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

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Objective. To describe the litigation experience in a state with strict tort reform of a large public university health system that has committed to transparency with patients and families in resolving medical errors.

Data Sources/Study Setting. Secondary data collected from The University of Texas System, which self-insures approximately 6,000 physicians at six health campuses across the state. We obtained internal case management data for all medical malpractice claims closed during 1 year before and 6 recent years following the enactment of state tort reform legislation.

Study Design. We retrospectively reviewed information about malpractice claimants, malpractice claims, and the process and outcome of dispute resolution.

Data Collection/Extraction Methods. We accessed an internal case management database, supplemented by both electronic and paper records compiled by the university's Office of General Counsel.

Principal Findings. Closed claims dropped from 244 in 2001–2002 to an annual mean of 96 in 2009–2015, closures following lawsuits from 136 in 2001–2002 to an annual mean of 28 in 2009–2015, and paid claims from 60 in 2001 to an annual mean of 20 in 2009–2015. Patterns of resolution suggest efforts by the university to provide some compensation to injured patients in cases that were no longer economically viable for plaintiffs' lawyers to litigate. The percentage of payments relating to cases in which lawsuits had been filed decreased from 82 percent in 2001–2002 to 47 percent in 2009–2012 and again to 29 percent in 2012–2015, although most paid claimants were represented by attorneys. Unrepresented patients received payment in 13 cases closed in 2009–2012 (22 percent of payments; mean amount \$60,566) and in 24 cases closed in 2012–2015 (41 percent of payments; mean amount \$109,410). Even after tort reform, however, claims that resulted in payment remained slow to resolve, which was worsened for claimants subject to Medicare secondary payer rules. Strict confidentiality became a more common condition of settlement, although restrictions were subsequently relaxed in order to further transparency and improve patient safety.

Conclusions. Malpractice litigation risk diminished substantially for a public university health system in Texas following legal changes that reduced rights to sue and available damages. Health systems operating in a low-tort environment should work with policy makers, plaintiffs' attorneys, and patient groups to assist unrepresented patients,

facilitate early mediation, limit nondisclosure obligations following settlement, and expedite the resolution of Medicare liens.

Key Words. Medical malpractice, patient safety, dispute resolution, tort reform, error disclosure

This article examines the recent claims experience of a large, self-insured public academic health system in a state that has become inhospitable to medical malpractice litigation, particularly for public providers. The University of Texas System (UT System) operates health campuses across the state, and self-insures malpractice risk. In keeping with national trends toward Communication-and-Resolution Programs (CRPs), UT System and its health campuses made a written commitment to transparency in cases of medical error in 2008, and began structured efforts in 2011 to operationalize that commitment as part of improving patient safety (Mello and Gallagher 2010).

These efforts have been challenged not by a high risk of malpractice litigation in Texas, but rather by the opposite. Government units, including UT System and other public academic institutions, have limited liability under the Texas Tort Claims Act (Tex. Civ. Prac. & Rem. Code Ann. § 101.021). Until recently, however, physicians employed by public systems could still be sued as individuals, exposing them to the prevailing tort climate. In 2003, Texas altered that climate to discourage suits by amending its constitution and passing aggressive tort reform legislation (Acts 2003). This reduced potential liability for all physicians. In 2011, liability for physicians employed by public universities was even more tightly constrained by the Texas Supreme Court, which ruled that government workers could no longer be sued as individuals (Franka v. Velasquez 2011).

In this article, we report the post-tort reform malpractice claims experience of UT System based on analysis of closed claims files. We document a sharp drop in claim closures and associated payments after 2003, which has persisted and strengthened since 2011. We examine how this environmental change may have influenced other aspects of claims resolution that are valued

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by the CRP movement, such as the ability to secure legal representation, the timeliness and nonadversarial quality of dispute resolution, and the potential for information exchange. We also evaluate potential barriers to optimal resolution, such as overreaching confidentiality requirements regarding settlement and delays in clearing Medicare liens.

