, at W5-240.
some reforms, and particularly damages caps, reduce loss payouts, establishing a link between reforms and lower premiums has been more elusive. Reports by governmental agencies released in the 1980s did not attempt to establish a link between tort reforms and lower liability insurance premiums. However, some more recent reports issued by governmental agencies have found this link. A 2002 report issued by HHS argued that damages caps have been shown to reduce malpractice liability costs and health care costs. The report blamed increased malpractice insurance premiums primarily on increases in large verdicts. The report noted that “[s]tates with limits of $250,000 or $350,000 on non-economic damages have average combined highest premium increases of 12-15%, compared to 44% in states without caps on non-economic damages.”

Focusing more specifically on the effect of MICRA, the report claimed that “(o)insurance premiums in California have risen by 167% (over the past 25 years). . .while those in the rest of the country have increased 550%.”

The 2002 HHS report was followed by an update issued by HHS in 2003 that claimed, “[p]remiums charged to specialists in 18 states without reasonable limits on non-economic damages increased by 39% between 2000 and 2001. Premiums in these states have now gone up an additional 51%.” This second report further asserted that, “[o]ver the last two years, states with limits of $250,000 or $350,000 on non-economic damages have seen average combined highest premium increases of 18%, but states without reasonable limits on non-economic damages . . . have seen average increases of 45%.”

In contrast, other governmental studies have concluded that establishing a direct link between malpractice reforms and reduced premiums is a task fraught with

87 Nelson, supra note 69, at 535-47.
89 Id. at 9-12.
90 Id. at 4.
91 Id. at 17.
93 Id. at 23.
For example, a June 2003 Report issued by GAO noted that it was impossible with currently available data to determine whether damages caps reduce premiums. The report described malpractice insurance premium increases in seven states (CA, FL, MN, MS, NV, PA & TX) and analyzed the factors that led to these increases. The GAO report asserted that a cap on non-economic damages could decrease loss severity and the frequency of claims by limiting loss payouts. It further theorized that decreases in the frequency and severity of losses could also reduce premium rates because insurers would be better able to predict their payouts for non-economic damages, thereby reducing uncertainty. Nonetheless, the report concluded that since no comprehensive source of data existed on the categorization of losses between economic and non-economic damages, it was impossible to quantify the impact of a damages cap on insurer's losses, claim frequency, or claims handling costs. It also noted that it was difficult to compare the impact of damages caps because they differ so much from state-to-state.

In a report issued in August 2003, the GAO looked at claims against all physicians from 1996 to 2002, concluding that loss payouts for malpractice claims against physicians were lower and grew more slowly in states with caps. It concluded that malpractice premiums for general surgeons, internists, and obstetricians/gynecologists grew more slowly in states with caps. More specifically, the Report stated that “from 2001 to 2002, the average rates of increase in the states with noneconomic damage caps of $250,000 and $500,000 or less were 10 and 9 percent, respectively, compared to 29 percent in the states with limited reforms.” The August 2003 report, however, further stated that “differences in both premiums and claims payments are also affected by multiple factors in addition to damage caps, and we could

95 Id. at 42-43.
96 Id. at 7-8, 41-43.
97 Id. at 41-42.
99 Id. at 42-43.
100 Id. at 43.
102 Id.
103 Id. at 31.
not determine the extent to which differences among states were attributable to the
damage caps or to additional factors.\footnote{Id. at 30.}

Empirical studies published in the mid-1980s found a link between some
reforms and reductions in claim severity, but they did not establish a link between the
reforms and lower premiums.\footnote{Nelson, supra note 69, at 535-47.} Since 1990, however, several published studies using
an econometric approach have found a link between the adoption of malpractice
reforms and lower malpractice premiums.\footnote{Zuckerman et al., supra note 57, at 167-82; BLACKMON & ZECKHAUSER, supra note 54; Daniel
consistently been shown by research studies to reduce premium levels and, arguably, it is
now clearly established that caps can reduce premium levels, with the only real question
remaining being whether the reductions are closer to six or 25 percent.\footnote{Leonard, J. Nelson, Michael Morrisey & Meredith Kilgore, Damages Caps in Medical Malpractice Cases, 85 MILBANK Q. 259, 269 (2007); see Kilgore et al., supra note 106, at 258-60.} The ability of
later studies to detect the effects of damages caps stem both from longer time periods
over which to observe the impacts and more sophisticated econometric techniques that
are able to control for alternative explanations for the trends in malpractice premiums
and for the fact that states enact damages cap laws due to state specific economic and
political factors.\footnote{See Nelson et al., supra note 107, at 264-66.}

Table One provides a detailed summary of these studies and provides the time
span considered by the study, notes on how the studies were conducted and the
principal findings. All of these studies used one form or another of regression analysis
to hold other factors constant while estimating the effects of tort reforms.
Fundamentally, there are four features that distinguish the studies from each other.
First, in terms of the time period of the study, the early studies in the table tend to have
used only three to five years of data. These small observational windows mean that the
studies had few observations with which to examine differences in trends between states
with and without reforms. They are also limited in their ability to account for other
factors because of the relative lack of observations.
TABLE ONE

Studies Estimating the Effects of Malpractice Reforms on Malpractice Premiums

<table>
<thead>
<tr>
<th>Study</th>
<th>Time Period</th>
<th>Methodological Notes</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sloan (1985)(^{109})</td>
<td>1974-78</td>
<td>HCFA Survey of Insurers</td>
<td>No statistically significant effects of damage caps</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average premiums for General Practitioners (GPs), Orthopedic Surgeons, Ophthalmologists in the state. Includes year dummies.</td>
<td></td>
</tr>
<tr>
<td>Zuckerman, Bovbjerg &amp; Sloan (1990)(^{110})</td>
<td>1974-86</td>
<td>HCFA Survey of Insurers</td>
<td>Caps reduce GP, GS and OB premiums by 13.4%, 14.3% and 16.9%, respectively, in short-run and 40.6%, 52.4% and 57.9% in the long-run.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average premiums for GPs, General Surgeons (GSs), Obstetricians/Gynecologists (OBs). Includes lagged premium and state fixed effects. (Argues that the lack of findings in Sloan (1985) probably due to short time period.)</td>
<td></td>
</tr>
<tr>
<td>Blackmon &amp; Zeckhauser (1990)(^{111})</td>
<td>1985-88</td>
<td>Aggregate state level premiums from <em>Best's Review</em>. Estimates a change in premiums equation as a function of 1986 reforms using weighted least squares.</td>
<td>Four reforms together estimated to reduce aggregate premiums by 16.6%</td>
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</tbody>
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\(^{109}\) Sloan, *supra* note 8, at 643.

\(^{110}\) Zuckerman et al., *supra* note 57.

\(^{111}\) BLACKMON & ZECKHAUSER, *supra* note 54.
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Methodology</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kessler &amp; McClellan (1997)</td>
<td>1985-93</td>
<td>Physician reported premiums &quot;Direct&quot; (essentially caps) and &quot;indirect&quot; reforms</td>
<td>3 years after enactment, direct reforms reduce growth in premiums by 8.4%</td>
</tr>
<tr>
<td>Danzon, Epstein &amp; Johnson (2003)</td>
<td>1994-03</td>
<td>Medical Liability Monitor data on internists, general surgeons and obstetricians.</td>
<td>Non-economic damage caps below $500K reduce change in premiums by 5.7%. No effects of higher caps or of total damage caps.</td>
</tr>
</tbody>
</table>

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113 Daniel P. Kessler & Mark B. McClellan, The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care, 60 LAW & CONTEMP. PROBS. 81, 83-85, 98 (1997).
114 Mark Paul Gius, Using Panel Data to Estimate the Determinants of Medical Malpractice Insurance Premiums, 5 APPLIED ECONOMIC LETTERS 37 (1998).
115 Danzon et al., supra note 18, at 2-5, 24-26, 30.
| Viscusi & Born (2004)\textsuperscript{116} | 1984-91 | NAIC aggregate medical malpractice premiums by firm-state-year. Expansion of Viscusi & Born (1995). Model includes lagged premium & more detailed measures of reforms. | Non-economic damages reduce aggregate short-run premiums by 6.2% and states that prohibit punitive damages have premiums that were 8.1% lower. Long-run effects 19.7% and 25.8%, respectively. |
| Kilgore, Morrisey & Nelson (2006)\textsuperscript{117} | 1991-04 | Malpractice Liability Monitor data on internists (I), general surgeons (GS) and obstetricians (OB). State and year fixed effects. | Damage caps reduce premiums by 17.3%, 20.7% and 25.5% for I, GS, and OB, respectively; each $100K increase in cap levels increase premiums by 3.9%. Alternatively, caps ≤ $250K reduce premiums substantially, those $250K-$500 reduce premiums; those $500K-$750K have no effect and those above $750K raise premiums substantially. |


\textsuperscript{117} Kilgore et al., \textit{supra} note 106, at 255, 265-67.
Second, the studies differ in how they measure malpractice premiums. One approach to premium measurement uses aggregate premium revenue obtained from sources such as the National Association of Insurance Commissioners (NAIC) or Best’s Review. These sources are unable to provide disaggregated premiums by physician specialty and sometimes are unable even to disaggregate the premium revenue by insurer. These studies are able to provide estimates of the global effect of reforms, but may be undercut by their inability to control for such things as the number of covered physicians or the mix of specialists covered. The other approach uses reported premiums for specific specialties of physicians, often internists, obstetricians and surgeons. These studies have the advantage of having actual premiums, at least by physician specialty, but are typically unable to provide a global assessment of the impact of the reforms.

Third, the studies differ in how they measure tort reforms. Four general approaches have been employed. First, some studies simply test whether “a reform” of any sort affected premiums. Second, some studies have categorized reforms into groups, “direct” and “indirect” being the most common. Direct reforms refer to damage caps and collateral source rules, while indirect reforms refer, for example, to contingency fee limits, limitations on joint and several liability, patient compensation funds. Third, some studies used separate measures for each of the reforms, thereby separately measuring several dimensions of the state reforms. Fourth, some studies have focused on capturing the magnitude of the damage caps. More detailed measures have the advantage of providing separate estimates of the impact of various elements of tort reform. However, there may not be enough observations to have statistical confidence that the various elements had any independent impacts. In contrast, categories of reforms are more likely to satisfy the statistical needs for many observations, but will yield results that are less helpful in determining which elements of the reform are effective.

Finally, the studies differ in how they account for other things that affect malpractice premiums and/or the enactment of the laws. Early studies typically included variables that differed across states and controlled for the average trends over time. The more recent studies, with greater econometric insight and longer time periods, have included state and year “fixed effects.” State fixed effects are simply a series of fifty 0-1 variables that take the value “1” when the observation relates to a particular state, and 0 otherwise. Under this approach, the regression analysis will include a binary variable for each state in the study. For example, Louisiana and Utah may differ in a variety of ways, but most of these differences are relatively stable over time. Thus, the binary variable for each state will control for the net average effect of all
the unobservables for each state. Year fixed effects are also 0-1 variables that take the value "1" whenever an observation relates to a particular year. These binary variables have the effect of controlling for the unobservable differences between, for example, 1999 and 2000, that are essentially in-common across the states. Fixed effects are a very powerful mechanism to control for other things that may be affecting malpractice premiums across states and across years. The disadvantages of fixed effects, however, are that they require a lot of observations and they allow the study only to estimate the impact of reforms that were enacted during the study period. A study of the 1985-to-2007 period, for example, would be unable to directly estimate the effects of California's reforms because those reforms had been in effect since 1975.

It is clear from Table One that across a number of rigorous studies using a variety of data periods, measures and methods, damage caps have been shown to be effective in reducing medical malpractice insurance premiums. The only real question remaining is whether the reductions in premiums are closer to six percent or twenty-five percent.118

B. The Effect of Malpractice Reforms on Defensive Medicine

Proponents of malpractice reform have argued that reform is necessary to reduce the costs of health care. Since the cost of medical liability insurance premiums is, however, only a miniscule percentage of the total expenditures on health care, the validity of this claim depends on the assertion that expenditures due to defensive medicine (e.g., ordering unnecessary additional diagnostic tests and procedures) induced by the fear of litigation comprises a significant portion of health care expenditures.119 A 1985 study by the AMA, based on a survey of physicians, claimed that the cost of defensive medicine was approximately $15 billion annually, but this study used unreliable empirical methods.120

In addition, there has been disagreement over the definition of defensive medicine. A 1994 study issued by the Office of Technology Assessment defined

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118 Kilgore et al., supra note 106, at 269.
119 A report issued by CBO notes: "But even large savings in premiums can have only a small direct impact on health care spending—private or governmental—because malpractice costs account for less than 2 percent of that spending." CONGRESSIONAL BUDGET OFFICE, supra note 16, at 1.
120 Glen O. Robinson, Rethinking the Allocation of Medical Malpractice Risks Between Patients and Provider, 49 L. & CONTEMP. PROBS. 173, 177, (commenting on SPECIAL TASK FORCE ON PROF. LIAB. AND INS., AM. MEDICAL ASS'N, PROFESSIONAL LIABILITY IN THE '80S, REPORT 1, at 6 (1984)).
defensive medicine as "when doctors order tests, procedures, or visits, or avoid high-risk patients or procedures, primarily (but not necessarily solely) to reduce their exposure to malpractice liability," but further observed that defensive medicine is "not always bad for patients" and may include practices that benefit patients. Further, it stated that damages caps may indiscriminately reduce both appropriate and inappropriate practices. In a study published in 1996, Kessler and McClellan defined defensive medicine as the administration of "precautionary treatments with minimal expected benefit out of fear of legal liability.”

In a study published in 2001, Thurston observed that malpractice law creates incentives for physicians to practice defensive medicine only if they cannot pass on the full cost of their malpractice insurance premiums to payers in the form of higher prices. Thurston uses data on physician fees and malpractice premiums from the 1983-1985 Physicians’ Practice Costs and Income Survey. Thurston found that both surgeons and non-surgeons were able to pass on premium increases to payers, but that significantly more of these costs were passed on to surgical as opposed to non-surgical patients. Thurston’s findings suggest that damages caps may not reduce defensive medicine.

More recently, in a study published in 2006, Pauly et al. examined net income data from single-specialty group practices in 1994, 1996, and 2002. They found no evidence that higher malpractice premiums depressed physician incomes over this period, suggesting that physicians had been able to pass the premium increases on to payers. In addition, in a 2002 article, Kessler and McClellan observed that managed care and tort reform measures may be substitutes for each other in reducing defensive medicine thereby suggesting that malpractice reforms may have little impact in a state

122 Id. at 3.
123 Id. at 11-12.
124 Kessler & McClellan, supra note 106, at 354.
126 Id. at 490-91.
127 Id. at 497.
128 See id.
130 Id. at 8.
with widespread prevalence of managed care. Based on these findings, Baker has argued that reforms to the health care system that promote evidence-based risk management would be more effective in reducing defensive medicine than tort reform.

Although several studies have failed to find a link between increased malpractice claims and increased defensive medicine, there are more recent studies that have found a link between the adoption of malpractice reforms and the reduction of defensive medical practices. There have also been a number of studies that have used cross-sectional comparisons, but these studies have not found evidence of changes in physician behavior. This finding has been explained by the reliance on comparisons across physicians rather than examining any change in physician behavior. Table Two summarizes the empirical studies that have used longitudinal data to look for changes in behavior.

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132 See Baker, supra note 21, at 136-37.
## TABLE TWO

Studies Estimating the Effects of Malpractice Reforms on Defensive Medicine

<table>
<thead>
<tr>
<th>Study</th>
<th>Time Period</th>
<th>Methodological Notes</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kessler &amp; McCellan (1996)</td>
<td>1984, 1987, 1990</td>
<td>New hospital admission for acute myocardial infarction or new ischemic heart disease. 1-year mortality, heart related re-admission. Medicare beneficiaries. State &amp; year fixed effects with 3 and 5 year lagged reforms. Direct and indirect reforms.</td>
<td>5 to 9% reduction in medical expenditures for heart disease 3 to 5 years after adoption of tort reform. No statistically significant effects on mortality or the rates of cardiac complications. Substantial reductions in expenditures with little reduction in outcomes.</td>
</tr>
</tbody>
</table>

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135 Kessler & McClellan, supra note 106.  
136 Kessler & McClellan, supra note 131.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Description</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dubay, Kaestner &amp; Waidman (2001)</td>
<td>1990-1992</td>
<td>Effects on access and utilization of prenatal care, and infant health measured as: Late initiation of prenatal care, Number of prenatal visits, Low-birth weight, and Apgar Score* &lt; 7</td>
<td>Decrease in malpractice premiums (due to tort reform) associated with 3 to 5.9% reduction in late initiation of prenatal care for black women and 2.2 to 4.7% for white women. No statistically significant effect on infant health.</td>
</tr>
<tr>
<td>Grant &amp; McInnes (2004)</td>
<td>1992-1995</td>
<td>Panel of Florida obstetricians. Measures of physician level severity and difficulty of resolving a malpractice claim. Hierarchical model of physician propensity to provide C-sections.</td>
<td>Only large claims affect C-section rates and even these effects are small, increasing the rate by no more than 1 percentage point.</td>
</tr>
</tbody>
</table>

* Apgar Score ranges from 1 to 10 and is based upon evaluation of a newborn’s skin color, heart rate, reflex irritability, muscle tone and respiration. Scores over 7 are generally considered normal.

