Healthcare Malpractice Claims: The Current Landscape

AIG

June 2015
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Foreword

Healthcare in the United States is in the midst of a seismic shift. Accountable Care Organizations continue to grow and rapid consolidation is taking place amongst healthcare providers. More physicians are affiliating with hospitals than ever before. The Affordable Care Act is incentivizing patient safety and highlighting better outcomes. Change in reimbursement structures are creating lower margins and pushing a shift in patient care from inpatient to outpatient services.

Understanding malpractice claims trends is a critical piece of this evolving landscape. In healthcare, claims matter. The impact to human beings when something does go wrong is dramatic. Potential reputation impact and rising costs are driving C-suite involvement. The relationship between a healthcare provider and healthcare malpractice insurer is critical.

As claims experts, the direct connection between our effort and ensuring patient safety isn’t always apparent. But an intelligent, analytical, proactive claims function provides a critical feedback loop to underwriting to send signals into the marketplace that help incentivize safety.

At American International Group (AIG), we greatly value our relationship with our valued clients. They give us the opportunity to share our unique view on claims, demonstrate a commitment to patient safety, expert underwriting, and bring a data-driven approach for their benefit. The topics addressed in “Healthcare Malpractice Claims: The Current Landscape” are a small representation of the challenges facing healthcare providers.

We hope you will find it insightful, and look forward to the opportunity to work with you.

Thank you,

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Healthcare Malpractice Claims At A Glance

A review of approximately 50,000 healthcare malpractice claims resolved by AIG insurers since 2002 shows that close to 79% were resolved without any indemnity payment. During that same period, AIG insurers made nearly $4 billion in indemnity payments, and expended an additional nearly $1 billion defending these claims. Approximately 1.3% of these claims resulted in indemnity payments of $1 million or greater. While comparatively small in number, these claims represent nearly $2.5 billion, or 62.5%, of the indemnity paid by AIG insurers over that period of time. The average indemnity payments for these larger claims range from $1.4 million in the $1 million-$2.49 million category, to $16.7 million in the $10+ million category, with Indemnity to Legal Expense Ratios ranging from 9.2-29.7 to 1. For purposes of this discussion, we will be examining only those claims with $1 million+ paid in indemnity by AIG insurers.

<table>
<thead>
<tr>
<th>Indemnity Paid</th>
<th>%*</th>
<th>Average Indemnity Paid (in millions)</th>
<th>Average Legal Expense Paid (in millions)</th>
<th>Average Total Paid (in millions)</th>
<th>Indemnity to Legal Expense Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0.00</td>
<td>78.65%</td>
<td>N/A</td>
<td>$0.01</td>
<td>$0.01</td>
<td>N/A</td>
</tr>
<tr>
<td>$0.01 - $9,999</td>
<td>3.25%</td>
<td>&lt;$0.01</td>
<td>$0.01</td>
<td>$0.01</td>
<td>0.4 to 1</td>
</tr>
<tr>
<td>$10,000 - $99,999</td>
<td>8.33%</td>
<td>$0.04</td>
<td>$0.03</td>
<td>$0.08</td>
<td>1.3 to 1</td>
</tr>
<tr>
<td>$100,000 - $499,999</td>
<td>6.90%</td>
<td>$0.22</td>
<td>$0.07</td>
<td>$0.29</td>
<td>3.5 to 1</td>
</tr>
<tr>
<td>$500,000 - $999,999</td>
<td>1.58%</td>
<td>$0.67</td>
<td>$0.11</td>
<td>$0.77</td>
<td>6.2 to 1</td>
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<tr>
<td>$1,000,000 - $2,499,999</td>
<td>0.84%</td>
<td>$1.45</td>
<td>$0.16</td>
<td>$1.61</td>
<td>9.2 to 1</td>
</tr>
<tr>
<td>$2,500,000 - $4,999,999</td>
<td>0.26%</td>
<td>$3.42</td>
<td>$0.14</td>
<td>$3.56</td>
<td>24.1 to 1</td>
</tr>
<tr>
<td>$5,000,000 - $9,999,999</td>
<td>0.15%</td>
<td>$6.73</td>
<td>$0.32</td>
<td>$7.04</td>
<td>21.3 to 1</td>
</tr>
<tr>
<td>$10,000,000+</td>
<td>0.05%</td>
<td>$16.72</td>
<td>$0.56</td>
<td>$17.28</td>
<td>29.7 to 1</td>
</tr>
</tbody>
</table>

Indemnity Ranges, $1M+

- **Average Legal Paid (in millions)**
- **Average Indemnity Paid (in millions)**

![Chart showing indemnity ranges and I/L ratios](image-url)
Early Resolution

Generally speaking, early resolution of claims leads to cost savings with respect to legal expenses due to a decrease in the length of the litigation phase and, in many instances, avoidance of litigation entirely. In our experience, early resolution has also lead to a reduction in indemnity expenditures. Our data shows combined expenses (Indemnity plus Legal) for claims resolved within 6 months to be $1.95 million, versus longer periods where combined expenses range from $2.93 million-$3.47 million. Additionally, our data also shows that matters resolved pre-suit average a combined expense of $1.95 million, while matters resolved post-suit, but pre-verdict, average a combined expense of $2.92 million, or roughly 50% more.