METHODS

As part of a long-term effort by a public academic health system to improve patient safety and dispute resolution, we examined the closed claims files of the University of Texas System (UT System). Under its Professional Medical Liability Benefit Plan, established in 1977, UT System self-insures medical liability claims against over 6,000 faculty physicians, dentists, residents, and fellows, as well as approximately 3,500 medical students (The University of Texas System 2014). The health law section of UT System's Office of General Counsel works in cooperation with risk managers at the health campuses to resolve claims and with the Texas Attorney General's Office to defend lawsuits. Health professionals covered by the Plan practice or train at six health campuses around the state: UT Southwestern Medical Center in Dallas, UT Health Science Center at San Antonio, UT Health Science Center at Houston, UT Medical Branch at Galveston, UT MD Anderson Cancer Center, and UT Health Science Center at Tyler. The UT System also self-insures malpractice risk for six hospitals owned or operated by certain campuses, but most hospital and clinic care provided by covered physicians occurs at independent but affiliated facilities. Two additional campuses, UT Dell Medical School in Austin and UT Rio Grande Valley in South Texas, were chartered recently and are not included in our study.

In 2008, UT System adopted a formal, system-wide commitment to disclose medical errors to patients, and in 2010 UT System hired a consultant (RF Strategies) to work with the health campuses to operationalize its commitment to transparency. As part of an AHRQ grant to evaluate that effort, which remains ongoing, our research team was given access to information maintained by UT System in an internal case management database, as well as to underlying documents in individual claim files, both on paper (earlier years) or electronically (later years). Most information we report was available from the case management database, but certain pieces of information (e.g., settlement agreements, existence of Medicare liens) required examination of the

complete file to ascertain. We relied on the accuracy of UT System's case management database and did not attempt to verify its quality.

We collected information on the incidence and disposition of malpractice claims against UT System physicians and their institutions, including whether a lawsuit was filed, the amount of any settlement payment, the timing of resolution, and whether settlement was conditioned on confidentiality. For the most recent 3 years (2012–2015), we also determined whether claimants receiving settlements without lawsuits were nonetheless represented by attorneys, whether and when mediation occurred, and whether Medicare asserted a right to repayment from the settlement. UT System's health law department categorizes cases by type, department, allegation, and outcome, which we recorded but did not independently verify. We report payment amounts in nominal dollars, not indexed for inflation.

We reviewed all malpractice claims covered by UT System's plan ($N = 822$) that were closed in UT System fiscal year 2001–2002 (244 claims closed with 60 settlements), 2009–2010 (99 claims with 16 settlements), 2010–2011 (111 claims with 22 settlements), 2011–2012 (113 claims with 22 settlements), 2012–2013 (102 claims with 30 settlements), 2013–2014 (80 claims with 12 settlements), and 2014–2015 (73 claims with 16 settlements). Each fiscal year runs from September 1 through August 31. We did not include 13 additional cases involving only minor dental injury in our analysis. Data from 2001 to 2002 were obtained from paper records; other years had all or mostly all electronic data available.

The years selected for review relate not only to UT System's commitment to transparency surrounding error and its efforts to operationalize that commitment but also to significant decreases in medical malpractice liability risk for UT System physicians. The first year we studied predates significant tort reform in Texas. Of the six post-tort reform years we reviewed, the first three predate the *Franka* decision strengthening governmental immunity. In our initial data collection, we also reviewed cases from 2006 to 2007 (141 claims with 23 settlements), but we do not present those results here because claims closed in that year mix pre- with post-tort reform claims. We developed a template for data collection prior to beginning the research. Data through 2011–2012 were collected directly by a law student supervised by one of the authors (W. M. S.) in 2012 and 2013; corresponding data from 2012 to 2015 were provided by UT System in 2016 in response to requests from our research team.

The research protocol was approved by the Institutional Review Board at the University of Texas Health Science Center at Houston. The data we

Figure 1: Total Paid Claims with and without Lawsuits, by Year

Note. [Color figure can be viewed at wileyonlinelibrary.com].

collected do not identify individual patients or health care professionals. Descriptive statistics, *t*-tests, and Pearson's chi-squared analysis were performed with the use of *SPSS Statistics for Mac, version 23.0* (SPSS).