The first two papers in Table Two employ the fixed-effects methodology discussed earlier. In contrast, the latter two papers use a two-stage modeling technique to control for confounding factors. The Dubay, Kaestner & Waidman study uses tort reforms to explain malpractice premium increases and then uses the predicted premiums to explore the provision of prenatal care. The Grant & McInnis paper also uses a two-

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137 Dubay et al., supra note 134.
138 Grant & McInnes, supra note 134.
stage model but uses it to control for the differing propensity of physicians to use Caesarian section delivery even in the absence of incentives for defensive medicine.

The studies are limited in that they only examine heart disease treatment or obstetrics care. Both heart disease studies were conducted by Kessler & McClellan using data from the Medicare program on the treatment for acute myocardial infarction and ischemic heart disease. In the earlier study (Kessler & McClellan 1996), they find that direct and indirect reforms reduce Medicare expenditures for these conditions by five to nine percent, but find no meaningful effects on mortality or readmissions. In the second study (Kessler & McClellan 2002), they find that the effects of malpractice reforms are smaller after one accounts for the expanded role of managed care.

The first of the two obstetrics studies (Dubay, Kaestner & Waidman 2001) examined the effects of tort reforms, acting through malpractice premiums, on access and use of prenatal care and the health status of newborns. They found that reforms led to greater use of prenatal care but had no effect on health status. The second study (Grant & McInnis 2004) found that large malpractice claims increased the use of Caesarian sections, but the effect was very small. Taken together, the more rigorous empirical studies find only small-to-modest defensive medicine effects but have only looked at two aspects of patient care. At this time, it is still uncertain whether malpractice reforms reduce defensive medicine, and additional studies are needed.

C. The Effects of Malpractice Reforms on Access to Care

It is not yet clear whether malpractice reforms can enhance physician supply. Proponents of tort reform argue that physicians are more likely to remain in practice in, or relocate their practices to, states with malpractice reforms and thus tort reforms will increase physician supply, but studies by Thurston and Pauly et al., supra, have found that physicians are able to pass on the increased costs of malpractice insurance, suggesting that physician location decisions may not be affected by malpractice reforms.139 Two studies have, however, found that damages caps can increase physician supply. A 2003 study by Fred Hellinger and William Encinosa, researchers affiliated with the Agency for Health Care Research and Quality, concluded that: “[S]tates with caps on noneconomic damages experienced about 12 percent more physicians per capita than States without such a cap.”140 Subsequently, in a study published in 2005, Encinosa and

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139 See Thurston, supra note 125, at 496; see also Pauly et al., supra note 129, at 8-9.
Hellinger again found a link between damages caps and physician supply in a fifty state study examining the period from 1985 to 2000 using county-level data. They found that counties in states with damages caps had 2.2 percent more physicians per capita and rural counties in those same states had 3.2 percent more physicians than in counties in states without caps. They also found that other malpractice reforms (i.e., collateral source rule, prejudgment interest, joint and several liability and punitive damages caps) had no impact on physician supply. Clearly, there is a need for additional research on this question.

D. The Impact of Malpractice Reforms on Health Insurance Premiums

Proponents of malpractice reform typically justify malpractice reforms by arguing that while they may adversely affect victims of malpractice by reducing recoveries, they will benefit consumers by reducing health care costs. There is, however, a paucity of studies on the question of whether malpractice reforms can reduce health care costs. In a 2007 study, we examined the effect of malpractice reforms on health insurance premiums paid by consumers. We noted that health insurance costs could be affected by malpractice reform in two ways: (1) providers could pass through cost reductions in liability insurance to consumers, and (2) reductions in defensive medicine could reduce the intensity of tests and other services. Studies indicating that damages caps reduce malpractice insurance premiums as summarized in Table One, supra, suggest that damages caps could reduce health care expenditures. Nonetheless, using data on health insurance costs of private sector employers for the years 1991-2004 from the HRET/Kaiser Employer Health Benefits Survey, we concluded that there was little evidence that malpractice reform legislation has reduced the costs of employer provided health insurance. Clearly, this is an important issue that deserves more attention by researchers.

E. The Effect of Malpractice Reforms on Patient Safety

Some have argued that reform is necessary because of the “fundamental

142 Id. at W5-255.
143 Id. at W5-256.
145 Id.
146 Id.
dissonance between the medical liability system and the patient safety movement.” 147 That is, on the one hand, it has been argued that under the current system, the creation and improvement of systems that will maximize patient safety is undermined by the fear of malpractice liability. More particularly, it has been argued that the design of these injury-prevention systems requires a medical culture that candidly recognizes errors and learns from them, but that the current medical liability system fosters a medical culture that conceals its errors. 148 On the other hand, in a 2005 article, Hyman and Silver countered that no “rigorous evidence show[s] that fear of malpractice lawsuits discourages error reporting . . .” 149 They further noted that damages caps may reduce incentives for avoiding errors, and have proposed that only providers who report medical errors promptly should receive the benefit of a cap and also that damages caps should be tied to the improvements in independent quality surveys.150

Some scholars have noted that even if malpractice reforms contribute to premium reductions and preserve access to health care for some patients, they fail to address the problem of medical error.151 In a 2003 study, Zeiler, using a game theory model, hypothesized that damages caps could actually increase the number of malpractice claims by reducing the level of compliant treatment by physicians, and that this in turn could increase the number of injuries caused by negligent medical care.152 It has also been argued that in light of evidence of widespread injuries to patients through preventable errors, reforms designed to decrease malpractice premiums without reducing the error rates may be ill-advised.153 Indeed, reforms that limit compensation without changing physician behavior may not reduce the costs of errors, but merely shift them to injured patients.154

148 Id. at 5.
150 Id. at 989.
153 See Sage, supra note 56, at 32.
154 ERIN NORDMAN, DAVIN CERMAK & KENNETH MCDANIEL, MEDICAL MALPRACTICE
Professor Baker has presented a compelling argument that there are too few—rather than too many—malpractice claims. He argues that there is "an epidemic of medical malpractice, not malpractice suits." After reviewing the hospital record studies documenting the relatively high rate of negligent injuries and the relatively low number of medical malpractice lawsuits, he concludes that medical malpractice lawsuits contribute to improved patient safety by identifying dangerous conditions and providing incentives for changes in the way that hospitals respond to and prevent patient injuries.

F. The Effect of Malpractice Reforms on the Compensation of Victims

Some researchers have focused primarily on the potentially unfair effects of malpractice reforms, and particularly of damages caps, on the compensation of victims of malpractice. Professor Mehlman has argued that even if they do stabilize premiums, caps unfairly impact the most seriously injured malpractice victims. A RAND study found that the MICRA cap was imposed more often in death cases (fifty-eight percent) than in non-death cases (forty-one percent). In a study published in 2004, Studdert et al. found that, under the MICRA cap, mean reductions for plaintiffs with grave injuries were seven times larger than for those with minor injuries. A 2006 study by Finley found that juries consistently awarded women higher damages for non-economic losses and that caps on non-economic damages had a disproportionately adverse impact on women particularly with respect to gynecological injuries. But in a 2005 study, Wolfson concluded that caps on non-economic damages may actually enhance minority access to health care.

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155 Baker, supra note 21, at 22.
156 Baker, supra note 21, at 22-24.
157 Baker, supra note 21, at 98-100.
160 Studdert et al., supra note 44, at 60.
161 Finley, supra note 42, at 1266.
III. Malpractice Reforms in Louisiana, Alabama and Mississippi

A. Louisiana

There are two statutory schemes dealing with medical malpractice actions in Louisiana: the Louisiana Medical Malpractice Act (MMA) and the Louisiana Medical Liability for State Services Act (MLSSA). In 1975, Louisiana’s legislature adopted several malpractice reform measures in an effort to allay concerns over what was considered at the time to be a “medical malpractice crisis.” During the early 1970’s, Louisiana malpractice insurance carriers claimed they were losing money and that the market in Louisiana was no longer profitable. These companies contended that the dollar amount of claims had become unpredictable, making it impossible to accurately forecast future liability verdicts and assess premiums levels.

In 1975, there were only six medical malpractice insurance carriers in Louisiana, four of which eventually abandoned the market altogether. This prompted the Louisiana legislature to enact the MMA. This legislation imposed an overall damages cap of $500,000, created a patient compensation fund, and mandated submission of all malpractice claims to medical review panels. In addition, other legislative enactments imposed restrictions on expert witnesses, tightened the statute of limitations, and modified joint and several liability. The 1975 MMA was modeled after legislation adopted in Indiana insofar as it coupled the creation of a PCF with an overall cap on damages. Subsequently, in 1976, the Louisiana legislature enacted the MLSSA, comprehensive legislation dealing with medical malpractice claims against the

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166 Id.
167 Id.
168 Id.
175 1987 La. Acts No. 373, § 1 (codified at LA. CIV. CODE ANN. art. 2324 (2007)).
The primary impetus for malpractice reform in Louisiana was the exit of insurers from the market.\textsuperscript{180} In Crier v. Whiteloud,\textsuperscript{181} decided in 1986, the Supreme Court of Louisiana upheld the constitutionality of the three year statute of repose passed as part of the MMA, noting that at the time of its enactment: “[M]alpractice claims were proliferating at the same time that the amounts of damage awards were increasing rapidly. Premiums for malpractice insurance had skyrocketed, forcing doctors to pass increased costs on to patients and creating fears that many physicians would simply abandon the practice of medicine.”\textsuperscript{182} Accordingly, the court concluded that “the statute is rationally related to the state’s interest in reasonable medical costs and readily available health care.”\textsuperscript{183}

Several years later, in 1995, a Louisiana Court of Appeals panel opinion questioned anew whether there was in fact an insurance crisis in 1975.\textsuperscript{184} In Whitnell v. Silverman,\textsuperscript{185} the Court of Appeals declared the three year statute of repose unconstitutional as applied to latency periods both over and under three years, finding that it improperly discriminated on the basis of physical condition.\textsuperscript{186} The court reviewed the entire record in the Crier case, finding no support in it for the Supreme Court’s conclusion that there was a malpractice crisis in 1975.\textsuperscript{187} In contrast, the Court of Appeals noted that the trial court in Whitnell held a three day hearing and found “that it is more probable than not that although the quantity of medical negligence cases being filed, the amounts being paid out by insurers, etc., were increasing, such was a normal actuarial aberration in figures that did not at that time (1975) warrant substantive action by the Legislature.”\textsuperscript{188} The Court of Appeals agreed with the trial court’s conclusion, noting that testimony by an actuary established that the spike in premium levels was due

\begin{itemize}
\item \textsuperscript{177} 1976 La. Acts No. 66, § 1 (codified at LA. REV. STAT. ANN. § 40:1299.39 (2007)).
\item \textsuperscript{178} LA. REV. STAT. ANN. § 40:1299.39(F) (2007).
\item \textsuperscript{179} LA. REV. STAT. ANN. § 40:1299.39.1 (2007).
\item \textsuperscript{180} Grey, supra note 165, at 547.
\item \textsuperscript{181} 496 So. 2d 305 (La. 1986).
\item \textsuperscript{182} Id. at 309.
\item \textsuperscript{183} Id.
\item \textsuperscript{184} See Whitnell v. Silverman, 646 So. 2d 989 (La. App. 1994), rev’d, 686 So. 2d 823 (La. 1996).
\item \textsuperscript{185} Id.
\item \textsuperscript{186} Id. at 993.
\item \textsuperscript{187} See id. at 994.
\item \textsuperscript{188} Whitnell, 646 So. 2d at 994.
\end{itemize}
to the insurance underwriting cycle rather than to a sudden increase in claims. The court further noted that there was no information available from the Louisiana Insurance Commissioner's office on malpractice claims in 1975. The remainder of this section will survey the components of malpractice reform legislation in Louisiana: the damages cap, the Louisiana Patient Compensation Fund, and medical review panels.

1. Damages Caps

The MMA cap limits the liability of "qualified" health care providers for injuries resulting from malpractice. The term "qualified health care providers" is broadly defined under the Act to include physicians and institutions, as well as any other person or entity licensed by the state to provide health care services. Health care providers may become "qualified" by filing proof that they are covered by a policy of malpractice liability insurance in an amount of at least $100,000 per claim, or if self-insured, depositing $125,000 with the fund or otherwise arranging for a letter of credit or other security. "Qualified health care providers" must also pay a surcharge assessed by the Louisiana Insurance Rating Commission.

Damages recoverable in malpractice actions against "qualified health care providers" are capped at a total of $500,000 plus interest and costs, and the liability of the individual health provider is capped at $100,000. This cap was set in 1975 and has not been increased for inflation, but in 1984 the statute was amended to exclude future health care expenses. Thus, plaintiffs are now entitled to recover for future health care costs without regard to the cap. The damages available to a successful plaintiff in an action against a "qualified health care provider" are paid both by the provider's insurer and the Louisiana Patient Compensation Fund (LPCF). No "qualified health care provider" can be held liable for more than $100,000 plus interest. Thus, any judgment amount in excess of the total liability for qualified health care providers of $100,000 is to be paid out of the LPCF. Future medical costs, which are not subject

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189 Id.
190 Id.
to the $500,000 cap, are also to be paid out of the LPCF. \( ^{200} \) Furthermore, Louisiana does not recognize punitive damages as an available common law remedy. \( ^{201} \)

Since 1975, there have been numerous cases in which plaintiffs have challenged the constitutionality of the damages cap available to private "qualified health care providers" in Louisiana, but the Supreme Court of Louisiana has upheld the constitutionality of the damages cap. \( ^{202} \) In 2006, the Third Circuit of the Louisiana Court of Appeals declared the damages cap unconstitutional in *Arrington v. ER Physicians Group, AMPC*, but this decision was later vacated by the Supreme Court of Louisiana. \( ^{203} \) Previously, in *Arrington* the Third Circuit had certified the following question to the Louisiana Supreme Court:

> Considering the devaluation of the dollar in the thirty years since the passage of the medical malpractice act is such that the $500,000 limit imposed in 1975 is now, according to competent evidence, worth only $160,000.00, and considering that Section 22 or Article I of the Louisiana Constitution of 1974 provides Louisiana citizens with an 'adequate remedy' under our law, is the limitation on recovery for general damages of $500,000.00 imposed by the Louisiana Medical Malpractice Act, La.R.S. 40:1299.41, et seq., still considered constitutional? \( ^{204} \)

\( ^{200} \) LA. REV. STAT. ANN. § 40:1299.42 (B)(1) (2007). The cap on Patient Compensation Fund liability established by § 40:1299.42(B) excludes from its scope "future medical care and related benefits" as provided in § 40:40:1299.43. Under § 40:1299.43, if a court determines that a claimant is in need of "future medical care and related benefits," defined as "all reasonable medical, surgical, hospitalization, physical rehabilitation, and custodial services" including "drugs, prosthetic devices, and other similar materials reasonably necessary in the provision of such services, incurred after the date of the injury," then damages are recoverable from the Patient Compensation without regard to the cap. In addition, the legislature is supposed to appropriate sufficient monies to pay claims in excess of the $500,000 limit for future medical care.


\( ^{202} \) Butler v. Flint Goodrich Hosp. of Dillard University, 607 So. 2d 517 (La. 1992); cf. Williams v. Kushner, 549 So. 2d 294, 308-09 (La. 1989) (holding that $400,000 limit on liability of LPCF is valid but declining to decide whether a limit of $100,000 against individual health care provider is constitutional).


\( ^{204} \) *Arrington v. ER Physicians Group, AMPC*, 940 So. 2d at 778.
The Supreme Court, however, denied the request for certification and remanded the case. This lawsuit was filed after the medical malpractice screening panel found against the physician defendant. The trial court approved the settlement by the primary insurer of the claim against the physician for $100,000, and thus liability was admitted. In addition, the court had approved a settlement against the LPCF for $500,000 including $390,000 in principal, $90,000 in interest, and $20,000 in expenses. After this settlement, the plaintiff released the physician, the LPCF and the primary insurer, but not the hospital. The plaintiff sought to recover all damages from the company that owned the hospital without limitation and attacked the constitutionality of the damages cap. The trial court upheld the constitutionality of the cap.

On appeal, the Court of Appeals held that the plaintiffs had carried their burden in proving that the cap violated the Louisiana Constitution, Article 1, Section 22, which guarantees an adequate remedy at law for personal injuries. The court noted that the plaintiffs' decedent was forty-three years old when he died in 1994 and had left a widow and two children. The court calculated that the economic loss of his family was $470,000 in lost wages even without factoring in future increases in his income. The court also relied on expert testimony that the present value of the cap in 1975 dollars would be at least $1,562,500.00. On that basis, the court concluded that the current $500,000 cap did not provide an adequate remedy. Subsequently, however, the Louisiana Supreme Court vacated the decision of the Court of Appeals, holding that it had improperly allowed the question of the constitutionality of the cap to be raised for the first time on appeal.

