Commentary: Binding Early Offers versus Caps for Medical Malpractice Claims?

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Like damages caps, early offer reform promises reduction in the costs of medical liability cases. In contrast to damages caps, early offer reform offers advantages to both claimant and defendant. Under early offer, the defendant would have the option to offer an injured patient periodic payments for the patient's net economic losses as they accrue, but not payments for noneconomic losses (pain and suffering). If an early offer were made and accepted, that would settle the claim. This commentary¹ explains how an early offer reform might work and summarizes data from a recent closed claim study of medical malpractice cases in Texas and Florida. The data show widespread opportunities for successful early offers and provide evidence that substantial per case savings would result.

Keywords: Medical malpractice, liability, tort reform.

THE LAST SENTENCE OF THE LUCID AND THOROUGH paper by Professors Nelson, Morrissey, and Kilgore contains its most salient idea—that caps on damages disadvantage only the “most seriously injured victims of malpractice [in return for] . . . the possibility of lower health care costs [for all]” (2007).

Historically, the best type of tort reform offers benefits and burdens to both claimants and defendants. Although such reform lessens compensation to accident victims, it also eases their access to it. For example, workers' compensation generally combines defendants' absolute liability for economic loss without reference to any fault but with no compensation for claimants' noneconomic loss. Unlike caps, such no-fault reform

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avoids leaving intact the intractable problems that make tort law so dysfunctional in the first place, by having to determine fault and the pecuniary value of nonpecuniary damages.

The problems with the existing medical malpractice law were recently encapsulated in a study of closed malpractice claims by the Harvard School of Public Health, which concluded that resolution takes far too long: on average five years from the occurrence, with one in three claims taking six or more years. Just as condemnatory, the study found that the system chews up far too much in overhead costs, principally legal fees on both sides, amounting to more than half (54 percent) of any compensation paid. As the authors concluded, reforms are needed “that improve the system’s efficiency in the handling of reasonable claims for compensation” (Studdert et al. 2006, 2024).

An Early Offer Reform

Unlike caps on damages and other one-sided reforms mentioned by Nelson and colleagues, an early offer reform proposes precisely the reforms urged in the Harvard study. Specifically, under the early offer reform that I have proposed, a health care provider would have the option, not the obligation, to offer an injured patient, within 180 days after a claim is filed, periodic payments of the patient’s net economic losses as they accrue. The early offer statute would guarantee coverage of medical expenses, including rehabilitation and lost wages, of all such costs not already covered by other sources such as health insurance, with an additional 10 percent payable for the claimant’s attorney’s fee. A defendant—that is, a health care provider or its insurer—could not make a lesser or “low ball” offer and still be protected by the statute. There would be no need for a court to determine whether the overall early offer was fair, as the early offer statute itself would define the fairness of such an offer, as does a workers’ compensation statute for workplace accidents. Of course, just as under workers’ compensation or any health or disability policy, such matters as whether a payee’s particular health service was necessary or disability has continued could be the subject of dispute.

If an early offer were made and accepted, that would settle the claim. If the defendant decided not to make an early offer, the injured patient could proceed with a normal tort claim for medical expenses and loss of

wages plus pain and suffering. Alternatively, if the claimant declined an early offer in favor of litigation, his or her case would be made more difficult to win because the statute would raise (1) the standard of misconduct, allowing payment only if gross, and “not just ordinary,” negligence were proven and (2) the standard of proof itself, requiring the patient to prove such misconduct beyond a reasonable doubt, rather than by only a preponderance of evidence as required by current law. Cases involving clearly provable gross negligence are not common. A recent study found that in Texas, where insurers are required to report all medical malpractice claims for punitive damages to the Texas Insurance Department, which normally entail allegations of gross negligence, only 521 of 16,437 (3 percent) medical malpractice cases from 1988 to 2002 paid under tort law included a claim for punitive damages (Hersch, O’Connell, and Viscusi 2006, 20).