RESULTS

Overview of Malpractice Claims and Outcomes

The most common types of cases that gave rise to malpractice claims against UT System were coded as treatment (316 cases; 38 percent), surgery (252 cases; 31 percent) and diagnosis/diagnostic procedures (89 cases; 11 percent). Additional case types accounting for more than 1 percent of claims included labor and delivery (42 cases; 5 percent), medication (29 cases; 4 percent), emergency care (27 cases; 3 percent), anesthesia (17 cases, 2 percent), and falls (14 cases; 2 percent). Wrongful death was alleged in 148 claims (18 percent).

Of the 822 closed claims we reviewed, payments were made to claimants in 178 cases (22 percent), while 644 cases (78 percent) were closed without payment. The number of closed claims, closures following lawsuits, and paid claims differed by year. All of these measures dropped after Texas enacted tort reform and strengthened governmental immunity (see Figure 1): closed claims from 244 in 2001–2002 to an annual mean of 96 in 2009–2015;

closures following lawsuits from 136 in 2001–2002 to an annual mean of 28 in 2009–2015; and paid claims from 60 in 2001 to an annual mean of 20 in 2009–2015. Counts of these measures did not differ substantially between the 2009–2012 and 2012–2015 periods.

Settlements and Payments

The mean amount paid by UT System for all study years was \$168,084 (median \$100,000; range \$119–1,450,000). In 27 of the 178 settled cases (15 percent), the only payment was made by a UT hospital or clinic; no payment involved a physician covered by the UT System plan. In 10 cases (6 percent), alternative or additional payments were made by a hospital not owned by UT System, yielding mean total compensation in those cases of \$1,043,435 (median \$48,750; range \$4,353–10,000,000). Payment amounts were higher in cases alleging wrongful death compared to cases involving nonfatal injuries (\$190,091 vs. \$130,189; $p = .077$), with borderline statistical significance.

Only one (1 percent) of the payments made in the years we reviewed resulted from a judgment at trial rather than a voluntary settlement between the parties. That case was tried during 2011–2012 solely against a UT-owned hospital. The jury found against UT System, the court reduced the verdict to the \$250,000 cap, and the case was ultimately settled at an appellate mediation for \$195,000.

Mean payment amounts dropped sharply from \$279,851 in 2001–2002 to \$92,661 in 2009–2012 and \$98,067 in 2012–2015 ($p < .001$ between the earlier and either later period). Table 1 shows amounts paid by UT System and total settlement amounts in each year by quartile.

Lawsuits, Attorney Involvement, and Mediation

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

Table 1: Settlement Amounts

<i>Variable</i>	<i>Mean (Range) by Study Quartile</i>			
	<i>First</i>	<i>Second</i>	<i>Third</i>	<i>Fourth</i>
Settlement amount, \$				
2001–2002 (<i>n</i> = 59)	46,543 (901–95,000) (<i>n</i> = 14)	167,726 (100,000–290,000) (<i>n</i> = 15)	448,867 (300,000–600,000) (<i>n</i> = 15)	1,695,267 (620,000–8,000,000) (<i>n</i> = 15)
2009–2012 (<i>n</i> = 60)	4,462 (500–12,000) (<i>n</i> = 15)	28,927 (14,000–50,000) (<i>n</i> = 15)	116,719 (70,000–150,000) (<i>n</i> = 15)	245,455 (165,000–500,000) (<i>n</i> = 15)
2012–2015 (<i>n</i> = 58)	6,019 (119–15,000) (<i>n</i> = 15)	50,335 (80,000–15,245) (<i>n</i> = 15)	139,068 (95,000–180,000) (<i>n</i> = 14)	282,500 (190,000–680,000) (<i>n</i> = 14)
Plan liability paid, \$				
2001–2002 (<i>n</i> = 59)	18,829 (0–67,000) (<i>n</i> = 14)	105,230 (75,000–165,000) (<i>n</i> = 15)	310,100 (190,000–449,000) (<i>n</i> = 15)	614,667 (450,000–1,250,000) (<i>n</i> = 15)
2009–2012 (<i>n</i> = 60)	822 (0–5,193) (<i>n</i> = 15)	21,062 (7,500–45,000) (<i>n</i> = 15)	94,167 (45,000–150,000) (<i>n</i> = 15)	220,000 (150,000–500,000) (<i>n</i> = 15)
2012–2015 (<i>n</i> = 58)	513 (0–3,850) (<i>n</i> = 15)	16,300 (5,000–50,000) (<i>n</i> = 15)	93,316 (50,000–150,000) (<i>n</i> = 14)	226,032 (150,000–250,000) (<i>n</i> = 14)
UT System paid, \$				
2001–2002 (<i>n</i> = 59)	31,218 (0–75,444) (<i>n</i> = 14)	127,167 (80,000–200,000) (<i>n</i> = 15)	318,500 (200,000–495,000) (<i>n</i> = 15)	644,600 (495,00–1,450,000) (<i>n</i> = 15)
2009–2012 (<i>n</i> = 60)	5,650 (0–15,000) (<i>n</i> = 15)	38,161 (20,000–75,000) (<i>n</i> = 15)	106,833 (75,000–150,000) (<i>n</i> = 15)	220,000 (150,000–500,000) (<i>n</i> = 15)
2012–2015 (<i>n</i> = 58)	6,019 (119–15,000) (<i>n</i> = 15)	41,038 (15,000–75,000) (<i>n</i> = 15)	121,614 (75,000–150,000) (<i>n</i> = 14)	234,246 (154,446–250,000) (<i>n</i> = 14)

