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# Insight & Perspectives

A publication of Sompo International Insurance's Healthcare Practice

## ABOUT US

Our U.S. and Bermuda teams provide healthcare professional liability coverage to non-profit and for-profit hospitals and other healthcare organizations.

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We are pleased to offer our latest installment of **Insight & Perspectives**. This newsletter is dedicated to sharing healthcare news, trends and developments impacting our brokers and insureds.

This installment features Phillip Ashley's article *Tort Reform 2017 Update: One Step Back, Two Steps Forward* highlighting a number of recent important actions in the area of tort reform.

As always, we appreciate your continued support and thank you for selecting Sompo International Insurance to be a part of your risk and insurance programs.

# Tort Reform 2017 Update: One Step Back, Two Steps Forward

*By Phillip Ashley, JD, CPCU, Wagstaff & Cartmell*
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Over the past year there have been a number of important actions in the area of tort reform around the country. Although the trend continues to ebb and flow between setbacks and gains, the steps forward are substantial with strong economic benefits providing a more positive outlook for the future of tort reform.

## Moving Forward

The concept of federal tort reform in the form of a national non-economic damages cap has come and gone over the years and has had many iterations. On June 28, 2017, the U.S. House approved a tort reform bill that would impose a $250,000 nationwide cap in medical malpractice cases as well as several other measures designed to lower healthcare costs. The bill has economic impact teeth as, according to the Congressional Budget Office, the measure could save up to $50 billion in healthcare costs over the next 10 years by lowering premiums for medical liability insurance and reducing costs associated with defensive medical practice. The bill would also reduce deficits by $14 billion over 5 years and reduce national health spending by 0.4 percent over 10 years. The cap would apply to anyone who received medical care through any federal program, such as Medicare, Medicaid or the ACA, or whose medical care was paid for by employer health plans. The bill also has a provision that puts a sliding scale on the percentage that attorneys can receive on a contingency

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basis. In addition, the bill would limit the statute of limitations to one year in most cases and would implement a "fair share" rule that would provide for several liability among co-defendants, thus abolishing joint liability. H.R. 1215: Protecting Access to Care Act of 2017 was assigned to the Senate Committee on the Judiciary where it presently remains.

Progress has been made in several states as well: In Kentucky, a new provision signed into law earlier this year requires that claims filed against doctors, hospitals and other health care providers be evaluated by a three member panel before they can proceed to court. The opinion of the panel is admissible in evidence in any future litigation. This is similar to the screening panel processes adopted in other states including Alaska, Delaware, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maine, Massachusetts, Montana, Nebraska, New Hampshire, New Mexico, Utah, Virginia, the Virgin Islands and Wyoming. However, there is already at least one pending challenge to the constitutionality of the new law. The challenge claims the law violates equal protection by barring timely access to courts in medical malpractice cases while litigants in other types of cases can move forward. The challenge also claims there is no rational basis for the requirement other than legislative whim. Similar screening panel processes have been upheld in some states and thrown out in others.

On June 22, 2017, the Eighth Circuit Court of Appeals affirmed a trial court's decision to reduce a $17 million jury verdict to $1.75 million pursuant to Nebraska's tort reform law, finding the cap did not violate the patient's constitutional rights.[1]

In late 2016 three more states, Oklahoma, Indiana and Delaware, have accepted the rule that amounts actually paid for medical services, versus the amounts billed, are proper evidence to put before juries in cases seeking reimbursement for past medical costs. The Delaware Supreme Court stated that "to recover amounts that are paid by no one" does not make an injured party whole. The Delaware ruling was limited to cases where Medicare or Medicaid paid the expenses but suggested the legislature may want to consider expanding the rule to cases where other payees are involved. Case law in slightly more than half the states holds that the amounts billed for medical expenses are proper evidence to put before juries in cases seeking reimbursement for past medical costs, and not the actual amounts paid for those services. The rule allowing evidence of the amounts actually paid appears to be gaining some ground though as evidenced by the rulings in the above three states. Several states have not firmly decided the issue.

## A Few Setbacks

On June 8, 2017, the Florida Supreme Court issued a decision striking down as unconstitutional Florida's non-economic damages caps in medical negligence cases.[2] The Supreme Court held that the caps violate equal protection and do not bear a rational relationship to the Legislature's stated interest in addressing the medical malpractice crisis. The statute, 766.118 Florida Statutes (2011), provided non-economic damages caps in medical negligence cases of either $500,000 or $1 million per practitioner, and either $750,000 or $1.5 million per non-practitioner (e.g., a hospital). The higher caps were reserved for cases involving death or permanent vegetative state, or if the court found the injury was catastrophic and the harm was particularly severe and a manifest injustice would occur if the lower caps applied.

In early July 2017, the Wisconsin First District Court of Appeals ruled the $750,000 cap on non-economic damages in medical malpractice cases is unconstitutional because it puts the most severely injured patients at a disadvantage over those with much less severe injuries. The court also said that the cap did not achieve any of the legislature's stated goals including encouraging doctors to practice in Wisconsin, containing healthcare costs by discouraging defensive medicine, and providing certainty in damage awards as well as protecting the solvency of the state compensation fund. The court analyzed each of these goals and found that the cap did not substantially promote or affect any of them. The court said, "We are left with literally no rational factual basis in the record before us which supports the legislature's determination that the $750,000 limitation on non-economic damages is necessary or appropriate to promote any of the stated legislative objectives." The decision will likely be appealed to the Wisconsin Supreme Court.[3]

On June 23, 2017, the Illinois Second District Appellate Court issued another adverse decision for hospitals. The Court ruled that quality control reports prepared pursuant to a policy to report incidents serving both quality improvement and risk management purposes were not privileged under the Medical Studies Act.[4] In the case at issue, hospital nurses prepared three quality control reports pertaining to an outpatient gynecological surgery. Both the trial court and appellate court ruled in favor of plaintiff stating that the reports were not privileged and should be provided to the plaintiff. The courts' decisions were grounded on the fact that the reports at issue were generated before the quality committee even knew about the incident. The courts said that the law allowed such a committee to designate a representative to investigate potential quality issues and thereafter cloak in privilege any documents generated. The courts stated that the designee cannot be declared and the privileged documents generated until after the committee knows about the incident. The decision is unfortunate but further emphasizes the need to carefully comply with all legal requirements in order for quality and peer review documents to remain privileged.

In summary, while existing tort reforms, specifically non-economic damages caps, continue to come under scrutiny, there have been advances in tort reform in several states. More importantly, a federal tort reform bill that imposes a nationwide cap on medical malpractice liability and potentially lowers healthcare costs may soon be a reality, clearing the way for more affordable healthcare, lower medical liability insurance premiums and reduced defensive legal costs.

[1] *Doran Schmidt, et al. v. Bellevue Medical Center L.L.C.,* et al., Nos. 16-1022, 16-1024, 8th Cir., 2017 U.S. App. LEXIS 11053).

[2] *North Broward Hospital District v. Kalitan,* 219 So. 3d 49 (Fla. 2017).

[3] *Mayo v. Wisconsin Injured Patients and Families Compensation Fund (IPFCF),* 2017 WL 2874614 (July5, 2017).

[4] *Nielson v. SwedishAmerican Hospital,* 80 N.E.3d 706 (Ill. App. Ct. 2017).