205 Id.
206 Id. at 779.
207 Id.
208 Arrington v. ER Physicians Group, AMPC, 940 So. 2d at 779.
209 Id.
210 Id.
211 Id.
212 Arrington v. ER Physicians Group, AMPC, 940 So. 2d at 785. The Louisiana Constitution, Article I, Section 22 provides: “All courts shall be open, and every person shall have an adequate remedy by due process of law and justice, administered with denial, partiality, or unreasonable delay, for injury to him in his person, property, reputation, or other rights.”
213 Id.
214 Id. at 784.
215 Id.
216 Id.
217 Arrington v. Galen-Med, Inc., 947 So. 2d 727 (La. 2007); see also Taylor v. Clement, 947 So. 2d 730, 732 (La. 2007) (vacating another Third Circuit Court of Appeals decision holding the cap unconstitutional).
Under the MLSSA, there is a separate statutory cap of $500,000 applicable in medical malpractice actions against "state health care providers" including physicians employed by state institutions and physicians that "gratuitously" provide treatment to patients referred by state hospitals. Initially, the Supreme Court held that this cap applied only to individual providers working for the state and to the vicarious liability of state institutions for their actions and not to the direct liability of state health care institutions for administrative negligence. Subsequently, however, the statute was amended so that it applied directly to protect state institutions rather than only to vicarious liability for individual providers. In addition, in 1985, the statute was amended to exclude future medical expenses from the $500,000 cap. In a 1985 decision, the constitutionality of this cap was upheld by the Louisiana Supreme Court. On rehearing, however, the case was remanded for an evidentiary hearing on whether the legislative classification of malpractice victims based on physical condition (i.e., between those with injuries fully compensable under the cap and those with injuries that would not be fully compensable under the cap) violated the equal protection provisions of the state constitution. This case was settled prior to the hearing on this question. In another case decided in 1997, the Supreme Court upheld the constitutionality of this cap.

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221 Sibley v. The Bd. of Supervisors of La. State Univ., 477 So. 2d 1094, 1099 (Sibley II) (La. 1985) (discussing Acts 1985, No. 239, § 1 and noting that the amendment excluding future medical expenses from the cap was expressly made applicable to pending litigation).
223 Sibley v. Bd. of Supervisors of La. State Univ. (Sibley II), 477 So. 2d 1094 (La. 1985). The constitutional provision in question, Louisiana constitution, article I, section 3, provides:

No person shall be denied the equal protection of the laws. No law shall discriminate against a person because of race or religious ideas, beliefs, or affiliations. No law shall arbitrarily, capriciously, or unreasonably discriminate against a person because of birth, age, sex, culture, physical condition, or political ideas or affiliations. Slavery and involuntary servitude are prohibited, except in the latter case as punishment for crime.

225 Williams v. State ex rel Dep't of Health and Hosps., 703 So. 2d 579, 583 (La. 1997) (holding statutory liability cap does not violate constitutional proscription of sovereign immunity, but refusing to decide whether it violates equal protection clause of Louisiana State Constitution because action was not properly presented); Williams v. Lallie Kemp Charity Hosp., 428 So. 2d 1000 (La. App. 1983).
2. The Louisiana Patient Compensation Fund

The LPCF was created by the 1975 MMA.226 In 1990, the LPCF was removed from the Department of Insurance and the Office of the Attorney General and placed under the supervision of the Office of Risk Management.227 At this time, the LPCF Oversight Board was also created.228 In 2000, the LPCF was removed from the Office of Risk Management and became an independent state agency. 229 The LPCF is responsible for paying awards in actions against “qualified health care providers” where damages are in excess of the $100,000 covered by the provider’s primary insurer but less than the total cap of $500,000, as well as (since 1984) future medical expenses in excess of the cap.230 According to the LPCF’s website:

The purpose of this legislation was twofold. First, to ensure that a stable and affordable market existed for malpractice insurance (and thereby keeping practitioners in the state); and second, to create a viable fund for compensating claimants while providing a statutory cap on total liability. The $500,000 cap was considered an equitable tradeoff between compensating the most injured claimants adequately and maintaining the financial stability of the Fund.231

In order to be a “qualified health care provider,” a physician must provide $100,000 of security for malpractice victims and pay a surcharge to the fund.232 The security requirement may be satisfied by providing proof of coverage by an occurrence policy, a claims made policy with adequate tail coverage, or, if self insured, depositing $125,000 with the fund or providing equivalent security.233 The coverage provided by the LPCF is the same as the underlying coverage, i.e., if the underlying coverage obtained by the provider for the first $100,000 is on a claims-made basis, then the LPCF’s coverage is also on a claims-made basis.234

227 Id.
228 Id.
229 Id.
230 LA. REV. STAT. ANN. § 40.1299.42 (B).
234 E-mail from Lorraine LeBlanc, Executive Director, Louisiana Patient Compensation Fund, to Leonard J. Nelson, III, Professor of Law, Cumberland School of Law (Apr. 17, 2006) (on file
3. Periodic Payout of Future Damages

In conjunction with the limitation on damages and the exclusion of the amount of future medical care costs from the damages cap, Louisiana also requires that the amount of future medical care and related benefits be deducted from the total amount awarded and paid by the LPCF in the future as incurred. In June 2004, this section was amended to establish a date from which to measure future medical care. In all malpractice actions that proceed to trial, the jury must be given a special interrogatory that asks if the “patient is in need of future medical care and related benefits and the amount thereof.” Thus, the provision for periodic payout of the costs of “future medical care” pertains to costs incurred after the date of the response to the special interrogatory.

4. Medical Review Panels

Pre-trial submission of malpractice claims against qualified health providers to medical review panels is required under the MMA, and is also required for claims against the state under the MLSSA. According to one insurers newsletter, “[O]nly 9 percent of all lawsuits are actually tried, with approximately 85 percent dismissed somewhere between the filing of the lawsuit and trials.” Louisiana law requires a malpractice complaint against a qualified health care provider to be filed initially with the Division of Administration of the Medical Review Panel. The complaint is then forwarded to the LPCF to determine whether the defendant is a qualified health care provider. The filing by the screening panel of a request for review of a claim tolls the statute of limitations. Furthermore, this section explicitly provides that no action may

with author).

238 LA. REV. STAT. ANN. § 40:1299.47 (A)(1)(a) (2007). The MMA statute requires that "[a]ll malpractice claims against health care providers covered by this Part, other than claims validly agreed for submission to a lawfully binding arbitration procedure, shall be reviewed by a medical review panel." Id. Therefore, not only does this section of the act mandate the use of a review panel, but it also implicitly endorses the use of arbitration agreements.
242 Id.
be commenced in court until a claimant’s complaint has been presented to a medical review panel, unless both parties agree to waive the use of such panel. \(^\text{244}\)

Complaints filed with the Medical Review Panel almost doubled between 1997 and 2002. \(^\text{245}\) Although the panel sides with the doctor in eighty-five percent of cases, this also increases costs for insurers because the winner pays the administrative costs, which typically range from $7000 to $9000. \(^\text{246}\) Plaintiffs’ lawyers, however, complain that the damages cap does not allow for adequate compensation in cases of the most egregious acts of malpractice and that the mandatory screening panels increase the costs to plaintiffs. \(^\text{247}\) On the other hand, some doctors and insurers claim that the screening panels have aggravated the malpractice insurance crisis in Louisiana. \(^\text{248}\) The President of the Louisiana Medical Society has complained that while the panels were supposed to screen out frivolous claims, in practice plaintiffs’ attorneys file claims with the panel by merely sending a letter and then use the panel proceeding to facilitate early discovery. \(^\text{249}\)

In terms of the structure and responsibilities of the panel, the statute requires that the panel consist of three health care providers that are licensed to practice in Louisiana and one attorney who will act as chairman of the panel in an advisory role, but will not have an actual vote. \(^\text{250}\) All physicians holding a license to practice medicine in Louisiana and engaged in the active practice of medicine in the state are eligible to be selected as panelists. \(^\text{251}\)

The purpose of the medical review panel is to render an expert opinion as to whether the evidence “supports the conclusion that the defendant or defendants acted or failed to act within the appropriate standards of care,” and it must render such opinion within 180 days of the selection of the last panel member. \(^\text{252}\) Alternatively, if

\(^{244}\) LA. REV. STAT. ANN §§ 40:1299.47 (B)(1)(a-c) (2007). This limitation applies only if the panel renders an opinion within 12 months of selecting an attorney chairman to oversee such panel.


\(^{246}\) \textit{Id.}

\(^{247}\) \textit{Id.}


\(^{249}\) \textit{Id.}

\(^{250}\) LA. REV. STAT. ANN § 40:1299.47 (C) (2007).


\(^{252}\) LA. REV. STAT. ANN § 40:1299.47 (G). It is worth noting that if the panel is unable to reach a decision within the time period required, either party may petition a court for an order to show cause why the panel should not be dissolved. \textit{See} LA. REV. STAT. ANN § 40:1299.47 (K) (2007).
the panel is unable to make a definitive determination as to liability, then it is to enter a finding that, as to such liability, "there is a material issue of fact, not requiring expert opinion," which must be considered by a court of law. 253 The reports provided by the panel are admissible as evidence at trial, but are not considered conclusive evidence. 254 The members of the panel may also be called to testify should a trial ensue, and their testimony will be considered expert opinion. 255 Finally, each panelist is granted absolute immunity from civil liability for their opinions and findings. 256

The party in whose favor the panel rules bears the expense of paying the panel for its duties. 257 If an action is later brought in court and the panel had given an unanimous opinion in favor of the defendant health care provider, then the claimant who brings an action in court in spite of such opinion must post a surety bond in order to reimburse the defendant health care provider for the costs of the panel. 258 Likewise, if the plaintiff receives a favorable opinion from the panel and the defendant health care provider subsequently fails to settle the claim (prompting the plaintiff to file suit), then the defendant must post a surety bond sufficient to cover the costs for the panel. 259 As with damage caps, there have been numerous cases in which plaintiffs challenged the constitutionality of medical review panels in Louisiana, but in all of these cases, the legislation has been upheld. 260

In the 2006 legislative session, LAMMICO successfully lobbied for changes in the medical review panel laws to permit the parties to utilize an expedited review panel

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258 LA. REV. STAT. ANN. § 40:1299.47 (I)(2)(c) (2007). The bond will not be used to reimburse the defendant health care provider, however, if such defendant is found liable for any damages. Id.
process. This legislation was signed into law by Democratic Governor Kathleen Blanco on June 13, 2006, and became effective on August 15, 2006. At the time of passage of the expedited review legislation, the average time for panel review was twenty-four months. In addition, the operation of the medical review panels had become costly: more than $10 million per year. The expedited review process is only available if all parties consent to its use. The expedited review panel is required to render its opinion within one year of the attorney chair of the panel being notified of his or her appointment. It provides for a “streamlined discovery process” with no interrogatories and no depositions. The opinion rendered by the expedited review panel is not admissible at trial and the panel members may not be called as witnesses at trial. In contrast, under the current full review, the panel opinion is typically used at trial and panel members are called as witnesses.

5. Statute of Limitations

In 1975, the Louisiana legislature enacted a medical malpractice statute of limitations requiring actions to be commenced within one year from the date of the alleged act, or within one year from the date of discovery of the alleged act. In addition, a statute of repose was adopted providing that actions must be filed within three years from the date of the allegedly tortious act. In 1976, the act was amended to add chiropractors to the list of those covered by this statute. The 1976 amendment also included the addition of subsection (B), which provides that the provisions shall apply to “all persons whether or not infirm or under disability of any kind and including minors and interdicts.” Additional amendments were made in 1987 and 1995, in which psychologists, optometrists, nurses and licensed midwife practitioners were added to the list of providers covered by the statute. An amendment in 2001 added nursing
homes to the list. The 2001 amendment also added subsection (C), which states that the provisions of the section shall apply to all healthcare providers “listed herein or defined in R.S. 40:1299.41 regardless of whether the healthcare provider avails itself of the protections and provisions of R.S. 40:1299.41 et seq., by fulfilling the requirements necessary to qualify as listed in R.S. 40:1299.42 and 1299.44.” This amendment is significant because it not only ties the statute of limitations to the specific list of those covered by the provisions of the MMA under section 40:1299.41, in which “health care provider” is very broadly defined with an extensive list, but it also includes actions against those not otherwise covered by the act. Thus, those health care providers who are not “qualified health care providers” are protected by the same statute of limitations as those who are “qualified health care providers.”

As with damage caps and medical review panels, the medical malpractice statute of limitations has been challenged numerous times on the basis that it denies equal protection and access to the courts and violates due process. In the face of such challenges, the Louisiana courts have upheld it, reasoning that there is no constitutional infirmity in the statute due to its advancement of the legitimate state interest in lowering health care costs. Several cases have rejected claims that the statute of limitations violated the state constitution’s equal protection guarantees because of discrimination on the basis of physical condition.

Some cases have considered whether the three-year statute of repose is unconstitutional insofar as it precluded the application of the equitable doctrine of contra non va/entem, which provides that prescription does not run against a party unable to act. Generally, these cases involve diseases with latency periods in excess of three years. The general view has been that the statute of repose preempts the doctrine of

275 2001 La. Acts No. 95, § 1.
276 Id.
277 Id. See also LA. REV. STAT. ANN. § 40; 1299.41 (2007)).
contra non valentem and that it does not apply to medical malpractice actions.\textsuperscript{281} Thus, in \textit{LeBlanc v. Meza},\textsuperscript{282} the Louisiana Court of Appeals upheld the constitutionality of the three-year statute of repose, but acknowledged that there were situations when such limitations would be unfair, particularly when a disease has a latency period of more than three years.\textsuperscript{283} The court also stated that a Supreme Court ruling would be required to resolve the issue of whether \textit{contra non valentem} should apply in such circumstances.\textsuperscript{284} Subsequently, in the 1996 case \textit{Whitnell v. Silverman},\textsuperscript{285} the Louisiana Supreme Court upheld the constitutionality of the statute, but left unanswered the question of whether it would be unconstitutional if it barred suit by a person with a disease with a latency period of more than three years.\textsuperscript{286}

In 2001, in \textit{Hardy v. Blood Systems, Inc.},\textsuperscript{287} the Court of Appeals again considered the problem of the application of the three-year statute of limitations to diseases with a latency period in excess of three years. As in \textit{LeBlanc}, the court recognized the strength of the plaintiff’s argument in favor of creating an exception in cases where diseases have a latency period of more than three years, but held the statute constitutional nonetheless.\textsuperscript{288} The Court indicated its reservation in making such a ruling, stating that the statute was constitutional “until the supreme court of this state rules otherwise or the legislature changes the law.”\textsuperscript{289}

Finally, in 2004, in \textit{Walker v. Bossier Medical Center},\textsuperscript{290} the Court of Appeals held that the three-year statute of repose was unconstitutional as applied to a patient who suffered from a disease with a latency period of more than three years.\textsuperscript{291} This case involved a woman who had received a transfusion of blood contaminated with Hepatitis C.\textsuperscript{292} The court reasoned that a three-year period was an unconstitutional denial of due process in this instance because it prevents “a small number of the least blameworthy, yet most seriously injured claimants from having their day in court.”\textsuperscript{293} Subsequently,
however, the Supreme Court of Louisiana, noting a conflict with a decision by another Court of Appeals panel, ordered the opinion vacated and remanded for an en banc hearing.294 On remand, the en banc Court of Appeals reversed the earlier decision and upheld the constitutionality of the three-year statute of repose as applied.295

The Supreme Court of Louisiana has also opined on the use of the continuing tort doctrine to extend the statute of repose. In 2001, in In re Medical Review Panel for the Claim of Moses,296 the Supreme Court of Louisiana rejected plaintiff's argument that the statutory period was tolled by the continuing tort doctrine where there had been no treatment by the physician following the initial act of negligence in failing to remove metal stitches. However, the court left “open the question of whether the continuing tort doctrine can be invoked to enlarge the three-year repose period.”297 Subsequently, in 2005, in Carter v. Haygood,298 the Supreme Court of Louisiana applied the continuous treatment doctrine to suspend the running of the statute of repose where a dentist had provided treatment to the patient to ameliorate problems caused by the initially improper extractions of eleven teeth until it became apparent to the patient that the dentist could not correct those problems.299

6. Joint and Several Liability

In 1996, the legislature abrogated the traditional doctrine of joint and several liability in all tort actions.300 When it adopted the Civil Code, Louisiana inherited a limited concept of joint and several liability, which provided that joint liability was permitted to the extent necessary for the injured claimant to recover fifty percent of his recoverable damages.301 In order to conform to a new system of comparative fault, this provision was amended in 1996 to provide that a joint tortfeasor is liable only for a proportionate degree of fault and is not jointly liable with any other person for damages attributable to the fault of such person.302 Not surprisingly, since this statute was not limited to medical malpractice actions, there have been no constitutional challenges to it.