Note: This table excludes one case categorized by UT System as a case with payment but with a \$0 settlement amount.

The percentage of closed claims in which lawsuits had been filed decreased significantly from 2001–2002 to 2009–2012 (56 percent vs. 31 percent; $p < .001$), with another nonsignificant decrease from 2009–2012 to 2012–2015 (31 percent vs. 26 percent; $p < .156$). The percentage of payments relating to cases in which lawsuits had been filed decreased from 82 percent (49/60) in 2001–2002 to 47 percent (28/60) in 2009–2012 ($p < .001$) and again to 29 percent (17/58) in 2012–2015 ($p = .052$ comparing 2009–2012 to 2012–2015).

Following tort reform, most patients and families were represented by an attorney even without formal litigation. In 2009–2012, payments were made in 20 cases (33 percent of payments) without lawsuits but with attorney representation. In 2012–2015, payments were made in 17 cases (29 percent of payments) without lawsuits but with attorney representation. Unrepresented patients received payment in 13 cases closed in 2009–2012 (22 percent of payments; mean amount \$60,566) and in 24 cases closed in 2012–2015 (41 percent of payments; mean amount \$109,410).

In 2012–2015, 21 (36 percent) of the cases resulting in payment underwent mediation. Of the mediated cases, the claimant was represented by an attorney in 20 cases (95 percent), and a lawsuit had been filed in 10 cases (48 percent). Mediation typically occurred late in the claims resolution process; mean time from event to mediation was 891 days (range 249–2,185 days), and mean time from claim to mediation was 617 days (range 133–2,043 days). All mediated cases received payment from UT System; the mean amount paid was \$98,116.

Times to Resolution; Medicare Liens

Resolving malpractice cases involving minors can be slower for two reasons: a longer statute of limitations that prolongs filing claims, and the requirement that settlements receive judicial approval, which may delay closure. For this reason, we report cases involving minors and adults separately.

For adults, the mean time from the clinical event triggering the claim until closure of the claim file was 878 days (range 124–2,596 days). The mean time from the event until the opening of the file was 329 days (range 5–2,455 days, while the mean time from opening to resolving the claim was 559 days (range 33–2,191 days). For minors, the mean time from the clinical event triggering the claim until closure of the claim file was 1,049 days (range 138–3,371 days). The mean time from the event until the opening of the file

was 582 days (range 38–2,721 days), while the mean time from opening to resolving the claim was 468 days (range 100–735 days).