Although the defendant’s insurer would have to make an early offer within 180 days of a claim, the claimant would be under no time constraint (other than the statute of limitation) as to when he or she made a claim or decided whether to accept the offer or pursue a tort claim for gross negligence.

Unlike caps, the early offer proposal would provide several advantages to injury victims in addition to benefiting health care providers. Although injury victims who accepted an early offer would lose their recourse to full-scale tort litigation, the uncertainty, delays, and transaction costs of such tort claims would be reduced. *Moreover, unlike with caps, claimants who received an early offer would be guaranteed prompt payment of their economic losses, plus their attorneys’ fees.* This would especially benefit severely injured patients whose economic losses have outstripped other applicable coverage.

A Hypothetical Illustration

An example illustrates how the early offer law would work. A patient injured in the course of treatment makes a medical malpractice claim against a health care provider. As is routine today, the defendant’s insurer sets aside funds (the “initial reserve”) for the possible payment of the claim based on an estimate of the odds that the claimant will prevail multiplied by the amount of damages, if any, that she might win. In this hypothetical case, the insurer predicts that if the patient wins

in court, she would be awarded \$1 million but that, given the risks of litigation, she has only a 50 percent chance of prevailing. Roughly calculated, the patient has a claim worth about \$500,000 (a 50 percent chance at \$1 million). The insurer further predicts that the cost of setting aside sufficient money to pay this patient for her net economic losses as they accrue will be about \$250,000 (an often realistic assumption). Were an early offer statute in place, the insurer would likely make the early offer, as \$250,000 clearly is less than \$500,000. In addition, the patient would likely accept, since if she pursued the case, she would face the heavy burden provided in the statute of proving her doctor guilty of gross negligence beyond a reasonable doubt. Now assume a change in the facts: same patient, same health care provider, and the same possible \$1 million verdict. But here the defendant's insurer calculates that the patient's chances of winning are only one in ten, with an expected value of \$100,000 (one-tenth of \$1 million). Here the defendant's insurer would not make an early offer, as \$100,000 clearly is less than \$250,000.

Other Aspects of Early Offer Reform

What would happen in a case that involves great tragedy but little economic loss, as with, say, the death of a child or a homemaker? In such cases, the statute could provide that any such claimant has a right to a lump-sum payment, which could be set at \$100,000, \$250,000, or \$500,000, depending on the legislature's discretion.

Insurance companies might be expected to "cherry-pick" by making payments to only clearly deserving claimants. But because of the uncertainty and cost of determining both liability and pain and suffering damages under tort law, defendants in many cases are likely to make early offers when the liability is unclear (Hersch, O'Connell, and Viscusi 2006, 2007).

Without an early offer statute, several factors make it unattractive for insurers to make early offers to settle. They may expect to be able to wear down some claimants, given the difficulties and delays in proving a tort claim. The long delay before trial may often enable defendants' insurers to bargain down claims even when the claimants seem likely to prevail eventually, because they may need money immediately for accrued and accruing medical bills and lost wages. Furthermore, insurers may fear

that an early offer to settle for claimants' net economic loss will be seen as a signal of weakness and encourage claimants and their lawyers to seek an even larger settlement than that originally sought. With an early offer statute in place, insurers would not fear the signal of weakness that an early offer might send, because the statute makes it unlikely that claimants could prevail if they pursued the claim after an early offer. On the other side, the early offer statute would eliminate plaintiffs' fears of signaling weakness by their willingness to settle for only net economic losses.

There are several reasons why no damages for pain and suffering are included in this early offer reform proposal. The uncertainty of determining both liability and damages for noneconomic damages is the key to understanding the inefficiencies of tort law and to framing a balanced solution that attempts to be fair to both injured patients and health care providers. Pain and suffering damages are especially indeterminate and highly volatile. Offers under an early offer system would provide prompt, essential compensation to many injured patients, but the prospect of payment of even such awards plus the possibility that early offers would neither be made nor accepted will continue to deter providers of goods and services from suboptimal performance.