In other words, our data suggests that early resolution of a claim (within 6 months, and/or prior to suit being filed) can lead to a cost reduction of as much as 50%. This is not to say that every claim must be or can be resolved within 6 months, or prior to filing of suit. There are a myriad of reasons why claims may take years to resolve. Development of liability and/or damage information is complicated for all parties involved, and the required information is not always readily available. However, setting an early resolution goal appears to have across-the-board benefits, not the least of which is compensating the plaintiff earlier for his or her loss, rather than having to navigate through protracted litigation.
**Age as a Factor**

As our data suggests, the age of the plaintiff at the time of the alleged incident will greatly impact the ultimate damage value and area of damage focus of a particular claim. This is largely due to its impact on the future lost earnings/future cost of care calculations. These economic damages can vary widely depending upon many factors. For example, with infants, we see exorbitant future cost of care estimates emanating primarily from severe birth related injuries, and therefore would expect to see greater average indemnity paid when compared to most other age categories. The middle age categories (30-59 years) bring an entirely different set of challenges. These are the traditional prime earning years for adults. Thus, the focus often switches from future cost of care to future lost wages. As the plaintiff’s age at the time of the alleged incident progresses to post-retirement age, we see a precipitous drop-off in the average indemnity paid, primarily driven by the reduced potential earning claim, as well as the limited life expectancy when calculating future cost of care.

### Claimant Age

<table>
<thead>
<tr>
<th>Claimant Age in Years</th>
<th>Average Indemnity Paid (in millions)</th>
<th>Average Legal Expense Paid (in millions)</th>
<th>Indemnity to Legal Expense Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Than 1 Year</td>
<td>$3.68</td>
<td>$0.20</td>
<td>18.8 to 1</td>
</tr>
<tr>
<td>1 to 5 Years</td>
<td>$2.06</td>
<td>$0.13</td>
<td>16.5 to 1</td>
</tr>
<tr>
<td>6 to 10 Years</td>
<td>$3.27</td>
<td>$0.07</td>
<td>45.0 to 1</td>
</tr>
<tr>
<td>11 to 19 Years</td>
<td>$3.75</td>
<td>$0.31</td>
<td>12.2 to 1</td>
</tr>
<tr>
<td>20 to 29 Years</td>
<td>$2.75</td>
<td>$0.19</td>
<td>14.1 to 1</td>
</tr>
<tr>
<td>30 to 39 Years</td>
<td>$3.26</td>
<td>$0.20</td>
<td>15.9 to 1</td>
</tr>
<tr>
<td>40 to 49 Years</td>
<td>$2.90</td>
<td>$0.18</td>
<td>16.3 to 1</td>
</tr>
<tr>
<td>50 to 59 Years</td>
<td>$2.40</td>
<td>$0.11</td>
<td>21.0 to 1</td>
</tr>
<tr>
<td>60 to 69 Years</td>
<td>$1.98</td>
<td>$0.17</td>
<td>11.7 to 1</td>
</tr>
<tr>
<td>70 to 79 Years</td>
<td>$1.45</td>
<td>$0.18</td>
<td>8.1 to 1</td>
</tr>
<tr>
<td>80+ Years</td>
<td>$2.04</td>
<td>$0.23</td>
<td>9.0 to 1</td>
</tr>
</tbody>
</table>
Severity of Injury

The graph below illustrates the average Indemnity and Legal Expenses paid on claims with the most severe, often catastrophic injuries, as well as the corresponding Indemnity to Legal paid ratios. Generally speaking, the ratios for these categories are fairly consistent, all in the double digits. However, when we examine the Psychological Injury category, we see that the Indemnity to Legal Defense Ratio changes dramatically. This change can be directly attributed to the issue of whether the plaintiff truly suffered a psychological injury, and if so, to what extent? It's significantly easier to determine the validity of, for example, an allegation of amputation resulting from the alleged wrongful act than it is to determine the validity of a psychological injury.