Filing a lawsuit was associated with increases in time from event to closure for claims involving adults, with each difference significant at $p < .001$. In 2001–2002, the mean time from event to closure in claims without a lawsuit was 543 days, versus 1,215 days with a lawsuit filed. In 2009–2012, the mean time was 631 days without a lawsuit versus 1,350 days with a lawsuit. In 2012–2015, the mean time was 686 days without a lawsuit versus 1,486 with a lawsuit. A similar pattern was observed for minors and was statistically significant for 2001–2002 and the entire 2009–2015 period. Time from event to claim was likely lengthened for litigated cases by the process of obtaining counsel, while differences in time from claim to closure probably reflect both the expiration of the statute of limitations for cases without lawsuits and pre-suit notice requirements and other delays inherent in the litigation process for litigated cases.

Overall time from event to closure dropped following the enactment of tort reform, likely because the statute of limitations was reduced, but time from claim to closure did not change significantly. For all cases (adult and minor) closed without payment, mean time from event to closure was 1,312 days in 2001–2002, 1,254 days in 2009–2012, and 1,193 days in 2012–2015. For adult cases with payment, mean time from event to closure was 1,064 days in 2001–2002, 937 days in 2009–2012, and 878 days in 2012–2015.

Table 2 shows times to resolution for paid claims by quartile. Mean times from event to closure were shorter for the fastest quartile in 2009–2015 than in 2001–2002 (287 days vs. 628 days; $p < .001$). Because payment amounts decreased following tort reform, however, quicker resolution may reflect lower compensation rather than an accelerated process for relatively simple claims.

The presence or absence of mediation was not associated with differences in time to resolution for claims without lawsuits. For claims with lawsuits, mean time from event to resolution was longer in mediated cases (1,797 vs. 865 days; $p = .006$), as was mean time from claim to resolution (1,446 vs. 622 days; $p = .016$). This suggests that mediation was often used to break impasses in litigation that had become protracted.

In recent years, the federal Medicare program has vigorously asserted its statutory right of repayment from tort settlements and other third-party funds under the Medicare as Secondary Payer regulations. In 2012–2015, 15 of the 58 settlements (26 percent) could not be finalized until the amount of a

Table 2: Time to Resolution

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

Medicare lien had been identified and negotiated. Mean time from claim to resolution was greater for claims with than for claims without Medicare liens (856 vs. 438 days; $p < .011$). For the 15 cases with Medicare liens, a median of 153 days elapsed between signing a settlement agreement and formally closing the case file (mean 449 days, range 1–1,574 days).

Confidentiality in Settlements

Omitting five cases where the only payment was made by a party other than the UT System, 88 percent of settlement agreements (152/173) included nondisclosure agreements selectively binding the claimant. All of the confidentiality clauses prohibited disclosing the amount and terms of the settlement agreement. Disclosure of the event of settlement was prohibited in 39 percent of clauses. Disclosure of the underlying facts and events of the medical care at issue in the case was prohibited by 45 percent of clauses. Complaints to professional licensing and regulatory bodies such as the state medical board were prohibited by 30 percent of clauses. Disparagement of the defendants was prohibited by 5 percent of clauses.

Table 3 shows the specific conduct prohibited by nondisclosure clauses in settlement agreements during the study period, and it further distinguishes the most recent 2 fiscal years from the immediately preceding years in order to isolate the changes in UT System settlement practices discussed below. Settlements in 2009–2013 were more likely than settlements in 2001–2002 to prohibit disclosing the event of settlement (55 percent vs. 33 percent; $p < .018$), to prohibit disclosing the underlying facts of the claims (57 percent vs. 28 percent; $p < .002$), and to prohibit complaints to regulatory bodies (43 percent vs. 7 percent; $p < .001$). However, explicit language imposing confidentiality on the attorney as well as the claimant decreased (22 percent vs. 75 percent; $p < .001$).