296 788 So. 2d 1173 (La. 2001).
297 Id. at 1187.
298 892 So. 2d 1261 (La. 2005).
299 Id. at 1273.
301 L.A. CIV. CODE ANN. art. 2324(B) (2007).
302 L.A. CIV. CODE ANN. art. 2324(B) (2007).
7. Arbitration

The Louisiana review panel legislation also suggests that pre-claim agreements to arbitrate malpractice disputes may be binding. This is implicit in the language of section 40:1299.47(A), which states: "All malpractice claims against health care providers covered by this Part, other than claims validly agreed for submission to a lawfully binding arbitration procedure, shall be reviewed by a medical review panel." Another statutory provision provides that persons eligible by statute to consent to health care for others also have the authority to consent to "binding medical arbitration agreements."

B. Alabama

Alabama first adopted comprehensive malpractice reform legislation in 1975. The 1975 Act adopted a discovery rule for the statute of limitations with a statute of repose, eliminated the ad damnum clauses in malpractice complaints, defined the standard of care in malpractice actions, precluded advance payments from being considered admissions of liability, authorized post-claim agreements to arbitrate, granted discretion to trial judges to order the periodic payout of damages in excess of $100,000, authorized the insurance commissioner to establish a joint underwriting association, and required insurance carriers to report malpractice claims and costs to the insurance commissioner annually.

In addition, special rules that limit recoveries apply to government owned hospitals. The Alabama Constitution provides that the State of Alabama may never be made a defendant in any court of law or equity, and this immunity includes hospitals owned and operated by a state university. Furthermore, the liability of county and

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304 Id. (emphasis added).
308 1975 Ala. Acts, No. 513, § 6, 1148 (codified at ALA. CODE §§ 6-5-484(a), (b)(2007)).
309 1975 Ala. Acts, No. 513, § 11, 1148 (codified at ALA. CODE §§ 6-5-487(a), (b) (2007)).
314 ALA. CONST. art. I, § 14. This provision of the state Constitution was applied to hospitals in a case in which a University was sued for services rendered to a patient. Sarradett v. Univ. of S. Ala. Med. Ctr., 484 So. 2d 426 (Ala. 1986).
municipal hospitals for total damages due to bodily injury or death is capped at $100,000 per claimant and $300,000 per occurrence. 315

In 1987, Alabama enacted both general tort reform and specific malpractice reform provisions. 316 This legislation was initially “spearheaded by...the Alabama Civil Justice Reform Commission (ACJRC), a coalition of sixty business and professional organizations.” 317 Eventually, Republican Governor Guy Hunt and the ACJRC agreed on a package of bills that were submitted to the legislature. 318 The Alabama Trial Lawyers Association, representing plaintiffs’ lawyers, negotiated with the Governor and ACJRC to develop legislation that it could ultimately support, and its assistance was essential to passage. 319

Several of the provisions of the 1987 legislation were based on MICRA 320 and included a cap of $400,000 on non-economic damages (including punitive damages), 321 a total cap of $1 million in wrongful death medical malpractice cases, 322 collateral source offset, 323 and mandatory periodic payout of future damages. 324 Legislative findings accompanying this legislation indicated that it was adopted in reaction to “the increasing threat of legal actions for alleged medical injuries.” 325

1. Damages Caps

The 1987 legislation included a cap of $400,000 on non-economic damages, including punitive damages, 326 and an overall cap of $1 million on damages in wrongful death malpractice actions. 327 Subsequently, however, a series of Alabama Supreme Court opinions declared these damages caps unconstitutional. In Moore v. Mobile Infirmary Association, 328 the $400,000 cap was held unconstitutional under the equal

317 Id. at 282.
318 Id. at 284.
319 Id. at 285.
321 ALA. CODE § 6-5-544 (b) (2007).
322 ALA. CODE § 6-5-547 (2007).
323 ALA. CODE § 6-5-545 (2007).
324 ALA. CODE § 6-5-543 (2007).
326 1987 Ala. Acts, No. 87-189, § 5, 261 (codified at ALA. CODE § 6-5-544(b) (2007)).
327 1987 Ala. Acts, No. 87-189, § 8, 261 (codified at ALA. CODE § 6-5-547 (2007)).
328 592 So. 2d 156, 171 ( Ala. 1991).
protection and the right to trial by jury provisions of the Alabama Constitution. In *Ray v. Anesthesia Associates of Mobile, P.C.* and *Smith v. Schulte*, the $1 million cap on total damages in wrongful death malpractice cases was held unconstitutional.

Following *Moore*, bills with similar caps on non-economic damages were considered by the legislature on several occasions, but were never enacted. During the 1990s, the ideological composition of the Supreme Court of Alabama was changed due to victories of several Republican justices supported by business interests, thereby increasing the possibility that damages caps might be upheld by a reconstituted Court. However, in a 2003 decision, the Supreme Court of Alabama declined the invitation to reinstate the $400,000 cap on non-economic damages.

Another statute passed in 1987 established a cap on punitive damages in all personal injury cases of $250,000 unless the conduct was intentional or malicious. In 1993, the Supreme Court of Alabama declared the cap unconstitutional in *Henderson By Hartsfield v. Alabama Power Company*, but subsequently the Court indicated it was abrogating *Henderson* insofar as it "held that § 11 [of the Alabama Constitution] restricted the Legislature from removing from the jury the unbridled right to punish." In 1999, the cap on punitive damages in physical injury cases was modified by the legislature to three times the awarded compensatory damages or $1,500,000, whichever is greater.

2. **Collateral Source Rule**

In 1987, Alabama abrogated the collateral source rule for medical malpractice

329 674 So. 2d 525 (Ala.1995).
330 671 So. 2d 1334 (Ala. 1995).
331 The Alabama Supreme Court, however, later indicated it was abrogating *Smith* insofar as *Smith* "held that § 11 [of the Alabama Constitution] restricted the Legislature from removing from the jury the unbridled right to punish." Ex parte Apicella, 809 So. 2d 865, 874 (Ala. 2001).
333 *Id.* at 228-30.
336 627 So. 2d 878, 894 (Ala. 1993).
337 Ex parte Apicella, 809 So. 2d 865, 874 (Ala. 2001).
claims with respect to reimbursement of medical or hospital expenses. The same year, Alabama also abrogated the collateral source rule in all civil cases. The latter was held unconstitutional in American Legion Post No. 57 v. Leabey, but Leabey was later overruled by Marsh v. Green. Although Marsh did not directly address the statute, it did undermine the reasoning in Leabey.

3. Statute of Limitations

In 1975, Alabama adopted a statute of limitations for medical malpractice cases that requires the claim to be filed within two years "after the act, or omission, or failure giving rise to the claim, and not afterwards;" or, if it is "not discovered and could not reasonably have been discovered within such period," then [the claim] must be filed within six months of discovery. There is also a statute of repose providing that in no circumstances may an action be filed more than four years after the act giving rise to the claim. The constitutionality of this statute has been upheld by the Supreme Court of Alabama on several occasions.

4. Periodic Payout

The 1975 legislation gave the trial judge the discretion to order periodic payout in malpractice cases where future damages were in excess of $100,000. In 1987, the legislature mandated that judges order future damages in malpractice cases in excess of $150,000 to be paid over a period of time. The judge was given discretion to fix the period, but it was not to exceed the estimated period where future damages would be incurred based on the evidence at trial. In 2005, in Lloyd Noland Hosp. v. Durham, this statute was held unconstitutional as violative of the right to trial by jury.

341 681 So. 2d 1337, 1347 (Ala. 1996).
342 782 So. 2d 223, 233 (Ala. 2000).
343 1975 Ala. Acts, No. 513, § 4, 1148 (codified at ALA. CODE § 6-5-482(a) (2007)).
344 Id.
347 1987 Ala. Acts, No. 87-189, § 5, 261 (codified at ALA. CODE ANN. § 6-5-543(b)(2) (2007)); see also Vaughan v. Oliver, 822 So. 2d 1163, 1179 (Ala. 2001) (holding that § 6-5-543(b) is mandatory).
349 906 So. 2d 157, 173 (Ala. 2005).
5. Restrictions on Expert Witnesses

In 1987, Alabama adopted a statute imposing stringent requirements on the admissibility of the testimony of expert witnesses in malpractice cases.\(^{350}\) The statute requires that expert witnesses be "similarly situated health care provider[s]."\(^{351}\) For board-certified physicians, this would require that witness be certified by an "appropriate American board in the same specialty" and "practiced in this specialty during the year preceding the alleged breach of the standard of care."\(^{352}\) The constitutionality of the "similarly situated health care provider" requirement has been held not to violate equal protection.\(^{353}\) In 1996, in response to decisions by the Alabama Supreme Court, the legislature amended the statute to add the following language:

> It is the intent of the Legislature that in the event the defendant health care provider is certified by an appropriate American board or in a particular specialty and is practicing that specialty at the time of the alleged breach of the standard of care, a health care provider may testify as an expert witness with respect to an alleged breach of the standard of care in any action for injury, damages, or wrongful death against another health care provider only if he or she is certified by the same American board in the same specialty.\(^{354}\)

The 1996 Amendment has also been upheld as applied to a plaintiff whose case was pending prior to its enactment.\(^{355}\) The statute has been rigorously applied by the Supreme Court of Alabama. For example, in one case, the court refused to allow the testimony of a surgeon certified by the American Board of Surgery in a malpractice against a surgeon who was certified by the American Osteopathic Board of Surgery without regard to the fact that the requisite qualifications of the two boards may have been virtually identical.\(^{356}\)

\(^{350}\) 1987 Ala. Acts, No. 87-189, § 9, 261 (codified at ALA. CODE § 6-5-548(b) (2007)).
\(^{351}\) ALA. CODE §§ 6-5-548(b),(c).
\(^{352}\) ALA. CODE §§ 6-5-548 (c)(3), (4).
\(^{354}\) ALA. CODE § 6-5-548(e) (2007).
\(^{356}\) Johnson v. Price, 743 So. 2d 436, 438 (Ala. 1999). In Holcomb v. Carraway, a board-certified oncologist was prohibited from testifying in an action against a surgeon for failure to timely diagnose breast cancer by performing biopsy. Holcomb v. Carraway, 945 So. 2d 1009, 1015 (Ala. 2006). In McGlothren v. E. Shore Family Practice, P.C., a physician who was board-certified in internal medicine was not permitted to testify against a physician who was board-certified in family medicine in an action alleging failure to timely diagnose and treat saddle black embolus.
6. Arbitration

By statute, Alabama recognizes the validity of post-claim agreements to arbitrate medical malpractice disputes.\(^\text{357}\) However, this provision has had virtually no impact in Alabama. Even if a plaintiff would want to arbitrate, it is doubtful that defense counsel would agree to arbitration in light of the apparent sympathy of Alabama juries for health care providers.

C. Mississippi

In 1976, as a result of the malpractice crisis of the mid-1970s, the Mississippi State Medical Association created a physician mutual, the Medical Assurance Company of Mississippi.\(^\text{358}\) In June 2002, the AMA designated Mississippi as a “crisis” state.\(^\text{359}\) In 2002, in response to a perceived medical malpractice crisis, the Democratic Governor, Ronnie Musgrove, called a special legislative session to deal with malpractice reform.\(^\text{360}\) The session was also supposed to consider reforms to the general civil liability system.\(^\text{361}\) Two tort reform bills were passed during the 2002 special legislative session. Prior to the eighty-three day special session, Musgrove backed a state-operated malpractice insurance risk pool.\(^\text{362}\) Although this proposal was not adopted in 2002,\(^\text{363}\) the legislature passed House Bill 2, focusing solely on medical liability reform.\(^\text{364}\) Most notably, its provisions included a cap of $500,000 on non-economic damages with exceptions for disfigurement cases and cases where the award of punitive damages was appropriate.\(^\text{365}\)

The 2002 legislation also included several other reforms: (1) a venue provision requiring actions against health care providers to be brought in the “county in which the

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\(^{357}\) 1975 Ala. Acts, No. 513, § 8, 1148 (codified at ALA. CODE § 6-5-485 (2007)).


\(^{361}\) Percy, supra note 359, at 1002.

\(^{362}\) Ben Bryant, Medical Crisis May Roll Over State, BILOXI SUN HERALD, Jan. 29, 2003, at A1.

\(^{363}\) Id.

\(^{364}\) Percy, supra note 359, at 1002.

alleged act occurred;\footnote{2002 Miss. Laws 3rd Ex. Sess., Ch. 2, § 1 (codified at MISS. CODE ANN. § 11-11-3(3) (2007)).} (2) an expansion of the immunities from liability applicable to the state and its employees so as to include physicians employed by various state entities;\footnote{2002 Miss. Laws 3rd Ex. Sess., Ch. 2, § 2 (codified at MISS. CODE ANN. § 11-46-1(f) (2007)).} (3) a requirement that pleadings in actions against physicians arising out of injuries caused by a prescription drug include specific facts showing negligence;\footnote{2002 Miss. Laws 3rd Ex. Sess., Ch. 2, § 3 (codified at MISS. CODE ANN. § 11-1-62 (2007)).} (4) modification of the rules of joint and several liability as applied to health care providers;\footnote{2002 Miss. Laws 3rd Ex. Sess., Ch. 2, § 4 (codified as MISS. CODE ANN. § 85-5-7 (2007)).} (5) a requirement that plaintiff serve a notice of intent to sue sixty days prior to the filing of the suit that includes information as to the basis of the claim, the type of loss and, with specificity, the nature of the injuries incurred;\footnote{2002 Miss. Laws 3rd Ex. Sess., Ch. 2, § 5 (codified at MISS. CODE ANN. § 15-1-36(15) (2007)).} and (6) a requirement that the plaintiff's attorney in a malpractice action file with the complaint a certificate of expert consultation.\footnote{2002 Miss. Laws 3rd Ex. Sess., Ch. 2, § 6 (codified at MISS. CODE § 11-1-58 (2007)). The certificate must aver that that the attorney has consulted with a qualified expert and believes that there is a reasonable basis for the suit, that the attorney was unable to consult with an expert because the statute of limitations was about to run, that the attorney had attempted in good faith to find a qualified expert but was unable to do so, that the action is based on the doctrine of informed consent, or that the attorney intends to rely on the doctrine of res ipsa loquitur.} A second piece of legislation passed during the 2002 special session, House Bill 19, contained some general tort reforms, "including caps on punitive damages, a prohibition on recovery for damages for loss of enjoyment of life resulting from death and a repeal of the fifteen percent penalty that was previously assessed to defendants who lost on appeal."\footnote{Percy, supra note 359, at 1002 (citing Act of Dec. 3, 2002, ch. 4, 2003 Miss. Laws 1289).}

In 2003, in reaction to continuing problems with insurance availability and affordability, the Mississippi legislature passed the Medical Malpractice Insurance Availability Act.\footnote{2003 Miss. Laws, Ch. 560, § 1 (codified at MISS. CODE ANN. §§ 83-48-1 through 83-48-9 (2007)).} This legislation, which was signed by Governor Musgrove on April 25, 2003, created a state run malpractice insurance risk pool to provide a "temporary market of last resort" for health care providers.\footnote{Mississippi Department of Insurance E-Newsletter (April 2003), at 1, available at http://www.doi.state.ms.us/newsletters/april03news.pdf.} This pool was to be run by the Mississippi Tort Claims Board.\footnote{Id.} The Board provided initial financing of $500,000, but otherwise the pool was to be financed by doctors and hospitals that used it.\footnote{Ben Bryant & David Tortorano, Mississippi Malpractice Crisis Insurance Pool Offers Hope, Some Doctors, Officials Fear Bill is a Band-Aid, BILOXI SUN HERALD, Feb. 1, 2003, at A1.} In late
2003, the Mississippi State Medical Association proposed that either the medical liability insurance pool be converted to a patient compensation fund or that a new patient compensation fund be created. During the 2004 regular session, a Senate Bill to create a patient compensation fund similar to the Louisiana Patient Compensation Fund died in committee.\footnote{S.B. 2870, Reg. Sess. (Miss. 2004), \textit{available at} http://billstatus.ls.state.ms.us/2004/html/Senate_authors/Robertson.htm. The bill died in committee on March 9, 2004. \textit{Id.}}

In 2004, Mississippi adopted comprehensive tort reform legislation applicable in all tort cases after a lengthy battle between trial lawyers and business interests.\footnote{Ross, \textit{supra} note 360, at 5.} Prior to these reforms, Mississippi had been labeled as a "Judicial Hellhole" by the American Tort Reform Association.\footnote{Ross, \textit{supra} note 360, at 6 (citing Am. Tort Reform Ass'n, \textit{Bringing Justice to Judicial Hellholes} (2003), \textit{available at} http://www.atra.org/reports/hellholes/2002/hellholes_report_2002.pdf).} In addition to comprehensive tort reform during the 2004 regular legislative session, Republican Governor Barbour advocated lowering the cap on non-economic damages in malpractice cases to $250,000 and requiring all medical malpractice claims to be reviewed by screening panels prior to filing suit, but these proposals were not adopted.\footnote{Percy, \textit{supra} note 359, at 1003 (citing Lynne Jeter, "Haley's Plan" to Address Mississippi's Major Healthcare Issues, MISS. BUS. J., Jan. 12, 2004, at B3.)} The 2004 legislation did include some provisions impacting malpractice cases, e.g., the exceptions to the $500,000 cap on non-economic for disfigurement cases and cases where the award of punitive damages was appropriate were removed by the 2004 legislation.\footnote{2002 Miss. Laws 3rd Ex. Sess., Ch. 2, §7, \textit{amended by} 2004 Miss. Laws 1st Ex. Sess., Ch. 1, § 2 (codified as amended at MISS. CODE § 11-1-60(1)(a) (2007)).}