Alleged Injury

- **Brain Damage**
  - Average Indemnity Paid: $3.74M
  - Average Legal Paid: $0.17M
  - I/L Ratio: 21.4 to 1

- **Quadriplegia/Paraplegia**
  - Average Indemnity Paid: $3.37M
  - Average Legal Paid: $0.23M
  - I/L Ratio: 14.6 to 1

- **Amputation**
  - Average Indemnity Paid: $2.78M
  - Average Legal Paid: $0.14M
  - I/L Ratio: 19.6 to 1

- **Psychological Injury**
  - Average Indemnity Paid: $3.37M
  - Average Legal Paid: $0.36M
  - I/L Ratio: 6.9 to 1

- **Death**
  - Average Indemnity Paid: $2.34M
  - Average Legal Paid: $0.20M
  - I/L Ratio: 11.6 to 1

Resolution of this issue often times requires additional expenditures, regardless of the severity of the alleged psychological injury. Whether it be through motion practice, discovery, or expert review, this at times amorphous injury allegation inevitably results in additional time and expense to root out the truth from fiction. It is only when both parties have, to their satisfaction, reasonably determined the extent of the alleged psychological injury that these matters put themselves on a path toward resolution.
In examining the Type of Claim alleged, be it by certain types of service provided, or by the alleged act, we see that many of the largest exposures emanate from Behavioral/Mental Health and OBGyn related matters, as opposed to the lower end of the spectrum Failure to Monitor claims. The Behavioral/Mental Health claims typically arise from an attempt, whether successful or not, to cause harm to themselves or others. These claims pose a unique problem for the healthcare provider. Can one truly stop others from harming themselves or third parties? Plaintiffs espouse the position that a mental health provider must take all steps necessary to prevent a tragic outcome, and that any harmful outcome, by its mere occurrence, stems from malpractice on the part of the healthcare provider. Defendants oppose this approach under the theory of inevitability. That is, a mental health provider must take reasonable steps to avoid the unwanted outcome, but ultimately the patient will likely succeed in at least attempting to do what they set out to do. Judges are not hesitant to prohibit introduction of evidence of the patient’s culpability altogether, leaving the jury no other option but to find the mental health provider at fault. However, when presented with evidence of the patient’s culpability, juries will often conclude that the patient must answer for his or her own actions, and return a verdict that places much, if not all, of the culpability on the patient.

A minority of jurisdictions (North Carolina, Virginia, District of Columbia, Alabama and Maryland) adhere to the doctrine of pure contributory negligence, whereby a claimant’s own negligence relieves a defendant of all liability for negligence. However, even within this minority group, North Carolina and Alabama courts have ruled that a patient’s suicide or attempted suicide could constitute a breach of this duty, resulting in a finding of negligence on the part of the defendants.
Regardless of the type of medical malpractice claim, a disturbing trend has emerged in recent years. Medical malpractice juries are awarding unprecedented damage amounts, some reaching into the hundreds of millions of dollars. These “mega-jury verdicts” continue to be a growing concern in the healthcare field. Against this high stakes backdrop, battles continue to rage between doctors and the plaintiffs’ bar over damage caps on healthcare malpractice awards.

In Estate of McCall v. United States, 134 So.3d 894, 901 (Fla. 2014), the plaintiffs’ bar won the battle in Florida; persuading the Florida Supreme Court that the state’s cap on non-economic damage was unconstitutional in wrongful death claims. However, an initiative on the November 2014 ballot in California to raise the medical malpractice non-economic damage cap from $250,000 to $1.1 million was soundly defeated by a 2 to 1 margin. After the election, however, the California Supreme Court accepted review of a case that challenges the constitutionality of the caps. Additionally, battles are being waged on many fronts with respect to the Affordable Care Act and it’s applicability to economic damages in personal injury claims.
Mega-Jury Verdicts; Healthcare Malpractice Damage Caps; and the Effect of the Affordable Care Act on Economic Damages

I. Mega-Jury Verdicts

In the past few years, there have been 12 healthcare malpractice verdicts of $50 million or more, with six of those verdicts exceeding $100 million:

- $178 million awarded by a jury in Jacksonville, Florida in 2012 to a former police officer who allegedly suffered severe complications, including brain damage, after gastric bypass surgery.9
- $144 million awarded by a jury in Cooperstown, New York in 2012 to a woman who alleged that hospital physicians caused severe damage to her heart.10
- $140 million awarded by a jury in Baldwin County, Alabama in 2012 in the death of a woman, allegedly as a result of medication error.11
- $130 million awarded by a jury in Suffolk County, New York in 2013 to a family who alleged their child suffered brain damage during delivery.12
- $120 million awarded by a jury in New York, New York in 2013 to a family who alleged their child suffered brain damage when her doctors failed to diagnose her rare skin disorder.13
- $103 million awarded by a jury in Staten Island, New York in 2012 to a family who alleged their child suffered brain damage during delivery.14
- $78.5 million awarded by a jury in Philadelphia, Pennsylvania in 2012 to the mother of a baby who allegedly became quadriplegic as a result of a delayed delivery.15
- $74 million awarded by a jury in San Luis Obispo, California in 2012 to a family who alleged their child suffered brain damage during delivery.16
- $64.3 million awarded by a jury in Brooklyn, New York in 2014 to a woman who required amputation of both legs, allegedly as a result of negligent surgery.17
- $55 million awarded by a jury in Leigh County, Pennsylvania in 2013 to a family who alleged their child suffered brain damage during delivery.18
- $55 million awarded by a jury in Baltimore, Maryland in 2012 to a family who alleged their child suffered brain damage during delivery.19
- $50 million awarded by a jury in Seattle, Washington in 2013 to a couple who alleged that a medical center and a laboratory testing facility failed to diagnose a serious genetic defect in their unborn child.20
Experts do not definitively agree on the reasons giving rise to the increase in mega-jury verdicts. Some experts believe that the poor economy led jurors to give larger awards. However, this theory would not explain the continuing trend of larger awards despite the improving economy.

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Some say the increase is partly a result of courts empanelling juries of less than 12 people, as well as permitting juries to reach verdicts that are not unanimous. These experts believe smaller juries give rise to "group think" in which the group will reach a result that the jurors would not reach individually. Psychological studies have found that in smaller juries, the members are more cohesive, while larger juries tend to be more argumentative; debate the issues more thoroughly; collectively recall more evidence; and make more consistently predictable decisions. However, the concept of smaller juries and non-unanimous verdicts in civil matters is not new to the tort world.

One could theoretically conclude that there are claims with more serious injuries occurring. However, the more likely explanation would point to several other factors, including the unintended consequence of tort reform, which has led to the plaintiffs' bar focusing more on quality (severity) rather than quantity (frequency).

The necessary shift by the plaintiffs’ bar from emphasis on non-economic damages to economic damages has likely resulted in more sustainable, larger verdicts. Rather than asking a jury for $50 million in pain and suffering, plaintiffs will put before the jury evidence that the injuries will result in economic harm to the plaintiff to the tune of $50 million.

Future life care costs can span many decades, and when inflationary models are introduced, increase the potential value presented to a jury exponentially. This exponential effect can have a devastating impact on the jury’s award. While the plaintiff will argue that their inflated figure is appropriate, the defense will counter that the actual economic damages are much lower. The plaintiff will then ask the jury, “You and my client only get one chance at this. If you’re going to be wrong on the damages, would you rather be wrong on the low side, or on the high side?” While this rationale is compelling, it may not fully explain the mega verdicts.
Further fueling this mega verdict trend, the average American has become desensitized to larger monetary figures in their every day lives. The general public is deluged with stories about lottery prizes and sports contracts in the hundreds of millions of dollars; twenty-something internet billionaires; and trillion dollar deficits. With those reference points, it cannot be surprising that a jury may be more willing than ever to award larger sums.

While this may explain a jury’s willingness to award higher amounts, plaintiffs still must present a compelling case to the jury, while defendants must battle plaintiff’s claims in order to keep the juries grounded.

Experts generally agree whether or not a jury returns a mega verdict rests on three basic principals:

(1) which side will win the battle of the “anchor” numbers selected by the jurors?

(2) will the plaintiff succeed in providing the elements of “moral outrage,” or can the defendants avoid the moral outrage outcome?; and

(3) are the members of the jury prone to awarding high verdicts?

a. The Anchor Number

Strong evidence in jury research suggests that jurors respond to conflicting damage evidence by selecting an “anchor” number from the trial testimony or arguments, or from their own experience. The jurors then incrementally adjust this number to arrive at the final result. “Anchors” are an example of an availability heuristic — a mental shortcut that relies on immediate examples that come to mind. The availability heuristic can be problematic for either party because jurors rely on these shortcuts instead of logically working through the issue of damages. Jurors with higher anchor numbers tend to award larger damage amounts. Conversely, jurors with lower anchor numbers tend to award smaller damage amounts.

Experts believe that because of the availability heuristic, extremely large damage awards can become self-perpetuating through media publicity. Cases that result in large damage awards are reported by the news media or other information sources more frequently than cases with small awards. Consequently jurors are more likely to remember the large damage awards. These large awards may become the “anchor number” that the jurors bring to the case. Additionally, because large damage awards are more easily remembered, potential jurors may wrongly perceive that large damage awards are awarded more frequently than is actually the case. Jurors who believe that large damage awards occur more frequently are more likely to vote for a large award.