In an earlier article, we published detailed data on the use of confidentiality clauses in the cases we reviewed through FY 2011–2012 (Sage, Jablonski, and Thomas 2015). We concluded that tightly restricting patients from disclosing information as a condition of settlement, which had been common, seemed incompatible with emerging understandings of patient safety, transparency, and compassionate care following unanticipated injury. As a result of that research, UT System changed its practices regarding restrictions on patients' disclosing underlying facts and on complaining to regulatory bodies. Settlements in 2013–2015 were less likely than settlements in 2009–2013 to prohibit disclosing the underlying facts of the claims (23 percent vs. 59

Table 3: Restrictions in Nondisclosure Agreements

	<i>Number of Settlements (%)</i>	<i>Number of Confidentiality Clauses (%)</i>	<i>Clauses Prohibiting Disclosure of Settlement Amount (%)</i>	<i>Clauses Prohibiting Disclosure of Settlement Terms (%)</i>	<i>Clauses Prohibiting Disclosure of Facts (%)</i>	<i>Clauses Prohibiting Disclosure to Regulators (%)</i>	<i>Clauses Prohibiting Disparagement of Defendants (%)</i>
2001–2002	57 (33)	43 (28)	43/43 (100)	43/43 (100)	12/43 (28)	3/43 (7)	0/43 (0)
2009–2011*	36 (21)	35 (23)	35/35 (100)	35/35 (100)	19/35 (54)	22/35 (63)	1/35 (3)
2011–2013*	52 (30)	52 (34)	52/52 (100)	52/52 (100)	32/52 (62)	17/52 (33)	2/52 (4)
2013–2015*	28 (16)	22 (15)	22/22 (100)	22/22 (100)	5/22 (23)	3/22 (14)	5/22 (23)
	173	151	151/151 (100)	151/151 (100)	68/151 (45)	45/151 (30)	8/151 (5)

*2009–20011 denotes FY's 2009–2010 and 2010–2011; 2011–2013 denotes FY's 2011–2012 and 2012–2013; 2013–2015 denotes FY's 2013–2014 and 2014–2015.

percent; $p < .003$), and to prohibit complaints to regulatory bodies (14 percent vs. 45 percent; $p < .007$). The overall use of nondisclosure clauses also decreased (79 percent vs. 99 percent; $p < .001$). On the other hand, clauses where they existed were more likely to explicitly prohibit disparagement of the physicians or health system (23 percent vs. 3 percent; $p < .002$).

DISCUSSION

Although physicians, malpractice insurers, and other critics of the personal injury bar are quick to identify harms associated with unconstrained liability, much less attention has been paid to the resolution of medical errors that occur on the “far side” of tort reform. In this article, we report the claims resolution experience of UT System, a large public academic health system in Texas that self-insures malpractice risk for over 6,000 employed physicians and several owned or operated hospitals. UT System is a sizeable clinical enterprise. Physician practice plan revenue grew from \$1.55 billion in 2010 to \$2.45 billion in 2015, while total clinical operating revenue grew from \$4.98 billion in 2010 to \$7.75 billion in 2015. In 2015, hospitals owned or operated by UT institutions comprised 2,172 staffed beds, accounted for 92,258 admissions and 586,056 patient days, and provided 2.85 million outpatient visits (UT System Office of Health Affairs, personal communication).

UT System and its health campuses have made explicit commitments to transparency surrounding error, to subsequent safety improvement, and to developing best practices for working with patients and families on resolving claims following injury. These commitments parallel increasing interest nationally in “communication-and-resolution” programs (CRPs) (Agency for Healthcare Research and Quality 2010). CRPs commit the sponsoring institution to vigilant detection of error, full disclosure to patients and families, and timely redress of injury (Mello et al. 2014). Although tort reform is neither a prerequisite nor a disqualification for CRPs, climatic extremes in the legal environment can reduce incentives for innovation in malpractice dispute resolution (Sage et al. 2014).

In the past 15 years, laws conferring rights to sue for medical injury have been substantially narrowed in Texas. For all malpractice claims filed on or after September 1, 2003, noneconomic damages (i.e., pain and suffering) were limited to \$250,000 against physicians and \$250,000 against up to two hospitals, for maximum damages of \$750,000 (Tex. Civ. Prac. & Rem. Code. § 74.301). In addition, the statute of limitations was reduced to 2 years from the

act or omission giving rise to the claim (Tex. Civ. Prac. & Rem. Code § 74.251 (a)), a new statute of repose was adopted with a similar timetable (Tex. Civ. Prac. & Rem. Code § 74.251(b)) and claims involving emergency care were barred unless negligence was “willful and wanton” (i.e., knowing) (Tex. Civ. Prac. & Rem. Code § 74.151). As a quid pro quo, the 2003 legislation increased the disciplinary authority of the state’s medical licensing board.