1. **Damages Caps**

   a. **Punitive Damages**

Mississippi has a cap that is applicable in any civil action where punitive damages are sought.\footnote{MISS. CODE § 11-1-65(3).} The cap is dependent on income/net worth. The original 1993 statute gave factors to consider when assessing punitive damages, but did not establish a cap.\footnote{1993 Miss. Laws, Ch. 302, § 5.} A 2002 Amendment introduced the damages caps.\footnote{S.B. 2870, Reg. Sess. (Miss. 2004), \textit{available at} http://billstatus.ls.state.ms.us/2004/html/Senate_authors/Robertson.htm. The bill died in committee on March 9, 2004. \textit{Id.}} In 2004, the legislature...
amended this statute, significantly reducing the level of the caps.385

b. Caps on Non-Economic Damages

In 2002, non-economic damages in medical liability actions were defined and capped at $500,000.386 In the 2002 legislation, this cap was set to increase to $750,000 in 2011 and to $1,000,000 in 2017.387 In 2004, this legislation was amended to provide a cap of $500,000 applicable in medical malpractice actions filed after September 1, 2004, without any provision for future increases.388

2. Other Limitations of Liability or Immunities

Mississippi has, by statute, granted immunity from liability to physicians and nurse practitioners who volunteer to provide services on a charitable basis where the patient signs a written waiver.389 The immunity is also provided to certain church-run charitable medical clinics.390 In addition, for tort claims against the state of Mississippi, the following caps are applicable: (1) $50,000 for claims occurring on or after July 1,

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<th>Net Worth: Above</th>
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<th>Cap</th>
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384 2002 Miss. Laws 3rd Ex. Session, Ch. 4, § 6. The caps were as follows:

385 2004 Miss. Laws 1st Ex. Sess., Ch. 1 (H.B. 13). These caps are as follows:


387 Id.


390 Id.
1993, but before July 1, 1997; (2) $250,000 for claims or causes of action arising from acts or omissions occurring on or after July 1, 1997, but before July 1, 2001; and (3) $500,000 for claims or causes of action arising from acts or omissions occurring on or after July 1, 2001.\textsuperscript{391}

3. Statute of Limitations

Mississippi has a two-year statute of limitations with a discovery rule and a seven-year statute of repose.\textsuperscript{392} Exceptions exist in cases of instruments left in the body and fraudulent concealment.\textsuperscript{393} Other exceptions exist for children younger than six years old, persons with unsound minds, and minors without parents/guardians.\textsuperscript{394} The 1976 version of the statute did not have the seven-year statute of repose and allowed an action to be brought within two years of the removal of a disability.\textsuperscript{395}

4. Restrictions on Expert Witnesses

Mississippi's only statutory requirement for experts is a requirement added in 1990 that the expert be a licensed physician in Mississippi or some other state.\textsuperscript{396}

5. Joint and Several Liability

Mississippi has modified the traditional rules governing joint and several liability. Under the 1989 legislation, joint and several liability was applicable to those who pursued a common plan.\textsuperscript{397} In other situations, under the 1989 act, there was joint and several liability only to the extent necessary to ensure that the plaintiff recovered 50% of his or her damages.\textsuperscript{398} In 2002, the legislature adopted an amendment applicable only in medical liability actions, which provided that for non-economic damages, liability was several only and for economic damages, liability was joint only for defendants who were more than thirty percent at fault and only to the extent necessary to allow plaintiff to recover fifty percent of his or her damages.\textsuperscript{399} In 2004, the legislature amended the

\begin{footnotes}
\textsuperscript{392} MISS. CODE ANN. § 15-1-36 (2007).
\textsuperscript{393} Id.
\textsuperscript{394} Id.
\textsuperscript{395} 1976 Miss. Laws Ch. 473, § 1 (codified at MISS. CODE ANN. § 15-1-36 (2007)).
\textsuperscript{397} 1989 Miss. Laws Ch. 311, § 1 (1989) (codified at MISS. ST. ANN. § 85-5-7 (2007)).
\textsuperscript{398} Id.
statute to provide that in all tort actions, liability may only be several, except for those who deliberately pursue a common plan.\textsuperscript{400}

6. Collateral Source Rule

The common law collateral source rule has not been statutorily modified in Mississippi.\textsuperscript{401} Until recently, however, Mississippi did not permit Medicaid recipients to sue for recovery of medical expenses covered by Medicaid because of a statutory provision giving the Medicaid agency the exclusive authority to pursue this recovery.\textsuperscript{402} However, this statute was changed by the legislature in 2000 to allow the Medicaid recipient to pursue recovery.\textsuperscript{403} The recovery is apportioned between the recipient and the Medicaid agency.\textsuperscript{404} Accordingly, the Mississippi Supreme Court recognized that Medicaid damages are subject to the collateral source doctrine and are recoverable.\textsuperscript{405}

IV. A Comparison of the Malpractice Environments in Louisiana, Alabama, and Mississippi

All three states have traditionally been viewed as having plaintiff-friendly litigation environments.\textsuperscript{406} In its January 2007 map identifying malpractice crisis states, the AMA designated Louisiana as a "stable" state and Mississippi and Alabama as "caution" states.\textsuperscript{407} However, physician perception of the malpractice environment of jurisdictions may not be based solely on objective factors; it is largely a function of physicians' collective anxieties about being sued, possible increases in medical liability premiums, or the possible loss of liability coverage.\textsuperscript{408} These perceptions may be influenced by factors such as "tighter reimbursement rates, more assertive patients, [and]
greater administrative burdens." Furthermore, the loss of professional autonomy through the growth of managed care may produce anxiety about the malpractice environment if physicians believe cost containment techniques expose them to additional liability risks.

Physicians' perceptions about the malpractice environment in a particular state may in turn exert an influence on the practice of defensive medicine, location decisions, and decisions to leave practice or retire. It has been argued with respect to the mid-1980s crisis that the crisis was "socially constructed," i.e., that the real cause of the crisis was loss of professional autonomy, but that it was socially constructed in economic terms because, traditionally, economics has been a more acceptable basis for labor unrest in the United States. It was particularly noted in this regard that physicians in New England had actually experienced increased income after expenses during the crisis period.

Clearly, physicians are litigaphobic, i.e., they over-predict their risks of being sued for malpractice. The personal fears of physicians about being sued may be influenced by characteristics such as area of specialization, age, and gender, e.g., those in high risk specialties, females, and younger physicians (age <40) are respectively more fearful than those in low risk specialties, males, and older physicians (age >40). In addition, those practicing in teaching hospitals may be less anxious about lawsuits than those in other practice settings. Notably, rural physicians are the most litigaphobic.

In light of these observations, it is, perhaps, not surprising that physician

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409 Studdert et al., supra note 134, at 2615.
410 Studdert et al., supra note 134, at 2615.
412 Id. at 287.
416 Id.
anxiety about a malpractice crisis may not be directly tied to the objective risks of being sued, premium levels, claim frequency, or loss payouts. For example, a comparison of a 2003 ranking of states in terms of claim frequency and severity developed by Kaiser Family Foundation's State Health Facts and the AMA's listing of crisis states revealed that the average claim payments in several of the AMA's crisis states (including Mississippi) ranked below the national average claim payment of $291,236. Similarly, a review of the rankings based on claim frequency revealed that five of the top ten states in the Kaiser rankings were not listed as crisis states, and several of the crisis states were near the bottom of the claim frequency ranking.

According to rankings for 2007 compiled by the Kaiser Family Foundation of all fifty states and the District of Columbia based on paid claims per 1,000 non-federal physicians, there is significant variation among our jurisdictions. As of June 30, 2007, Louisiana was ranked number six among all fifty-one jurisdictions in the number of paid claims per 1,000 non-federal physicians, with a total of twenty-two paid claims per 1,000 physicians. Mississippi was ranked number seventeen with at 15.9 claims per 1,000 physicians, and Alabama was ranked number fifty-one with only four paid claims per 1,000 physicians.

For 2007, there was variation among the three states in the amounts of the average and total paid claims. As of June 30, 2007, the national average for paid claims was $290,662. Alabama had an average paid claim of $225,198, Mississippi had an average paid claim of $285,208, and Louisiana's average paid claim was $171,927. As of June 30, 2007, Louisiana had total paid claims of $47,280,000, Mississippi had

417 Id.
419 Id.
421 Id.
422 Id.
424 Id.
425 Id.
426 Id.
total paid claims of $29,376,500, and Alabama had total paid claims of $10,809,500.

In the following sections, we will discuss the malpractice environment in each of our jurisdictions and conclude with a series of tables comparing the levels of total paid claims and medical liability insurance premiums.

A. Louisiana

Providers and insurers in Louisiana continue to be supporters of the malpractice reforms adopted in 1975. The first issue of the LPCF quarterly newsletter published in 2005 "proudly boasts stability in the medical malpractice insurance market." The same issue of the newsletter claims that "Louisiana is currently only one of SIX [emphasis in original] states not considered in [sic] medical malpractice crisis" When interviewed in 2004, Donald J. Palmisano, a New Orleans surgeon and past president of the AMA, noted that the 1975 MMA had been successful in ending that earlier crisis. Not surprisingly, however, he also claimed that insurance rates were still higher than they ought to be because "Louisiana has a culture of litigation where frivolous lawsuits have caused inflated insurance rates." In January 2007, however, the AMA recognized that Louisiana (along with CA, CO, NM, ID, IN, TX, WI) was one of eight states not experiencing a crisis.

As noted supra, Louisiana has an overall cap on awards of $500,000, but this cap does not apply to future medical expenses. In addition, the liability of individual physicians is capped at $100,000. Physicians in Louisiana make two payments annually for malpractice insurance: one is a premium that goes to a private insurer and the other is a surcharge paid to the LPCF. These payments vary according to area of specialization and are substantial for some specialties. For example, in 2002, neurosurgeons paid approximately $90,000 annually for their combined premium and surcharge, ob/gyns paid approximately $60,000 and generally surgeons paid approximately $37,000.

4&sort=698.
428 Id.
429 Id.
431 Id. at 1.
433 Id.
434 AMA (Jan. 2007), supra note 409.
435 Alisa Stingley, Louisiana Ahead of Other States in Malpractice, THE TIMES (Shreveport), Jan. 3,
The LPCF in effect acts as an excess insurer covering damages over the first layer of coverage of $100,000.\textsuperscript{436} The underlying insurer does not have to pay the full $100,000 prior to the LPCF making payments if the damages are in excess of $100,000.\textsuperscript{437} If a provider's insurer settles with the plaintiff for $100,000, then the LPCF may not contest liability.\textsuperscript{438} Thus, the initial decision as to whether a case should be settled or defended is made by the primary insurer.\textsuperscript{439} If the primary insurer settles with the plaintiff at the PCF threshold, this is "particularly advantageous for the plaintiff as he will no longer need a medical expert to prove medical malpractice."\textsuperscript{440} The settlement must be approved by the court and the fund is given notice of the proposed settlement and an opportunity to contest it.\textsuperscript{441} Although the fund may not contest liability in such actions, it may contest quantum (i.e., damages).\textsuperscript{442} Thus, although court approval of a settlement for $100,000 establishes liability, the plaintiff still has the burden of establishing that the defendant's malpractice caused damages in excess of $100,000, and the LPCF is permitted to introduce evidence that the victim or a third party caused damages.\textsuperscript{443} The LPCF is permitted to contest liability where the settlement is for less than $100,000.\textsuperscript{444}

Most Louisiana physicians purchase their primary coverage from the Louisiana Medical Mutual Insurance Company (LAMMICO), a physician's mutual company that was formed in the early 1980s in response to the first insurance crisis.\textsuperscript{445} LAMMICO provides both occurrence-based and claims-made coverage to "qualified health care providers."\textsuperscript{446} It only sells policies to physicians who are qualified health care providers under the LPCF legislation.\textsuperscript{447} It sells policies with limits that coordinate with the

\begin{footnotes}
\textsuperscript{436} E-mail from Lorraine LeBlanc, \textit{supra} note 234.
\textsuperscript{437} E-mail from Lorraine LeBlanc, \textit{supra} note 234.
\textsuperscript{438} LA. REV. STAT. ANN. § 40.1299.44 (C)(5)(e) (2007).
\textsuperscript{439} E-mail from Lorraine LeBlanc, \textit{supra} note 234.
\textsuperscript{440} E-mail from Lorraine LeBlanc, \textit{supra} note 234.
\textsuperscript{441} LA. REV. STAT. ANN. § 40.1299.44 (C) (2007). The Supreme Court of Louisiana has required strict compliance with this statute in order to bind the LPCF and preclude it from contesting liability. Ginn v. Woman’s Hosp. Found., 842 So. 2d 338 (La. 2003).
\textsuperscript{442} Stuka v. Fleming, 561 So. 2d 1371 (La. 1990).
\textsuperscript{443} Conner v. Stelly, 807 So. 2d 827 (La. 2002).
\textsuperscript{444} Russo v. Vasquez, 648 So. 2d 879, 882 (La. 1995).
\textsuperscript{445} Louisiana Medical Mutual Insurance Company, About Us, at http://www.lammico.com/about/.
\textsuperscript{446} Telephone Interview with Joan Burmaster, General Counsel, Louisiana Patient Compensation Fund, Dec. 4, 2006.
\textsuperscript{447} Id.
\end{footnotes}
$100,000 limit on provider liability set forth in the LPCF legislation. In addition, LAMMICO sells policies with higher limits that are purchased by qualified health care providers to provide coverage for any claims that might fall outside the parameters of the LPCF legislation. At one time, there was a concern about a possible trend in decisions by Louisiana courts toward finding that cases were outside the LPCF legislation and accordingly not subject to coverage by the LPCF and the cap on damages. This trend has not been as discernible in recent years. The rates for coverage in excess of amount of liability under the LPCF legislation are discounted in recognition of the fact that most cases will fall under the LPCF.

Since LAMMICO is only liable for the first $100,000 of liability under the LPCF legislation, it might be expected that the company would be inclined to settle in those cases where the costs of defense would approach that limit of coverage. That propensity is, according to the General Counsel for LAMMICO, counteracted by the fact that as a physician's mutual, LAMMICO is particularly concerned about the reputational impact of settlements that would be reportable to the Louisiana Board of Medical Examiners and the National Practitioner's Data Bank. LAMMICO also includes a provision in its policies requiring the consent of the insured to settle a claim, but there is no evidence that this affects their approach to settlement.

As noted, the number of paid claims per 1,000 physicians and the total amount of paid claims is higher in Louisiana than in Alabama or Mississippi. The reasons for this may be seen in the particular characteristics of the Louisiana reforms. In this regard, it is instructive to compare the Louisiana experience with that of Indiana because the 1975 Louisiana MMA was modeled after legislation adopted in Indiana. In 1975, Indiana adopted a cap on total damages of $500,000, with a cap of $100,000 on the liability of the individual provider and the remainder to be paid by the Indiana

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448 Id.
449 Id.
450 Burmaster, supra note 446; see O'Brien v. Rivzi, 898 So. 2d 360 (La. 2005) (holding physician staffing company is not qualified health care provider and physician employee who was not licensed in Louisiana is not “qualified health care provider”); Jackson v. Dunlap, 654 So. 2d 888 (La. Ct. App. 1995) (holding chiropractor who provided proof of responsibility for first $100,000 of liability but failed to pay surcharge to LPCF was not “qualified health care provider” under act).
451 Burmaster, supra note 446.
452 Burmaster, supra note 446.
453 Burmaster, supra note 446.
454 Burmaster, supra note 446.
Patient Compensation Fund (IPCF). As in Louisiana, if the provider's insurer settles the claim at the IPCF threshold of $100,000, then the PCF can only contest the extent of damages and not liability. It also adopted mandatory screening panel review for claims over $15,000.

In a 1991 study, Gronfein and Kinney used "a sample of large claims filed after July 1975 and closed from 1977-1988 in Indiana, Michigan and Ohio." They found that the mean for paid malpractice claims was actually higher in Indiana, a jurisdiction with a cap on total damages, than in Michigan and Ohio, jurisdictions without damages caps at that time. The mean Indiana claim payment was 39.6 percent greater than the mean paid claim in Michigan and 33.5 percent greater than the mean paid claim in Ohio. Gronfein and Kinney further noted that there was evidence that the defense of claims had been less vigorous in Indiana than in Michigan and Ohio. In Indiana, the provider's insurers were inclined to settle for the IPCF threshold, leaving the relatively inexperienced attorneys representing the IPCF to contest damages against more experienced plaintiff's lawyers. Gronfein and Kinney also found that proportionately more claims were paid at the $500,000 level in Indiana as compared to Ohio and Michigan.