One recent study exposed participants to an article about a $14 million products liability verdict, and then had the participants evaluate liability and damages in a different products liability case either three days or three weeks later. Other participants were exposed to articles about a $4.75 million verdict and an $800,000 verdict. Participants who read the article about the $14 million verdict awarded over $1 million in the case before them, while those who read the articles about the lesser verdicts returned awards ranging from $96,000 to $226,000.
Thus, the challenge faced by defendants is either to rid jurors of this belief, or to convince jurors to anchor to a lower figure. This is no small feat considering society’s general desensitization to large sums of money.

One of the most formidable anchors in a jury trial is the damage amount suggested by the plaintiffs’ counsel. Numerous studies have shown that the higher the demand, the higher the award, with the caveat that a plaintiff’s credibility can be damaged by asking for an unreasonably large award. In order to combat this anchoring effect, defense counsel should present jurors a counter anchor.

Some defense attorneys may be reluctant to counter the plaintiff’s demand because they believe that offering an alternative damage number will be seen by the jury as a concession of liability, and that an alternative damage amount could become a floor for the jury.

Studies have shown that proposing a counter anchor is preferable to leaving the jury to consider only the plaintiff’s figure. In a 2000 report, published after the Pennzoil-Texaco $10.53 billion verdict, several jurors stated after the verdict that they accepted the plaintiff’s damage number as correct because the defense did not challenge it, or propose a counter in closing arguments. Similarly, a study of North Carolina juries found that when defendants produced no testimony contesting the plaintiff’s damage estimates, jurors felt they had no choice but to rely on the plaintiff’s damage evidence.

A recent mock juror study also concluded that the larger the award asked for by the plaintiff, the larger the award given by the jury. The study also found that the defense was best able to reduce the case value by providing a reasonable counter damage figure. While the study found that providing a counter number was not seen as a concession of liability by the defendant, the authors noted that the case presented to the mock jurors was a close call on liability, with the plaintiff winning about 40 percent of the time. The authors noted that other studies have found that providing an alternative damage figure where liability defenses are strong, may be seen as a concession of liability.

Despite the potential risk involved in arguing both for a defense verdict on liability and to propose reasonable alternative damages, it is nonetheless essential for the defense to do so. The research is clear that without a reasonable anchor to balance the plaintiff’s demand, jurors likely will rely upon the plaintiff’s demand as the focal point of their damage evaluation and ultimately award higher damages than if given an alternative, lower figure by the defense.

Another key to avoiding a mega-jury verdict is to make the jury understand just how far, for example, $1 million can go in today’s world. This will assist in further grounding the jury, likely resulting in the jury questioning whether the figures proposed by the plaintiff are realistic.
b. “Moral outrage,” The “Reptile” Theory, and its impact on Jury Awards

Savvy plaintiffs’ lawyers know that a desirable healthcare malpractice case has a likeable plaintiff who will be perceived as vulnerable by the jury, a potentially unlikeable defendant, and serious and permanent injuries, preferably to a living victim. Knowing that this will fuel extreme verdicts, the plaintiffs’ lawyer will try to evoke moral outrage from the jury. A morally outraged jury is more likely to (1) find against the defendant, (2) be more punitive in setting damage amounts, and (3) be more certain that their verdict is correct.38

In recent years, the plaintiffs bar has taken to utilizing the “reptile” theory39 in an attempt to convince jurors to return mega awards. Basically, the plaintiff portrays the defendant’s conduct as a threat to jurors’ own safety and the safety of others. A reptile theorist’s goal is to get the jurors out of their normal world and into survival mode. They want the jurors to believe that in order to protect and preserve society, the defendant must be punished.

How does the plaintiffs bar accomplish this? They attempt to persuade the jurors that if they don’t punish the defendants, the jurors themselves are likely to suffer the same fate as the plaintiff once they walk out of the courthouse. The reptile theorist wants the jury to ask themselves “What if this happened to me?” The plaintiff bar will attempt to talk about “safety” rather than “standard of care.” They will implore the jury to ask “What would have kept the plaintiff and society safe?” This is not the appropriate standard. The appropriate standard is reasonableness. The expectation is that, armed with this outrage and fear, the jury will ignore the facts and the law, and instead punish the defendant by returning a mega award.

Moral outrage evokes dangerous emotional reactions from jurors, including more reliance on prejudices and stereotyping. At the same time, it makes jurors less likely to process information carefully and thoughtfully, and results in superficial information processing.40 This process leads to “motivated reasoning.” That is, once a person knows what decision they want to make, then they’ll find the rationale to support their decision.