Public entities in Texas, as in other states, are subject to additional liability rules. The Texas Tort Claims Act waives sovereign immunity for government workers acting within the scope of their employment only under certain circumstances (Tex. Civ. Prac. & Rem. Code Ann. § 101.021). For medical injuries, the most important limitation is that a nexus must exist between the claimant’s injury and the “use or misuse of tangible personal property” (Dallas Area Rapid Transit v. Whitley 2002). As a result, failure to recommend a diagnostic test, or an error in interpreting a properly conducted test, may not qualify for liability (Anderson v. City of San Antonio 2003). In addition, total damages against state agencies are effectively capped at \$250,000 (Tex. Civ. Prac. & Rem. Code Ann. § 101.023). However, these restrictions did not override general liability rules for public academic physicians until the *Franka* decision in 2011, when the Texas Supreme Court ruled that government workers acting within the scope of their employment may not be sued as individuals (Franka v. Velasquez 2011).

Other research has shown that paid claims per physician dropped throughout the United States between 1992 and 2012, though slightly more in “new-cap” states such as Texas (64 percent vs. 57 percent), whereas payouts per large claims increased in “no-cap” and “old-cap” states during that period but decreased by 21 percent in “new-cap” states, with the differences largely attributable to legislative caps on damages (Paik, Black, and Hyman 2013a,b). Researchers have estimated that instituting a \$250,000 noneconomic damage cap similar to that in Texas would reduce payouts in malpractice suits against physicians by approximately 20 percent (Seabury, Helland, and Jena 2014). A sharp drop in claims and payouts following tort reform was also predicted using detailed data from Texas specifically (Hyman et al. 2009). This was borne out by a subsequent study of Texas, which showed a decline in claims per 100,000 adult nonelderly persons from 4.6 in 2003 to 1.8 in 2009 and per 100,000 elderly persons from 9.2 in 2003 to 3.2 in 2009, while total payouts dropped by 78 percent for the adult nonelderly and 80 percent for the elderly (Paik et al. 2012).

Similarly, our findings show a very substantial reduction in claims, lawsuits, and payments involving physicians at the University of Texas, which is a

self-insured public academic health system. This comports with evidence of decreasing liability-related costs for the participating health campuses. According to UT System's 2007 annual report on its self-insurance program, "an immediate reduction in Plan rates averaging 44 percent was made in 2003, [and i]n August 2007, the Board of Regents adopted another 40 percent reduction in the premium rates for faculty and residents and a 50 percent rate reduction for medical students" (The University of Texas System 2007).

Neither UT System as a whole nor any of its component institutions has created a formal CRP. Notwithstanding the paucity of actual litigation following tort reform and the UT System's limited exposure to damages, however, our data show that claims continued to be resolved following tort reform, although settlement amounts were reduced. Mediation was used in a substantial percentage of recent cases, whether or not a lawsuit had been filed. In several recent cases, settlements were reached in claims aired directly by patients or family members, without attorney representation. More often, patients were represented by attorneys during settlement without a lawsuit being filed. Still, even a public health care system that is willing to acknowledge error cannot lawfully compensate injuries for which it is legally immune from suit, such as those lacking any arguable nexus to "tangible personal property" as required to waive government immunity under Texas law.