In a second article, Gronfein and Kinney noted that the provider's insurers push "claims involving serious injury to the PCF by agreeing to pay claimants the requisite amount to make cases eligible for PCF payment." They characterize the Indiana system as "no-fault by accident" system noting that as a "result of these incentives [i.e., on the private insurer to settle the claim] ... a state-run insurance fund is paying large sums of money to most PCF claimants without a formal determination of fault." While it may be that the defense of claims by the primary insurer in Louisiana is more vigorous than in Indiana, there still appears to be substantially greater likelihood that a claim will be paid in Louisiana than in Alabama or Mississippi. This is

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457 Id. at 443.
458 Id. at 442.
459 Id. at 445.
460 Gronfein, *supra* 456, at 447.
463 Gronfein, *supra* 456, at 460.
465 Id. at 189.
undoubtedly due to the fact that primary insurers are more inclined to settle at policy limits (only $100,000), thereby leaving only the questions of damages for litigation by the LPCF.

1. Malpractice Insurance Premium Rates

Under the MMA, “qualified health care providers” are subject to an annual surcharge in order to maintain the solvency of the LPCF.466 From 1975 to 1990, surcharge rates were kept relatively low, but the LPCF did not provide claims administration and did not set aside adequate reserves.467 After the establishment of the LPCF Oversight Board in 1990, claims administration was improved.468 There were also substantial annual rate increases in order to make up for the previous fifteen years of inadequate increases.469 In addition, effective July 1, 1993, the LPCF began an experience-rating program for physicians and hospital classes in order “to apportion a greater percentage of needed premium increases to those providers who are generated a greater-than-expected number of losses.”470

The 2005-2006 strategic plan states that the vision of the LPCF Oversight Board is “to progressively close [sic] the gap between outstanding liabilities and current assets, without relying exclusively on annual rate increases, so that private health care providers in Louisiana can have stable and reasonable surcharge rates...”471 The plan asserted that improving the fiscal health of the plan would have the salubrious effect of drawing more malpractice insurers to Louisiana, thereby increasing competition and reducing rates.472 The plan also noted that in the past, the Louisiana Insurance Rating Commission had refused to approve rate increases at the level requested by the LPCF Board even though the requested rates were actuarially indicated.473

Surcharges assessed by the LPCF, which are paid by qualified health care providers in addition to premiums for the base line coverage of $100,000, saw significant

468 Id.
469 Id.
471 Strategic Plan supra note 467.
472 Strategic Plan supra note 467.
473 Strategic Plan supra note 467, at 8.
increases in the 2000s. In 2003, the overall rate increase for the LPCF was approximately nineteen percent for physicians.\textsuperscript{474} The Executive Director of the LPCF attributed the increase in surcharges by the LPCF, which have to be paid by physicians in addition to the premiums for the private insurance, primarily to rising medical costs.\textsuperscript{475} In 2004, there was an overall rate increase by the LPCF for all physician classes of 9.8%.\textsuperscript{476} In 2005, there were no overall rate increases for physicians, but family practitioners experienced a 7.7% increase while other specialties actually experienced rate decreases ranging from 20% to 21.6%.\textsuperscript{477} The rate increases for physicians effective January 1, 2006, ranged from 6.7% to 9.5%.\textsuperscript{478} The rate increases effective January 1, 2007, include an average rate increase for physicians of 11% with a range of 7.6% to 13.1% depending on rate classification.\textsuperscript{479}

Premiums for private insurance coverage also increased in the early 2000s after no rate increases from 1995 to 2001.\textsuperscript{480} In 2002, the Department of Insurance approved a 23.5% increase for LAMMICO, the state's largest malpractice carrier.\textsuperscript{481} The acting State Insurance Commissioner indicated that the rate increase was warranted because LAMMICO had a loss ratio of 116%.\textsuperscript{482} The acting commissioner further stated that LAMMICO's claim frequency had increased from twenty-six to twenty-eight claims per 100 doctors to thirty-one claims per doctor.\textsuperscript{483} Rate increases by “[o]ther companies were even higher, according to the Department of Insurance.”\textsuperscript{484} In 2004, American Casualty Company requested a 29.4% rate hike, an increase that would affect 6,700 policy holders.\textsuperscript{485}

\textsuperscript{474} Walsh, supra note 245.
\textsuperscript{475} Walsh, supra note 245.
\textsuperscript{480} Walsh, supra note 245, at 1.
\textsuperscript{481} Kamerick, supra note 248.
\textsuperscript{482} Kamerick, supra note 248.
\textsuperscript{483} Kamerick, supra note 248.
\textsuperscript{484} Walsh, supra note 245, at 1.
\textsuperscript{485} Liability Rate Hikes Affect Health Care, THE TIMES (SHREVEPORT, LA), Dec. 16, 2004, at 9A.
As for LAMMICO, there have been no rate increases requested in the last three years (2005, 2006, and 2007), and for some physicians (those in Caddo and Bossier parishes) the 2007 rates for basic limits coverage will decrease by 10%, the first decrease in LAMMICO's history. Furthermore, it was announced that effective July 1, 2007, that rates for all physicians would be reduced at the time of renewal of their policies with an overall decrease in their base rates of five percent.

2. Loss Payouts

As for loss payouts, over the past ten years, claim payments by the LPCF have increased fifty-six percent, or an average of 5.6% per year. In addition to the $400,000 cap, the fund is obligated to pay future medical costs related to the injury without limitation. Interest and court costs do not fall within the statutory cap. The fund had not paid any judgments in excess of $2 million since 1976, but the LPCF paid four judgments in excess of $2 million in the first six months of 2006.

3. Claim Frequency

The LAMMICO website notes that while claim severity is "staying fairly constant...frequency is on the rise." Its website further notes, "[A]t LAMMICO, there are about 30 claims filed per 100 doctors insured, which is among the highest in the country." This high level of claims has been attributed by some in part to the ease with which plaintiffs' counsel can file a claim triggering the medical panel review process which is then used as a mechanism to gather information about their claim. The LPCF has experienced "a slow, but steady increase in the number of claims filed each..."
year." There were 1,329 requests for screening panels in 1990, 1,626 in 1995, and by 2005 the number had increased to 2,161. However, a chart prepared by the LPCF, infra, shows that the number of panel requests seemed to peak in 2001 and decline thereafter.

LPCF SCREENING PANEL REQUESTS AND FILING FEES

In 1976, Mutual Assurance Society of Alabama (MASA), a physicians’ mutual, was created to provide malpractice coverage to Alabama physicians. In 1991, MASA

495 Lorraine LeBlanc, From the Director, 1 LPCF Q. 1, 3 (2006), available at http://www.lapcf.state.la.us/Website_ActiveFiles/Newsletter/Newsletter.htm (follow “PDF” under “March 2006”).
497 Lorraine LeBlanc, From the Director, 1 LPCF Q. 1, 3 (2006), available at http://www.lapcf.state.la.us/Website_ActiveFiles/Newsletter/Newsletter.htm (follow “PDF” under “March 2006”).
became a stock company and changed its name to Medical Assurance, Incorporated.\textsuperscript{500} It has dominated the market for malpractice liability insurance in Alabama with a market share that by 2005 had reached approximately sixty-one percent of the malpractice policies issued in Alabama with coverage for more than 80% of the physicians in the state.\textsuperscript{501} In 2001, Medical Assurance combined with Professional Groups, Inc., to form Proassurance, Inc., the fourth largest medical liability insurer in the United States.\textsuperscript{502}

From the beginning, Medical Assurance has been known for its vigorous defense of medical liability claims and its reluctance to settle claims.\textsuperscript{503} This factor, coupled with the apparent sympathy that Alabama juries have for physicians who are malpractice defendants, are the most critical factors in analyzing the malpractice environment in Alabama. For example, in 2006, there were thirty-two verdicts in medical malpractice in Alabama. This number was down from fifty-four verdicts in 2002, and fifty-two in 2003, but up from fifteen in 2005.\textsuperscript{504} Of the thirty-two verdicts rendered in 2006, plaintiffs prevailed in only four cases and defendants prevailed in twenty-eight.\textsuperscript{505} The average verdict for plaintiffs in these four cases was $2,718,750,\textsuperscript{506} thereby suggesting that plaintiffs are able to prevail only in cases where the injuries are catastrophic.

As a result of the success of its unrelenting approach to the defense of claims and widespread sympathy for healthcare providers among prospective jurors, Alabama has developed the reputation of having a very difficult litigation environment for plaintiffs in malpractice actions.\textsuperscript{507} In 1997, Bruce McKee, a leading plaintiff's attorney practicing in Birmingham noted that “[i]t is still practically impossible to win a medical malpractice trial in Alabama. Statistics from Mutual Assurance (MASA), the largest medical malpractice carrier in Alabama, show that doctors won about 98% of the trials in Alabama from 1983 to 1992.”\textsuperscript{508} Juror attitudes may be influenced by the important role of health care in the economy. For example, in Birmingham, the state's largest city,
the health care sector replaced the steel industry as the largest employer. In rural counties, jurors may be concerned about retaining physicians, and thus be reluctant to return verdicts against their local doctors. The attitude of Alabama jurors toward malpractice claims and the tough settlement policy of Medical Assurance may explain the very low claim frequency in Alabama, noted supra. The tough settlement policy may also explain the relatively high average paid claim: i.e., defendants may take some cases to trial that should be settled.

As noted supra, Alabama’s medical malpractice damages caps have been declared unconstitutional by the Supreme Court of Alabama. The $400,000 cap on non-economic damages was held unconstitutional in 1991, and the $1 million cap on wrongful death damages was invalidated in 1995. A study published in 2001 by Albert Yoon concluded that average relative recoveries by plaintiffs decreased by approximately $20,000 after enactment of the damages cap legislation and increased by approximately twice that following judicial invalidation. Yoon used a data set from 1987-1999 provided by the Medical Services Division of St. Paul Fire & Marine Insurance Company to analyze the impact of court decisions in Alabama declaring damages caps unconstitutional. In his analysis, he used a control group of neighboring states, Arkansas, Mississippi and Tennessee, that did not have damages caps in place during this time. He looked at the effects of the Alabama damages caps before and after implementation, and before and after nullification. The data set provided by St. Paul covered claims against physicians insured by St. Paul from 1987-1999 in the four states and included the following information: an identifier, state of litigation, month and year of incident, month and year claim filed, allegation of malpractice, date case was resolved, and loss payout in constant 1999 dollars. Yoon found that the average relative recovery by Alabama claimants decreased by $20,000 after enactment of the caps and increased by approximately double that amount after the caps were ruled unconstitutional by the Alabama Supreme Court.

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511 Yoon, supra note 86, at 203.
512 Yoon, supra note 86, at 208-09.
513 Yoon, supra note 86, at 209-10.
514 Yoon, supra note 86, at 209-10.
515 Yoon, supra note 86, at 209-10.
516 Yoon, supra note 86, at 216-20.
C. Mississippi

As discussed, supra, in 2002, the Mississippi legislature passed malpractice reform legislation that included a cap on non-economic damages of $500,000. During the special legislative session that was called to focus on malpractice reform, the Medical Assurance Company of Mississippi (MACM) notified physicians that it would be increasing rates by forty-five percent in January 2003.517 In the controversy leading up to the passage of medical malpractice reform in 2002, proponents of reform argued that juries in four predominantly African-American counties (Claiborne, Hinds, Holmes, and Jefferson) had rendered outrageously high verdicts that had driven up malpractice premiums.518 Opponents of reform, however, argued that the sudden spikes in malpractice premium rates in the early 2000s were not caused by an increase in loss payouts, noting that while plaintiffs nationally win almost twenty-five percent of medical malpractice cases that go to trial, plaintiffs in Mississippi win only eleven percent.519 In addition, in 2000, Mississippi was below the national average in claims per 1,000 physicians: 2.11 claims in Mississippi versus 2.21 nationally.520 In 2002, Mississippi’s average claim payment was below the national average: $211,725 compared with $248,947.521

The controversy continued even after the enactment of the malpractice reforms by the special legislative session in late 2002. Initially, the fact that the cap did not go into effect until January 1, 2003, led to a spike in last minute filings of lawsuits to avoid the cap.522 After the adoption of the cap, opponents of reform argued that the damages cap would not reduce liability insurance rates and pointed to Louisiana as the prime exemplar noting that Louisiana physicians paid higher premiums despite the presence of a cap there for more than twenty years.523

Notwithstanding the enactment of the 2002 reform legislation, anecdotal reports of problems with the malpractice environment in Mississippi continued to abound after passage. In January 2003, a Biloxi newspaper reported that nine surgeons

519 Id.
520 Id.
521 Id.
at a local hospital were required to take leaves of absence because they no longer had malpractice insurance.\textsuperscript{524} The worsening crisis was attributed to several factors: e.g., a large number of suits had been filed before the reforms became effective, a number of insurers had pulled out of the market, and premium prices had “skyrocketed.”\textsuperscript{525} The three admitted companies writing the largest blocks of malpractice insurance, Medical Assurance Company of Mississippi, the Medical Protective Company, and the Doctor's Company, had “placed a moratorium on writing new policies.”\textsuperscript{526} The Mississippi Insurance Commissioner attributed the moratoria to the desire to “wait and see” whether the reforms were upheld by the courts and the continuing losses on medical liability lines of business.\textsuperscript{527}

A January 3, 2003, report issued by the Mississippi Department of Insurance on the availability and affordability of malpractice insurance based on a survey of physicians found the costs of premiums continued to increase after enactment of the 2002 malpractice reform legislation. Questionnaires were sent to 5,025 physicians and 2,178 completed questionnaires were returned. Fifty-four percent of responding physicians reported that they had experienced increases in their liability insurance premiums ranging from twenty-six to fifty percent in 2002, and thirty-one percent reported a premium increase in excess of fifty percent.\textsuperscript{528} Two percent of the responding physicians did not have liability insurance, up from one percent in 2001.\textsuperscript{529} Approximately one-third of responding physicians reported that malpractice claims had been filed against them in the past three years and of those, seventy-six percent had one or two claims.\textsuperscript{530} Approximately twenty percent of physicians were required by insurers to reduce their risks by “limiting procedures, limiting patients, and restricting their practice in certain high risk specialties.”\textsuperscript{531} The report notes that seventy-nine physicians reported they had considered leaving Mississippi, “ten physicians reported they had left or planned to leave the state,” twenty-nine had considered retirement, and twenty-six

\textsuperscript{525} \textit{Id.}
\textsuperscript{527} \textit{Id.}
\textsuperscript{528} MISSISSIPPI DEPARTMENT OF INSURANCE, REPORT ON THE AVAILABILITY AND AFFORDABILITY OF MEDICAL MALPRACTICE INSURANCE IN THE STATE OF MISSISSIPPI 1, 4 (2003), available at \textit{http://www.doi.state.ms.us/pdf/medmalavailabilityreport.pdf}.
\textsuperscript{529} \textit{Id.} at 3.
\textsuperscript{530} \textit{Id.} at 4.
\textsuperscript{531} \textit{Id.}
had retired. 532

In a June 2003 report on the medical malpractice insurance crisis issued by the General Accounting Office, Mississippi was one of seven sample states selected for in depth analysis.533 These seven states were selected based on the following criteria: “extent of any recent increases in premium rates, status as a ‘crisis state’ according to the [AMA], presence of caps on noneconomic damages, state population, and aggregate loss ratios for medical malpractice insurers within the state.”534 The report noted that in Mississippi, “the amount insurers paid annually on malpractice claims, or paid losses, increased by approximately 142 percent from 1998 to 2001 after adjusting for inflation.”535 The changes in percent of premium base rates for Medical Assurance of Mississippi for three specialties during the period 1999-2002 were: general surgery (120%); internal medicine (10%); and obstetrics/gynecology (21%).536 The 2002 medical malpractice insurance premium base rates for Medical Assurance of Mississippi for the same three specialties were: general surgery ($33,000); internal medicine ($5,000); and obstetrics/gynecology ($45,000).537 Aggregate incurred losses by malpractice insurers in Mississippi increased 197.5% from 1998 to 2001.538 Aggregate incurred losses (the loss ratio) as a percentage of premiums exceeded 150% in 2001.539

As to the characteristics of the Mississippi market for medical liability insurance, the June 2003 GAO report noted that insurance in the state was typically being written on a claims made basis and insurers treated Mississippi as a single market area.540 According to a 2003 survey, several insurers were moving from an admitted market to a surplus lines market, and most insurance was being written in the surplus lines market.541 The largest insurers in 2001 were: Mutual Assurance Company of Mississippi (34%), Reciprocal (21%), St Paul (10%), Doctors Insurance Reciprocal (8%), and Doctor's Company (6%).542 The report noted that in 2002, St. Paul stopped writing