The early offer proposal could be applied either more narrowly or broadly than to medical malpractice claims, for example, to only natal or surgical cases or to all personal injury claims, including those from, say, allegedly defective products, including pharmaceuticals.

Why Not No Fault?

Under workers' compensation laws, an industrial accident victim is compensated for an "injury arising out of, and in the course of, employment." A complete no-fault plan for prompt payment of economic losses resulting from medical care is much less feasible, as it often is impossible to determine whether a patient was injured by the treatment rendered or by a normal extension of the condition prompting the treatment in the first place. A health care provider should not be expected to pay every patient whose condition worsens after treatment. Thus a comprehensive preaccident no-fault solution seems unworkable in health care. The proposed early offer system for medical accidental injuries calls for a postaccident comparison, when the facts are much better known, of the estimated

cost of a tort claim versus that of an estimated early offer. The early offer system thus provides what seems a workable, economical, equitable, and simplifying solution.

Because personal injury claims alone, among all other damages claims, routinely entail damages for both economic and noneconomic losses, defendants are uniquely positioned not only to make but also to enforce, by means of statutory early offers, socially attractive settlements only for economic loss. In nonpersonal injury claims, in which only economic damages are at stake, no comparably fair means are available to sanction a claimant who refuses to accept an offer of only a portion of the total losses claimed.

A Cost Study

Newly available data show how the costs under an early offer program compare with the costs under the existing tort system (Hersch, O'Connell, and Viscusi 2006, 2007). The analysis is based on a closed claim study of actual court settlements and verdicts of medical malpractice cases in Texas and Florida between 1998 and 2002, using \$2002.

The key to estimating the effect of early offers is comparing the amount the insurer sets aside in its initial reserve to pay a given medical malpractice claim with the amount that would have been required to pay an early offer covering the claimant's net economic loss plus attorney's fees. If the former is greater than the latter, an early offer likely would have been made.

Had insurers made early offer decisions based on their initial reserves, 1,055 (54 percent) of the 1,938 claimants in the study suffering severe nonfatal injuries who were paid under tort law would have been tendered early offers under the proposed statute. The early offer would have covered an average of \$246,543 of economic loss.² These claimants would have been paid, on average, 2.4 years (859 days) faster than under tort law, with the total litigation costs reduced by an average of \$225,500 per claim. The total cost savings from paying such claims (not just the savings from litigation expenses) would have averaged \$578,788 per claim.

The early offer settlements would reduce the payment to claimants by \$321,583 per claim, with only 2.75 percent of the claimants receiving

more under an early offer than under a tort claim.³ This raises an important question for policymakers: given that early offers would result in far lower payments by insurers (and presumably with a substantial eventual reduction in medical malpractice premiums), do the greater speed and certainty of such payments, as well as the lower transaction costs, justify the early offer proposal? I argue that the trade-off does justify it, especially for seriously injured patients, about whom, after all, any insurance scheme should be primarily concerned.

The discrepancy between payments under early offers and today's law would be reduced if the statute provided that early offers for patients suffering little economic loss after severe nonfatal injuries (or death) would be offered a net economic loss or a minimum of, say, \$250,000. If such an option were in place, the study shows that the number of claimants who would lose an amount of compensation would fall from 1,055 to 498, with the percentage of claimants gaining in compensation rising from 2.75 percent to 29.12 percent. In contrast, the number of severe nonfatal injury cases receiving early offers would drop from 1,186 to 539, with the remaining claimants consigned to the vicissitudes of the current tort system.