While some experts say that outrage is only a stronger word for anger, research41 suggests that moral outrage is a combination of both anger and disgust. To test this theory, researchers reviewed mock juror reactions to felony murder and rape trials, as well as a civil trial with allegations of intentional infliction of emotions distress based upon funeral picketers carrying signs that said “Thank God for dead soldiers.” The researchers concluded that moral outrage required both anger and disgust, and that disgust was a more consistent predictor of moral outrage than anger.

It is incumbent upon the defendant to prepare a counter to this strategy, attack it head-on, gain the moral high ground, and get the jury back to the facts and the law of the case. The defense must thwart any attempts by the plaintiff to dehumanize the defendants, and instead show the jury their human side. They must bring the jury back from the emotional pull of the plaintiff, to the logical/
fact based decision they should be making. That is, get the jury to be motivated by fairness under the facts and law of the case, rather than fear and outrage.\textsuperscript{42} Experts say that the single biggest factor in avoiding moral outrage in healthcare malpractice cases is for the jury to perceive the defendant as likeable.\textsuperscript{43} A defendant who is perceived by the jury as belligerent or arrogant is likely to provoke moral outrage. To avoid this outcome, a defendant needs to come across as someone with humility whose interest lies in aiding patients.\textsuperscript{44} Experts agree that defendants who make a favorable impression on the jury are rarely subject to extreme damage awards, regardless of the evidence against them.\textsuperscript{45}

c. Identifying the High Verdict Juror

It is essential for the defense team to identify potential high verdict jurors during the voir dire process. There are many methods employed, all of which have merit. While many take the approach of attempting to identify common characteristics in a high verdict juror, the best indicators of a juror’s approach to the claim emanate from the juror’s own life experiences. Accordingly, the defense team should engage in a line of questioning that encourage the potential juror to share any life experience that may influence their verdict.

II. Healthcare Malpractice Damages Caps

The struggle continues over healthcare malpractice damage caps. Approximately one-half of the fifty states currently have some form of cap on healthcare malpractice damages. Of the half that do not, ten states statutorily enacted healthcare malpractice damage caps which were then struck down by their respective state courts.\textsuperscript{46} In five other states, such caps are expressly prohibited by the state constitution.\textsuperscript{47} Among those states with caps still in place, several have caps with built in increases.\textsuperscript{48}

The disparity between states that have enacted a malpractice cap and those that appear to be moving away from caps are indicative of an ongoing debate regarding the utility of such caps. Those in favor of caps espouse the position that caps result in reduced healthcare malpractice premiums, and near elimination of frivolous suits, thus freeing up court dockets. Those opposed to caps argue that premiums have not been reduced, and that caps result in lack of appropriate compensation to those who have been injured as the result of malpractice. Opponents also argue that caps result in less motivation on the part of healthcare providers to avoid negligent care, although studies do not support this proposition.
a. Florida—Judicial Rejection of Caps

Recent developments in Florida highlight the nature of the dispute and potentially offer insight into the future landscape of healthcare malpractice damage caps in the U.S. In McCall v. U.S., 134 So.3d 894 (Fla. 2014), the Florida Supreme Court reviewed the constitutionality of a legislative cap on non-economic damages\textsuperscript{49} in wrongful death healthcare malpractice cases. In a 5-2 decision, the court concluded that the cap was unconstitutional, reasoning that it was arbitrary and unrelated to any true state interest, and that it imposed an unfair burden on injured parties. Some of the judges in the majority also took issue with the validity of the legislature’s stated position that caps were an appropriate response to the state’s healthcare malpractice crisis, stating that they believe the crises has passed.

b. California—Voter Review of Caps

In November 2014, Californians voted “No”\textsuperscript{50} on an initiative that would have, among other things, raised medical malpractice caps on non-economic damages (MICRA\textsuperscript{51}) from $250,000 to over $1.1 million (thereafter indexed to inflation) for all unresolved claims on January 1, 2015, whether filed pre- or post-enactment. Proposition 46, officially entitled “Drug and Alcohol Testing of Doctors. Medical Negligence Lawsuits. Initiative Statute,” also required random drug testing of physicians. Opponents of the initiative pointed to the prejudicial impact of having the cap issue paired with the drug testing issue. By some estimates, more than $60 million combined was raised by both sides to espouse their respective positions on this initiative, making it by far the most expensive referendum in U.S. history.\textsuperscript{52}

The fiscal impact statement, jointly prepared by the state’s Legislative Analyst and its Director of Finance, prior to the vote stated:

“State and local government costs associated with higher net medical malpractice costs, likely at least in the low tens of millions of dollars annually, potentially ranging to over one hundred million dollars annually. Potential net state and local government costs associated with changes in the amount and types of healthcare services that, while highly uncertain, potentially range from minor to hundreds of millions of dollars annually.”\textsuperscript{53}

While this initiative was defeated, the California Supreme Court has accepted review of a case challenging the constitutionality of the malpractice cap.\textsuperscript{54}
III. Damages Awards After Healthcare Reform

The full implementation of the Affordable Care Act or “ACA” raises an interesting specter in the healthcare malpractice tort field. Under the ACA, health insurers are now required to provide coverage regardless of preexisting conditions, and the law mandates that everyone obtain coverage. Accordingly, for the cost of the premium, patients injured by medical malpractice are guaranteed the right to purchase healthcare coverage for most categories of future medical expenses. This change in the legal landscape undermines the justification for traditional state-law doctrines that barred a defendant’s ability to reduce damages by amounts the plaintiff recovers from other sources.

The common-law collateral source rule precludes offsetting a damages award by amounts that the plaintiff would recover from insurance. For example, if patient incurred $10,000 in medical bills allegedly as a result of medical malpractice, the defense was barred from offering evidence that the patient’s health insurance paid any portion of the $10,000. In theory therefore, the patient could recover $10,000 from the medical provider despite the fact that his insurer paid that entire amount. This rule survives in various forms in many states today. Courts reason that it is better to permit the plaintiff a double recovery than to allow the defendant to escape paying damages for wrongdoing by the fortuity that the plaintiff had the foresight to procure insurance. Additionally, courts reasoned that to do otherwise would be to discourage the purchase of insurance, and that insurance might be unavailable for the injured plaintiff.

This rationale is considerably weaker in an era of guaranteed issue and individual mandates under the ACA. The health insurance mandate — determined by the U.S. Supreme Court to be a “tax” — directly encourages the purchase of insurance. This determination effectively renders moot the age-old argument that collateral source evidence has a chilling effect on the optional purchase of health insurance by an injured party. A person considering whether to buy health insurance is likely to consider the threat of the IRS collecting a penalty payment to be far more significant than any potential chilling effect. In addition, a person injured by medical malpractice will be able to purchase health insurance notwithstanding any pre-existing condition.

Careful and strategic efforts to address this issue with courts are paramount. Adverse rulings can have long-term damaging effects in other jurisdictions, where the plaintiff bar will cite the adverse ruling as precedent in favor of the survival of the collateral source rule.

Calculation of future medical expenses routinely involves estimates of the full future cost of an array of medical products and services, with totals often in the millions of dollars. Under the ACA most, if not all, of these medical costs will be covered for the cost of premiums (currently a maximum of $6,250 per year for an individual) plus the legal maximum out-of-pocket expenses.
Defendants arguing for limits on future medical expenses should carefully prepare expert testimony to analyze precisely what portions of the plaintiff’s claimed future medical expenses are reasonably certain to be covered by available health insurance under the ACA, and further analyze the marginal cost to procure that coverage. The expert should demonstrate that much of the lifetime care the injured plaintiff claims is necessary will be paid by the plaintiff’s health insurer at a marginal cost to the disabled plaintiff. While it might be appropriate to award damages representing the cost of the premiums and potential of out-of-pocket expenses, awards assuming that the plaintiff will have to expend all sums for the projected care are unrealistic.

The healthcare reform legislation also presents an intriguing opportunity to attack alleged past medical billings as excessive. For example, hospitals routinely list the price of care at a rate well above that paid by any insurer. Health insurers routinely negotiate rates well below the hospital’s “list price.” When a plaintiff presents bills for medical care incurred between the time of injury and the trial, many courts will disallow evidence that the hospital (or other healthcare provider) accepted as payment in full an amount significantly below the amount shown on the face of the bills. The plaintiff often argued that even though the hospital routinely wrote down or wrote off these charges when an uninsured patient was unable to pay, it theoretically could seek to collect the full amount. However, in a post-healthcare-reform world, the law assumes that the uninsured population is effectively zero. All patients are presumed to have insurance, and health insurance companies do not typically pay the inflated list price. In these circumstances, arguments that the list price rather than the cost to the insurer represents the actual cost of medical expenses are considerably weaker.

IV. Conclusion

The current picture on healthcare malpractice claims is not all bleak. Without question, extreme jury awards are outliers. Generally speaking, only about 7% of all healthcare malpractice cases ever go to trial.58 Of those, medical providers successfully defend the vast majority – with some studies suggesting more than 75% result in defense verdicts.59 Even in matters where the plaintiffs succeed on liability, the average damage award is approximately $800,00060 – a significant sum, but still a far cry from the tens of millions of dollars awarded in extreme cases.