535 U.S. GEN. ACCOUNTING OFFICE (June 2003), supra note 94, at 4 (citations omitted).
536 U.S. GEN. ACCOUNTING OFFICE (June 2003), supra note 94, at 12.
537 U.S. GEN. ACCOUNTING OFFICE (June 2003), supra note 94, at 14.
538 U.S. GEN. ACCOUNTING OFFICE (June 2003), supra note 94, at 20.
540 U.S. GEN. ACCOUNTING OFFICE (June 2003), supra note 94, at 62.
541 U.S. GEN. ACCOUNTING OFFICE (June 2003), supra note 94, at 62.
542 U.S. GEN. ACCOUNTING OFFICE (June 2003), supra note 94, at 62.
malpractice insurance nationwide,\textsuperscript{543} and Doctors Insurance Reciprocal, a Tennessee-based company declared bankruptcy in 2003.\textsuperscript{544} In February 2003, “Reciprocal of America, a Virginia based company which insured 535 doctors and 46 hospitals in Mississippi, was placed in receivership . . . .”\textsuperscript{545}

In an August 2003 Report, GAO looked at a purported link between increasing malpractice premiums and reductions in access to care in five crisis states (FL, MS, NV, PA, and WV).\textsuperscript{546} Generally, the report found that access problems were not widespread in any of the states and concluded that “many of the reported provider actions taken in response to malpractice pressures were not substantiated or did not widely affect access to health care[.]”\textsuperscript{547} but it did note some problems with access to care in Mississippi.\textsuperscript{548} Specifically, it found that “[r]eductions in ER on-call surgical coverage and newborn delivery services have created access problems in certain areas of Mississippi.”\textsuperscript{549} Further, “pregnant women in rural central Mississippi must now travel about 65 miles to the nearest hospital obstetrics ward to deliver because family practitioners at the local hospital, faced with rising malpractice insurance premiums, stopped providing obstetrics services.”\textsuperscript{550}

In addition, “[p]rovider groups also asserted that some physicians in each of the five states are moving, retiring, or closing practices in response to malpractice pressures.”\textsuperscript{551} Relying on a variety of sources, the August 2003 GAO Report provided the following numbers for physician departures in Mississippi: neurosurgeons (5); orthopedic surgeons (3); other surgeons (11); ob/gyns (5); and other physicians (50).\textsuperscript{552} However, the report also noted that the documented departures in Mississippi attributed to malpractice pressures amounted to only one percent of all licensed physicians and were “scattered throughout the state.”\textsuperscript{553} It further noted “the number of physicians per capita has remained essentially unchanged since 1997.”\textsuperscript{554} Although providers reported

\textsuperscript{543} U.S. GEN. ACCOUNTING OFFICE (June 2003), \textit{supra} note 94, at 31.
\textsuperscript{545} Percy, \textit{supra} note 361, at 1003.
\textsuperscript{546} \textit{See} U.S. GEN. ACCOUNTING OFFICE (Aug. 2003), \textit{supra} note 101, at 1-3.
\textsuperscript{547} U.S. GEN. ACCOUNTING OFFICE (Aug. 2003), \textit{supra} note 101, at 5.
\textsuperscript{548} \textit{See} U.S. GEN. ACCOUNTING OFFICE (Aug. 2003), \textit{supra} note 101, at 14.
\textsuperscript{549} U.S. GEN. ACCOUNTING OFFICE (Aug. 2003), \textit{supra} note 101, at 14.
\textsuperscript{550} U.S. GEN. ACCOUNTING OFFICE (Aug. 2003), \textit{supra} note 101, at 5.
\textsuperscript{551} U.S. GEN. ACCOUNTING OFFICE (Aug. 2003), \textit{supra} note 101, at 17.
\textsuperscript{552} U.S. GEN. ACCOUNTING OFFICE (Aug. 2003), \textit{supra} note 101, at 17.
\textsuperscript{553} U.S. GEN. ACCOUNTING OFFICE (Aug. 2003), \textit{supra} note 101, at 18.
\textsuperscript{554} U.S. GEN. ACCOUNTING OFFICE (Aug. 2003), \textit{supra} note 101, at 18 (citations omitted).
reducing certain services, access to care in the five states did not seem to be significantly affected. The most frequently reported cutbacks were in spinal surgeries and joint revisions and repairs, but utilization rates for these services for Medicare beneficiaries had not decreased, and, in fact, spinal surgeries in the five states actually increased from July 2000 to June 2002. The August 2003 GAO report further asserted that providers in the five crisis states had devised various strategies to avoid access problems including hospitals assuming physician liability costs, either by hiring them as employees or subsidizing their premiums.

In 2003, after the adoption of malpractice reform legislation, premiums charged by Medical Assurance Company of Mississippi (MACM), the company that insured most Mississippi physicians, increased by fifty-four percent, and that was followed by an increase of nineteen percent for 2004. By late 2004, however, the problems in malpractice insurance seem to have abated. In September 2004, the Mississippi Insurance Commission, which was responsible for providing insurance to sixty percent of Mississippi doctors, announced that it declined to increase premiums for 2005. In June of 2005, MACM announced that it would begin writing new policies after a period of inactivity. And in October of 2005, MACM announced that physician premiums would be decreased five percent in 2006.

In a 2004 article, Professor E. Farish Percy of the University of Mississippi examined the need for additional malpractice reforms in Mississippi. Professor Percy reviewed financial data on the MACM, the largest medical malpractice insurer in Mississippi, finding that the volatility in MACM's premium levels had been affected by investment losses. She also found that MACM had been investing more of its assets in the stock market than most insurers. Further, she found that MACM's gross paid expenses as a percentage of gross earned premiums decreased.

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559 Tort Reform is Making a Difference, HATTIESBURG AMERICAN, Oct. 10, 2004, at 8.
562 See Percy, supra note 359, at 1001.
563 See Percy, supra note 359, at 1010-11.
564 Percy, supra note 359, at 1071-72.
losses had actually declined from 2001 to 2003 by twenty-six percent, “from more than $19 million to less than $14 million.”

After reviewing data from the National Practitioner Data Bank, Professor Percy found that the mean and median insurer payouts for medical malpractice claims in Mississippi were lower than the national mean and median and “that in 2003, there was a substantial decrease in the total amount paid on behalf of Mississippi physicians . . . .”

After reviewing rate surveys published by the Medical Liability Monitor, she found that 2003 premium rates in Mississippi were lower than or comparable to rates in states where tort reform measures had been in place for several years. Finally, she found that although claims had spiked in 2002 due in part to the desire of claimants to avoid the application of newly adopted reforms that applied only to cases filed after January 1, 2003, data from the Mississippi Administrative Office of the Courts revealed that fewer claims were filed in 2003 than in any year from 1998 to 2002.

As further evidence of an improved malpractice climate for physicians, Professor Percy has noted that while physicians in the past had often been named in as parties in mass tort claims against pharmaceutical manufacturers, and thereby required to defend claims in venues favorable to plaintiffs, the exposure of physicians to these types of claims had been reduced due to a 2004 decision by the Mississippi Supreme Court. Percy noted that in several cases, the Mississippi Supreme Court “has indicated that, in today’s political climate, it is closely reviewing medical malpractice awards as well as high damage awards in other types of tort cases.” Based on these findings, she concluded that the adoption of additional tort reform measures, e.g., reducing the cap on non-economic damages to $250,000, was not warranted.

In February 2008, the American Medical Association claimed that the adoption of medical malpractice reforms in Mississippi “have had results,” specifically noting:

[MACM], the state’s largest medical malpractice insurer announced a 5 percent decrease in premiums for 2006. The Mississippi insurer’s board also voted to refund at least 20 percent of each policyholder’s annual

565 Percy, supra note 359, at 1104-05.
566 Percy, supra note 359, at 1012.
567 Percy, supra note 359, at 1012.
568 Percy, supra note 359, at 1012.
569 Id. at 1048-51 (discussing Janssen Pharmaceutical, Inc. v. Armond, 866 So. 2d 1092, 1095 (Miss. 2004)).
570 Percy, supra note 359, at 1051.
premium in 2006.70 In 2007, MACM reduced premiums by 10 percent and planned to decrease premiums by 15.5 percent in 2008 [citation omitted].”571

D. Comparison of Empirical Data on the Effects of Tort Reform in Alabama, Louisiana, and Mississippi

In this section, the effects of tort reform on claim frequency, claim severity (loss payouts), and medical malpractice insurance premiums are compared across the three states. The data on tort reforms was collected by the authors as described elsewhere.572 Data on medical malpractice insurance premiums was obtained from The Medical Liability Monitor annual surveys from 1991 through 2004, and data on claims paid and payment amounts for physicians was from the National Practitioner Data Base (NPDB).

In Alabama, see Table Four, infra, there were no changes in tort reforms observed during the period, and there were no systematic trends in claim frequency or in inflation adjusted loss payouts. Inflation-adjusted malpractice premiums declined for obstetrician/gynecologists and general surgeons, but were flat for internists. Both declines were statistically significant, p < 0.001 and p < 0.10, respectively. It is not possible to assess the policy effects of reforms that were already in place because there were no changes in tort law, so something else must account for the declines in malpractice premiums for the high risk specialties.

Louisiana, Table Five, infra, had a cap on damages available from health care providers in place from 1975 to the present. Indeed, this cap set at a nominal $100,000 was one of the lowest in the United States. Since the cap was set in nominal dollars, the real value has declined over time as a result of inflation, thereby making it easier for any given claim to exceed the provider’s medical liability limit. The value, nominal 2004 dollars calculated using the Consumer Price Index, fell from $137,739 in 1991 to $100,000 in 2004. In addition, there was a total cap in place of $500,000, with $400,000 being payable from the LPCF. Future medical expenses were excluded from the cap in 1984.

In Louisiana, claims and payouts rose from 1991 to a peak in 1999 then declined. Indeed, the payout per claim declined in every year after 1999, save for 2003. Louisiana made changes in the rule governing joint and several liability in 1996. The

571 AM. MED. ASS’N (Feb. 5, 2008), supra note 20, at 19.
572 See Kilgore et al., supra note 106, at 255.
modification of the joint and several liability rules preceded a significant decrease in the
number of claims and in payouts. Although the difference was statistically significant (p < 0.012), we cannot draw any causal inference because other unobserved factors could
be in play.

The malpractice premiums reported in Table Five do not include surcharges
paid to the LPCF, in which physicians must participate to be covered by the cap on
medical malpractice awards. The total loss payouts set out in Table Five only include
payments from providers and their primary insurers and not from the LPCF. Surcharges paid by providers to the LPCF are set forth in Table Six, infra. Table Seven, infra, sets out payments from the LPCF and the number of settlements for the years
1991-2007. The number of settlements includes cases where the court has approved a
settlement that is binding on the LPCF.573

Finally, Mississippi, see Table Eight, infra, adopted a cap on non-economic
damages that went into effect in 2003. This took place after a long period of increasing
claim frequency and payouts. Subsequent to passage of the cap, both claims and
payouts declined substantially (p < 0.009), but malpractice premiums rose precipitously
at the same time. It is possible that some of the effects observed could be attributed to
an increase in claims filed in anticipation of passage of the cap, and that the rise in
premiums will correct after a suitable lag time. In fact, as noted, supra, the major insurer
in Mississippi announced a decrease in premiums for 2006. Mississippi made other
changes in tort law prior to 1991: a two-year statute of limitations, a seven-year statute
of repose, and a modification to the rules governing joint and several liability.

573 LeBlanc E-mail, supra note 234.
**TABLE FOUR**

ALABAMA: NUMBER OF PAID MEDICAL MALPRACTICE CLAIMS, LOSS PAYOUTS AND LIABILITY INSURANCE PREMIUMS 1991-2004

<table>
<thead>
<tr>
<th>Year</th>
<th>Damage Cap Amount*</th>
<th>Malpractice Claims</th>
<th>Malpractice Payouts*</th>
<th>OB/GYN</th>
<th>Internal Medicine</th>
<th>General Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>(none)</td>
<td>78</td>
<td>13,045,937</td>
<td>62,978</td>
<td>6,911</td>
<td>35,368</td>
</tr>
<tr>
<td>1992</td>
<td>(none)</td>
<td>72</td>
<td>20,996,664</td>
<td>61,154</td>
<td>9,305</td>
<td>34,343</td>
</tr>
<tr>
<td>1993</td>
<td>(none)</td>
<td>87</td>
<td>26,089,823</td>
<td>57,691</td>
<td>7,019</td>
<td>32,408</td>
</tr>
<tr>
<td>1994</td>
<td>(none)</td>
<td>78</td>
<td>25,170,289</td>
<td>56,359</td>
<td>6,222</td>
<td>31,660</td>
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<tr>
<td>1995</td>
<td>(none)</td>
<td>76</td>
<td>26,329,698</td>
<td>54,584</td>
<td>6,026</td>
<td>30,663</td>
</tr>
<tr>
<td>1996</td>
<td>(none)</td>
<td>93</td>
<td>49,188,652</td>
<td>53,253</td>
<td>5,879</td>
<td>29,915</td>
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<tr>
<td>1997</td>
<td>(none)</td>
<td>89</td>
<td>23,393,868</td>
<td>45,446</td>
<td>8,811</td>
<td>26,407</td>
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<tr>
<td>1998</td>
<td>(none)</td>
<td>89</td>
<td>30,238,255</td>
<td>42,071</td>
<td>6,618</td>
<td>26,071</td>
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<tr>
<td>1999</td>
<td>(none)</td>
<td>71</td>
<td>22,004,533</td>
<td>40,633</td>
<td>7,117</td>
<td>25,662</td>
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<tr>
<td>2000</td>
<td>(none)</td>
<td>102</td>
<td>41,168,709</td>
<td>40,863</td>
<td>7,332</td>
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<tr>
<td>2001</td>
<td>(none)</td>
<td>99</td>
<td>25,598,850</td>
<td>39,709</td>
<td>7,383</td>
<td>25,556</td>
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<tr>
<td>2002</td>
<td>(none)</td>
<td>87</td>
<td>21,260,615</td>
<td>39,197</td>
<td>6,681</td>
<td>25,061</td>
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<tr>
<td>2003</td>
<td>(none)</td>
<td>72</td>
<td>15,600,883</td>
<td>42,572</td>
<td>7,634</td>
<td>31,125</td>
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<tr>
<td>2004</td>
<td>(none)</td>
<td>77</td>
<td>16,261,000</td>
<td>41,737</td>
<td>7,484</td>
<td>30,515</td>
</tr>
</tbody>
</table>

*All monetary values expressed in constant 2004 dollars

Alabama made no effective changes in tort law during this period. Alabama tort laws include disclosure of collateral sources, provides for a 4 year statutes of repose, allows periodic payment of awards, and recognizes arbitration results.
TABLE FIVE

LOUISIANA: NUMBER OF PAID MEDICAL LIABILITY CLAIMS, LOSS PAYOUTS AND LIABILITY INSURANCE PREMIUMS 1991-2004

<table>
<thead>
<tr>
<th>Year</th>
<th>Damage Cap Amount*</th>
<th>Malpractice Claims</th>
<th>Malpractice Payouts*</th>
<th>OB/GYN</th>
<th>Internal Medicine</th>
<th>General Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>137,739</td>
<td>316</td>
<td>35,757,772</td>
<td>38,643</td>
<td>5,880</td>
<td>28,002</td>
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<tr>
<td>1992</td>
<td>133,714</td>
<td>332</td>
<td>37,061,658</td>
<td>39,266</td>
<td>6,555</td>
<td>28,467</td>
</tr>
<tr>
<td>1993</td>
<td>129,827</td>
<td>362</td>
<td>60,197,533</td>
<td>39,477</td>
<td>7,010</td>
<td>28,614</td>
</tr>
<tr>
<td>1994</td>
<td>126,586</td>
<td>323</td>
<td>43,316,279</td>
<td>43,087</td>
<td>7,656</td>
<td>31,276</td>
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<tr>
<td>1995</td>
<td>123,097</td>
<td>219</td>
<td>25,962,502</td>
<td>44,204</td>
<td>8,227</td>
<td>32,088</td>
</tr>
<tr>
<td>1996**</td>
<td>119,567</td>
<td>272</td>
<td>34,321,614</td>
<td>42,166</td>
<td>8,554</td>
<td>31,803</td>
</tr>
<tr>
<td>1997</td>
<td>116,885</td>
<td>307</td>
<td>51,746,347</td>
<td>34,619</td>
<td>6,705</td>
<td>24,928</td>
</tr>
<tr>
<td>1998</td>
<td>115,092</td>
<td>330</td>
<td>44,962,629</td>
<td>34,027</td>
<td>6,590</td>
<td>24,502</td>
</tr>
<tr>
<td>1999</td>
<td>112,605</td>
<td>356</td>
<td>65,325,834</td>
<td>45,207</td>
<td>8,457</td>
<td>27,018</td>
</tr>
<tr>
<td>2000</td>
<td>108,943</td>
<td>337</td>
<td>58,604,115</td>
<td>43,606</td>
<td>8,158</td>
<td>26,062</td>
</tr>
<tr>
<td>2001</td>
<td>105,929</td>
<td>342</td>
<td>57,207,603</td>
<td>42,411</td>
<td>8,239</td>
<td>25,372</td>
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<tr>
<td>2002</td>
<td>104,280</td>
<td>355</td>
<td>52,270,426</td>
<td>34,284</td>
<td>7,195</td>
<td>24,731</td>
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<tr>
<td>2003</td>
<td>101,957</td>
<td>326</td>
<td>51,011,541</td>
<td>43,124</td>
<td>9,051</td>
<td>31,117</td>
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<tr>
<td>2004</td>
<td>100,000</td>
<td>317</td>
<td>39,568,800</td>
<td>47,068</td>
<td>9,878</td>
<td>33,952</td>
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</tbody>
</table>

*All monetary values expressed in constant 2004 dollars; premiums do not include LPCF surcharges and payouts do not include payments by the LPCF.