An important element of the cost study of early offers is that the insurer's initial (or early) dollar reserve allocated to pay a claim often turned out to underestimate its ultimate value, as has been shown in previous research (Ganer and Patterson 1999; Grace 1990; Petroni 1992). If the early offer decision were based on the final reserves (just before the case was resolved), the savings would equal \$1,367,000 per case, compared with the savings of \$578,788 per case, using the initial reserves as the base. Similarly, the average litigation costs would drop by \$225,200 per case based on the initial reserves versus \$333,677 under the final reserves. In addition, the number of injured patients receiving early offers would grow from 1,055 of the 1,938 cases to 1,893. Because final reserves are so much larger than initial reserves, insurers are more likely to make early offers if their decisions are based on a more realistic projection of the final reserve. This would result in not only lower overall costs (and premiums) for providers but also more early offer payees, prompter payments, and much lower litigation costs. Although insurers cannot know the amount of the later reserve at the time they are estimating the initial reserve, if an early offer system were in place insurers would have an incentive to analyze the claim more carefully and at an earlier stage than they do at present. But even without raising the initial reserve values to reflect the

likely better estimates that would be made in an early offer regime, the data still seem to indicate widespread opportunities for successful early offers in cases of severe injury.

The same could be true for fatalities and for all cases taken together. For example, in cases of death, the average savings per case for malpractice insurers would be \$388,282 based on the early reserve and \$652,112 based on the final reserve, with the average litigation cost per case reduced, respectively, by \$106,993 and \$146,945. For all cases together (large, medium, and small), the average savings per case would be \$241,533 based on the early reserve and \$556,429 based on the final reserve, with the average litigation cost per case reduced, respectively, by \$82,648 and \$130,651. In this connection, an earlier economic model costing early offers closely anticipated the findings of the new closed claim study that I have been describing (O'Connell, Kidd, and Stephenson 2005).

Conclusion

Professors Nelson, Morrissey, and Kilgore effectively document, among other things, how hard it is to arrive at a consensus regarding whether the present medical malpractice regime deters lapses by health care providers as effectively as alternative legal regimes would (2007). One study by the Harvard School of Public Health indicates that increased malpractice litigation under the tort system may actually reduce the quality and availability of health care (Mello et al. 2004). Arguably, the early offer approach would improve the current system by providing timely and certain compensation with lower litigation costs, goals much more readily accomplished than the elusive goal of improved deterrence (O'Connell and Pohl 1997–98, 359–75). Nonetheless, the incentives for responsible care that are part of providers' liability for errors would continue to exist under an early offer system, because health care providers would continue to be liable for substantial costs of alleged medical mistakes. The certainty and greater speed of these payments under early offers could enhance deterrence compared with the current system because, to be effective, deterrence must be swift and certain, two adjectives not applicable to the present tort system (Zimring 1971).

The early offer device was originally proposed as long ago as the 1980s, so why has it never been adopted, even though bills to enact it have been introduced at both the state and federal levels? First, on the claimants'

side, the opposition of the plaintiffs' bar cannot be overlooked. Second, on the defense side, health care providers have focused, often successfully as demonstrated by Professor Nelson and colleagues, on legislation just limiting claims. Third, until recently, no research has been available to show how effective the early offer plan could be, not only in dramatically reducing the amount of money spent on medical malpractice litigation, but also in making better use of it. Without a demonstration of the proposal's huge advantages, there has been little hope of reaching over past opposition to enact balanced reform in the broader public interest.

Endnotes

1. This commentary is adapted from J. Hersch, J. O'Connell, and K. Viscusi, *Evaluation of Early Offer Reform of Medical Malpractice Claims: Final Report 2006* (Washington, D.C.: U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long Term Care Policy, 2006).
Another article, more complete than this one and focusing more on empirical research methodology, is by J. Hersch, J. O'Connell, and K. Viscusi, An Empirical Assessment of Early Offer Reform for Medical Malpractice, *Journal of Legal Studies* 36(2, pt. 2) (2007, forthcoming).
Jeffrey O'Connell is solely responsible for this article.
2. These data are conservative estimates that do not include deductions from early offer payment amounts received from other sources such as health insurance.
3. These figures cannot be combined because of the method of calculation (see Hersch, O'Connell, and Viscusi, app. C, 2007).

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