On the other hand, vestiges of the prior, more litigation-oriented environment were apparent. Notably, times to resolve disputes remained as long after tort reform as before, even though the financial consequences of claims had diminished. Prompt resolution of claims is a useful marker for many desirable attributes of a malpractice system, including relief of emotional distress for patients and caregivers, financial assistance, safety improvement, and insurance market stability (Sage 2014). Our data suggest that expedited procedures are underdeveloped, even though UT System has committed to transparency. For example, mediation, while common, tended to be deployed late in the process of resolving claims, rather than as an early intervention. Our data also confirm significant delays associated with quantifying and clearing government liens placed on tort recoveries by Medicare beneficiaries, which is well known as a practical barrier to prompt settlement but has not been previously studied (Sage et al. 2014). The Centers for Medicare and Medicaid Services recently published a final rule expanding online access to lien amounts, which may begin to ameliorate this problem (Centers for Medicare & Medicaid Services 2016). In order to understand the sources of delay and work to reduce them, we suggest that health systems precisely track each stage

of the dispute resolution process, including impediments to agreeing on terms of settlement and to finalizing payment after an agreement is in place.

Our data on the use of nondisclosure agreements as a condition of settlement show both the perils of backsliding on malpractice innovation after tort reform and the potential for improvement if such undesirable behavior is recognized. Settlement continued to be perceived as inviting additional litigation, notwithstanding the dampening effects of tort reform. Even after UT System adopted a policy of honesty regarding errors in clinical care, it continued to restrict over half of claimants who received compensation from discussing all aspects of that care with others. Moreover, settlement agreements after tort reform became more likely to condition payment on not complaining to the Texas Medical Board, which had received additional enforcement powers when private rights to litigate were curtailed. Courts typically regard such contractual restrictions as unenforceable because of the strong public interest in effective regulation (Fromm 2001), and California passed a law prohibiting them in 2012 (California Assembly Bill 2570 2011). These provisions, unexpected because UT System is itself a public entity, were present in nearly half of settlement agreements between 2009 and 2013. As a result of participating in this study, the UT System determined in 2014 that restrictions on reporting to regulators would no longer be included in malpractice settlement agreements. The data we present confirm that this has occurred, along with a general decrease in the use of confidentiality clauses and fewer prohibitions on disclosing the underlying facts of claims. Instead, UT System has begun to prohibit settling claimants from publicly disparaging the providers involved in their care, which is a much more focused restriction.

Our study has several limitations. We examined only one academic health care system in a single state. Although several states have tort reforms similar to Texas, and government immunity applies to some degree in all states, our specific findings may not be generalizable (Mello et al. 2014). We have no information about underlying rates of medical error, about claims that were not filed, or about the sufficiency of the payments received to compensate the injuries suffered. While tort reform and institutional policy changes appear to be important causal factors in our findings, unexplored factors such as patient demographics and differences in the clinical care received may have contributed to the changes that occurred over time. With respect to the 2001–2002 pre-tort reform baseline year, it is possible that impending tort reform influenced claims and payments.

CONCLUSION

In a large, self-insured public academic health system in Texas, malpractice claims and payments decreased sharply following legal changes that reduced rights to sue and available damages. Patterns of resolution suggest efforts by the university to provide some compensation to injured patients in cases that were no longer economically viable for plaintiffs' lawyers to litigate. A higher percentage of settlements were reached without formal litigation, although most claimants were represented by attorneys. Even after tort reform, however, claims that resulted in payment remained slow to resolve, which was worsened for claimants subject to Medicare secondary payer rules. Strict confidentiality became a more common condition of settlement, although restrictions were subsequently relaxed in order to further transparency and improve patient safety. Based on this experience, health systems operating in a low-tort environment should work with policy makers, plaintiffs' attorneys, and patient groups to assist unrepresented patients, facilitate early mediation, limit nondisclosure obligations following settlement, and expedite the resolution of Medicare liens.

ACKNOWLEDGMENTS

Joint Acknowledgment/Disclosure Statement: This project was funded by an award from the Agency for Healthcare Research and Quality (R18-HS019561-01). The content is solely the responsibility of the authors and does not necessarily represent the official views of the Agency for Healthcare Research and Quality. The authors thank Raymond S. Greenberg, MD, PhD, Kenneth I. Shine, MD, Melodie Krane, JD, Allene Evans, JD, Erika Kenney, BA, and Kathy Smith, BA, from the University of Texas System. Former University of Texas law students Joseph Jablonski, JD, Spencer Bloom, JD, and Jessica Winchell, JD, provided research assistance.

Disclosures: None.

Disclaimers: None.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article:

Appendix SA1: Author Matrix.