**In 1996 Louisiana modified the joint and several liability rule; throughout the period the state has allowed periodic payment of awards.

TABLE SIX

LPCF SURCHARGE RATES 2001-2008 CLAIMS MADE YEAR FIVE

<table>
<thead>
<tr>
<th>YEAR</th>
<th>OB/GYN Surgery</th>
<th>Internal Medicine No Surgery</th>
<th>General Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>23,586</td>
<td>3,716</td>
<td>12,345</td>
</tr>
<tr>
<td>2002</td>
<td>25,096</td>
<td>4,162</td>
<td>13,135</td>
</tr>
<tr>
<td>2003</td>
<td>29,143</td>
<td>5,136</td>
<td>15,394</td>
</tr>
<tr>
<td>2004</td>
<td>32,295</td>
<td>6,062</td>
<td>21,016</td>
</tr>
<tr>
<td>2005</td>
<td>32,295</td>
<td>6,062</td>
<td>21,016</td>
</tr>
<tr>
<td>2006</td>
<td>34,459</td>
<td>6,638</td>
<td>23,013</td>
</tr>
<tr>
<td>2007</td>
<td>38,043</td>
<td>7,508</td>
<td>26,028</td>
</tr>
<tr>
<td>2008</td>
<td>40,477</td>
<td>8,183</td>
<td>28,370</td>
</tr>
</tbody>
</table>
TABLE SEVEN


<table>
<thead>
<tr>
<th>Year</th>
<th># of Settlements</th>
<th>Amounts Paid *</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>101</td>
<td>$ 26,782,074.94</td>
</tr>
<tr>
<td>1992</td>
<td>103</td>
<td>$ 28,908,519.53</td>
</tr>
<tr>
<td>1993</td>
<td>123</td>
<td>$ 41,250,085.30</td>
</tr>
<tr>
<td>1994</td>
<td>106</td>
<td>$ 31,717,980.16</td>
</tr>
<tr>
<td>1995</td>
<td>112</td>
<td>$ 36,026,660.07</td>
</tr>
<tr>
<td>1996</td>
<td>151</td>
<td>$ 51,336,266.18</td>
</tr>
<tr>
<td>1997</td>
<td>158</td>
<td>$ 44,488,994.58</td>
</tr>
<tr>
<td>1998</td>
<td>186</td>
<td>$ 55,324,804.95</td>
</tr>
<tr>
<td>1999</td>
<td>166</td>
<td>$ 70,914,903.95</td>
</tr>
<tr>
<td>2000</td>
<td>170</td>
<td>$ 52,636,218.11</td>
</tr>
<tr>
<td>2001</td>
<td>180</td>
<td>$ 53,056,960.72</td>
</tr>
<tr>
<td>2002</td>
<td>205</td>
<td>$ 54,837,576.31</td>
</tr>
<tr>
<td>2003</td>
<td>181</td>
<td>$ 52,595,045.48</td>
</tr>
<tr>
<td>2004</td>
<td>183</td>
<td>$ 46,318,795.67</td>
</tr>
<tr>
<td>2005</td>
<td>183</td>
<td>$ 47,532,255.99</td>
</tr>
<tr>
<td>2006</td>
<td>278</td>
<td>$ 83,757,175.77</td>
</tr>
<tr>
<td>2007</td>
<td>311</td>
<td>$ 86,774,229.79</td>
</tr>
<tr>
<td>Grand Total</td>
<td>2897</td>
<td>$ 864,258,547.50</td>
</tr>
</tbody>
</table>

*Table Seven include all payments made out of the LPCF pursuant to settlements with injured patients on behalf of qualified health care providers either before or after a judgment exclusive of legal costs. These payment amounts do not include payments at full value of final judgments. They do, however, include settlements of judgments that were rendered against a primary insurer in which the primary did not appeal and the plaintiff settled with the LPCF for an amount less than the judgment to avoid an appeal by the LPCF. Most claims are settled by the LPCF rather than litigated.
TABLE EIGHT

MISSISSIPPI: NUMBER OF PAID MEDICAL MALPRACTICE CLAIMS, PAYOUTS AND LIABILITY INSURANCE PREMIUMS 1991-2004

<table>
<thead>
<tr>
<th>Year</th>
<th>Damage Cap Amount*</th>
<th>Malpractice Claims</th>
<th>Malpractice Payouts*</th>
<th>Malpractice Premiums*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>(none)</td>
<td>77</td>
<td>10,210,629</td>
<td>37,869</td>
</tr>
<tr>
<td>1992</td>
<td>(none)</td>
<td>128</td>
<td>18,783,920</td>
<td>37,440</td>
</tr>
<tr>
<td>1993</td>
<td>(none)</td>
<td>123</td>
<td>23,861,513</td>
<td>31,756</td>
</tr>
<tr>
<td>1994</td>
<td>(none)</td>
<td>131</td>
<td>18,907,058</td>
<td>31,024</td>
</tr>
<tr>
<td>1995</td>
<td>(none)</td>
<td>120</td>
<td>29,445,999</td>
<td>33,340</td>
</tr>
<tr>
<td>1996</td>
<td>(none)</td>
<td>140</td>
<td>26,780,292</td>
<td>40,688</td>
</tr>
<tr>
<td>1997</td>
<td>(none)</td>
<td>145</td>
<td>35,103,607</td>
<td>36,125</td>
</tr>
<tr>
<td>1998</td>
<td>(none)</td>
<td>142</td>
<td>29,082,761</td>
<td>38,796</td>
</tr>
<tr>
<td>1999</td>
<td>(none)</td>
<td>114</td>
<td>29,759,093</td>
<td>38,121</td>
</tr>
<tr>
<td>2000</td>
<td>(none)</td>
<td>135</td>
<td>27,108,869</td>
<td>36,772</td>
</tr>
<tr>
<td>2001</td>
<td>(none)</td>
<td>160</td>
<td>42,353,527</td>
<td>35,760</td>
</tr>
<tr>
<td>2002</td>
<td>(none)</td>
<td>187</td>
<td>44,620,128</td>
<td>44,951</td>
</tr>
<tr>
<td>2003</td>
<td>509,783</td>
<td>115</td>
<td>30,438,746</td>
<td>54,447</td>
</tr>
<tr>
<td>2004</td>
<td>500,000</td>
<td>115</td>
<td>31,701,050</td>
<td>60,120</td>
</tr>
</tbody>
</table>

*All monetary values expressed in constant 2004 dollars
Mississippi made no changes in tort law during this period other than the addition of the damages cap. There was a 2 year statute of limitations and a 7 year statute of repose; there was also a modification of joint and several liability.

In Table Nine, infra, a comparison of Louisiana’s combined premium plus surcharge costs for 2004 with Alabama’s and Mississippi’s costs for 2004 shows that the costs of liability insurance in Mississippi and Louisiana were roughly comparable, but the costs for Alabama were substantially lower than either Louisiana or Mississippi. This occurred as Mississippi rates rose to the level of Louisiana rates in 2004. Tables Ten through Twelve, infra, present the four year premium trends (2001-2004) for ob/gyns, internal medicine and general surgeons in Alabama, Mississippi and Louisiana.
TABLE NINE

A COMPARISON OF TOTAL COSTS FOR MEDICAL LIABILITY INSURANCE COVERAGE IN ALABAMA, LOUISIANA AND MISSISSIPPI FOR 2004

<table>
<thead>
<tr>
<th>STATE</th>
<th>OB/GYN</th>
<th>INTERNAL MEDICINE</th>
<th>GENERAL SURGERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA</td>
<td>41,737</td>
<td>7,484</td>
<td>30,515</td>
</tr>
<tr>
<td>LOUISIANA</td>
<td>79,363</td>
<td>15,940</td>
<td>54,968</td>
</tr>
<tr>
<td>(Surcharge plus Medical liability insurance premium)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MISSISSIPPI</td>
<td>80,102</td>
<td>12,667</td>
<td>57,266</td>
</tr>
</tbody>
</table>

TABLE TEN

OB/GYN FOUR YEAR PREMIUM TRENDS 2001-2004: AL, MS, LA
TABLE ELEVEN

IM FOUR YEAR PREMIUM TRENDS 2001-2004: AL, MS, LA

TABLE TWELVE

GS FOUR YEAR PREMIUM TRENDS 2001-2004: AL, MS, LA

Conclusion

A comparison of such objective indicators as the total value of paid claims and the number of paid claims per 1,000 physicians suggests that out of our three states,
Louisiana has the most plaintiff-friendly malpractice environment. This finding is despite the fact that Louisiana is the only state that has had significant tort reforms (including a damages cap and mandatory screening panels) in place since 1975. On the other hand, Alabama, where the most significant reforms (i.e., the damages caps) were declared unconstitutional in the 1990s, appears to be the most difficult environment for plaintiffs with its relatively lower number of paid claims per 1,000 physicians and lower total value of paid claims. Nonetheless, while medical liability insurance premiums are higher in Louisiana than in Alabama, providers and insurers in Louisiana seem to view the situation in that state as one of stability and continue to support the 1975 reforms.

The relatively higher medical liability insurance premiums in Louisiana as compared to Alabama may be explained in part by the fact that the cap in Louisiana is set at a relatively high level: now at $500,000 for total damages excepting future health care costs (one of the major cost components of an award). Indeed, our own research indicates that “caps from $500,000 to $750,000 raised premiums.” The relatively higher number of paid claims per 1,000 physicians and the relatively lower average paid claim in Louisiana as compared to Alabama may be explained by the fact that there are stronger incentives in Louisiana to pursue even relatively lower value malpractice claims. These incentives include the fact that the LPCF cannot contest liability in cases that are settled with court approval by the provider’s primary liability insurer at the $100,000 threshold. And if the case is settled with court approval by the primary insurer, then plaintiffs may be able to collect damages from the LPCF without incurring the costs of a medical expert. Moreover, even in cases of doubtful merit, plaintiffs’ attorneys may be able to use the screening panel proceeding as an opportunity for early discovery knowing that the costs of the panel proceeding will be paid by the provider’s insurer if the defendant prevails.

In Alabama, factors such as positive juror attitudes toward physicians and the aggressive defense of malpractice claims by the leading malpractice insurer may have resulted in relatively lower paid claims per 1,000 physicians and lower total paid claims in that state. Another factor that may have fostered the development of an unfavorable malpractice environment for plaintiffs in Alabama may be the propensity that the Supreme Court of Alabama has had in recent years for overturning plaintiffs’ verdicts appealed to it. During the period of 2001-2007, there were 109 appeals in medical malpractice cases to the Supreme Court of Alabama, but only twelve of those cases involved jury verdicts for the plaintiff, and the Supreme Court of Alabama reversed in

574 Kilgore et al., supra note 106, at 264.
six of these cases and reduced damages in two of the six it affirmed.\textsuperscript{575} On the other hand, the relatively higher average paid claim in Alabama as compared to Louisiana may

\textsuperscript{575} During the period from 2001 to 2007 jury verdicts for plaintiffs were set aside by the Supreme Court of Alabama in the following cases: Long v. Wade, No. 1041887, No. 1050001, 2007 WL 2459976, at *1-*3, *9 (Ala. Aug. 1, 2007) (child born with severe neurological injuries and developed cerebral palsy; general verdict for $3,850,000 in compensatory damages; trial court erred in allowing jury to base its verdict on specific allegations not supported by substantial evidence even though other allegation were supported by substantial evidence); Ware v. Timmons, 954 So. 2d 545 \textit{passim} (Ala. 2006) (jury verdict of $14.5 million reduced by credit for amount received in settlement with hospital; action for anesthesia related death against anesthesiologist and CRNA; on appeal anesthesiologist held not liable as matter of law for negligence of CRNA even though he supervised her work and had the right to control it; new trial ordered for all defendants); Houseman v. Garrett, 902 So. 2d 670, 671-76 (Ala. 2004) (action against surgeon arising from leaving gauze pad in patient after surgery; jury verdict against surgeon and his professional corporation of $358,000 reduced to $200,000 by credits from settlement with other parties; reversed on appeal because of failure of trial judge to clearly instruct jury surgeon could rebut prima facie case of negligence by evidence showing that she was not responsible for erroneous pad count); Breau v. Thurston, 888 So. 2d 1208, 1210-14, 1223 (Ala. 2004) (action arising from leaving surgical clamp in plaintiff following gastric bypass surgery; jury verdict of $300,000 against surgeon and his professional corporation reversed on appeal due to trial court’s erroneous instruction to jury that instrument count was responsibility of surgeon and failure to instruct jury surgeon could rebut prima facie case by evidence showing that he was not responsible for erroneous instrument count); DCH Health Auth. v. Duckworth, 883 So. 2d 1214, 1216-17, 1220-21 (Ala. 2003) (action arising out of dilatory treatment of head injury received in fall on d hospital’s escalator; jury verdict for $350,000 set aside on appeal due to lack of substantial evidence of medical causation, i.e., that quicker treatment would have improved outcome); East Ala. Behavioral Med. v. Chancy, 883 So. 2d 162, 165-66, 173 (Ala. 2003) (verdict for $1.00 in compensatory damages and $495,000 in punitive damages against the employer of psychologist who became involved in sexual relationship with a patient reversed on appeal because psychologist held not to be acting within scope of her employment; court also held plaintiff’s claims of ratification, and direct liability based on abandonment failed as a matter of law). The six cases where a verdict for plaintiff was affirmed by the Supreme Court of Alabama are: Mobile Infirmary Ass’n v. Tyler, 2007 WL 2687321, No. 1041484, at *24 (Ala. Sept. 14, 2007) (wrongful death action; jury award against Infirmary for $5.5 million in punitive damages reduced to $3 million); Boles v. Perris, 952 So. 2d 364, 368 (Ala. 2006) (wrongful death award of $1.375 million in punitive damages affirmed); Lloyd Nolan Hosp. v. Durham, 906 So. 2d 157, 174 (Ala. 2005) (affirming verdict against hospital for $762,920); Mobile Infirmary Med. Ctr. v. Hodgen, 884 So. 2d 801, 818-19 (Ala. 2003) (jury verdict of $2.25 million in punitive damages; affirmed if plaintiff accepted reduction to $1.5 million); Springhill Hosp. v. Dixon, 883 So. 2d 159, 159-61 (Ala. 2003) (action against hospital and nurse; jury award of damages affirmed by per curiam opinion in amounts of $175,000 in past compensatory damages, $62,000 in future compensatory damages, and $345,000 in punitive damages); Vaughan v. Oliver, 822 So. 2d 1163, 1166, 1179 (Ala. 2001) (action against radiologist and group; jury awarded damages of $2 million in future compensatory damages and $500,000 in past compensatory damages; on appeal court upheld damages awarded but held future damages in excess of $150,000 was subject to periodic payout statute).
be due to the tough litigation strategy of the major liability insurer in Alabama, which results in the failure to settle cases even where there is a relatively clear liability and high potential damages, and a strong disincentive to bring claims in relatively lower value cases.

Thus, it may be that despite its higher costs, Louisiana’s peculiar combination of the LPCF with a total damages cap that does not include future medical expenses may provide a more useful model to deal with what should be the real issues of tort reform, i.e. enhancing patient safety and providing compensation to those who suffer preventable iatrogenic injuries. Health care providers in Louisiana seem satisfied with the current system, thereby suggesting that for providers, stability in the health insurance market may be more significant than the actual amount of the premiums. If providers are able to pass along the premium increases to health care payors, then they should be largely indifferent to the actual premium costs. On the other hand, they would not be indifferent to the unavailability of liability insurance or to sudden spikes in premium costs that may be more difficult to pass on to payors. Tort reformers are typically focused on reducing malpractice insurance premiums by exerting downward pressure on claim frequency and severity rather than on providing fair compensation for victims of malpractice. However, in light of compelling evidence that most victims of malpractice never receive any compensation, it is unfair to focus only on the effects of tort reforms on providers. In fact, traditional tort reforms provide an uncertain promise of lower cost health care and improved access for patients in exchange for the limitation of compensation for the victims of malpractice.

It may be that in practice, the Louisiana system has evolved away from a traditional fault-based system to a system that provides compensation for iatrogenic injuries that are preventable or avoidable. According to Kinney and Gronfein, this is what has happened in Indiana, a state with virtually the same reforms as Louisiana. Additional study of Louisiana malpractice claims would be necessary to determine whether this has also happened in Louisiana. Regardless, it appears that Louisiana has established a system that is both supported by providers and insurers and provides compensation for more victims of malpractice than the traditional fault-based system with a damages cap as seen in Mississippi or in Alabama, where traditional tort reforms, including damages caps, were for the most part declared unconstitutional by the Supreme Court of Alabama.

576 Kinney & Gronfein, supra note 464, at 190-91.