Additionally, the jury verdict is not the last word. A Rand Corporation study61 showed that post-trial settlements are more common when a large verdict is returned, and often lead to substantial reductions in the amount that plaintiffs ultimately receive. This is in large part driven by the risk of reversal of the verdict, or reduction of the award by the trial or appellate court.62 It is axiomatic that continued strong team work between the medical provider, carrier, and defense counsel is essential when defending these matters.
Citations

1 Marco Spadacenta is the Senior Vice President of Healthcare Malpractice Claims at AIG. He is a graduate of St. John’s University, earning both a Bachelor of Science Degree in Management (1987), and a Doctor of Jurisprudence Degree (1990).

2 Failure to Monitor Claims include: failure to respond to system alarms; failure to regularly check on the patient; and failure to take regular periodic action, such as turning the patient or monitoring vital signs.

3 By contrast, the majority of jurisdictions follow the doctrine of comparative negligence, whereby “[a] plaintiff’s own negligence . . . proportionally reduces the damages recoverable from a defendant.” Black’s Law Dictionary (9th ed. 2009), negligence.

4 See, e.g., Patton v. Thompson, 958 So 2d 303, 311 (Ala. 2006) (plaintiff may prevail in malpractice action with substantial evidence that psychiatrist breached applicable standard of care and breach was proximate cause of patient’s death); Muse v. Charter Hosp. of Winston-Salem, Inc., 117 N.C. App. 468, 478 (N.C. Ct. App. 1995) (contributory negligence no bar to recovery in case involving suicide where defendant’s conduct wanton or willful).

5 As of this publication, the Florida Supreme Court is weighing the constitutionality of the state’s cap on non-economic damage in non-wrongful death medical malpractice claims.

6 The initiative also includes subsequent incremental increases over the coming years.


24 The only positive outcome from immense future care costs being presented to a jury is that these cases seldom result in significant non-economic awards, as juries are reticent to award large non-economic damage amounts on top of immense economic damage awards.


29 However, the article’s effect three weeks later was minimal.

30 Interestingly, the jurors who awarded the higher damages three days after reading the study were participants least likely to say that the news article affected their decision.


34 Campbell, supra note 5, at 20.

36 The study also concluded that as the plaintiff’s demand increased, so did plaintiff’s chances of an adverse verdict on liability.

37 Campbell, supra note 5 at 10, 17-20; Vidmar, supra note 11.


40 When people are angry or disgusted, they are less likely to process information carefully, to use new information, or to think about alternatives. Peter-Hagene, supra note 14 at 7.

41 Peter-Hagene, supra note 14 at 4-5.

42 Another approach is to turn the moral outrage on the plaintiff by showing that the plaintiff is putting her or her own economic self interests above those of society as a whole.


44 It is important to note that cases are often won or lost at deposition. Donald F. Ladd, Kevin C. Cottone, General Guidelines for the Physician’s Deposition in a Medical Malpractice Case, http://www.whiteandwilliams.com/resources-alerts-59.html (last visited Feb. 21, 2015); O’Toole, supra note 42. Plaintiff’s attorneys will make every attempt to goad the medical provider into angry outbursts during deposition that may be difficult to defend at trial. Needless to say, preparing a witness for deposition is vital. Id. When preparing a medical provider for deposition, the defense team should remind the provider of the Biblical admonition: “A soft answer turns away wrath, but a harsh word stirs up anger.”

45 Belk, supra note 38.


47 Arizona, Arkansas, Kentucky, Pennsylvania and Wyoming.


49 The cap is $500,000 or $1 million depending upon the number of medical providers or plaintiffs involved.

50 The finals results were 67% opposed to the initiative and 33% in favor of the initiative.

51 The Medical Injury Compensation Reform Act (MICRA), signed into law in California in 1975, capped non-economic damages resulting from medical malpractice at $250K. The cap has been the subject of political maneuvering and nonstop debate between the medical industry and trial lawyers over the last four decades. Recently, (prior to the initiative), State Senate President Darrell Steinberg (D) unsuccessfully tried to broker a legislative compromise that would have raised the cap to $500K. See, e.g., Sharon Bernstein, California Measure to Raise Malpractice Cap Gets High Profile Backer, Reuters (Mar. 31, 2014, 2:00 PM), http://reuters.com.


54 Schencker, supra note 7.


57 See Joshua Congdon-Hohman & Victor A. Matheson, Potential Effects of the Affordable Care Act on the Award of Life Care Expenses [Dec. 2013], http://www.holycross.edu/departments/economics. Some expenses, such as long-term facility care or some types of in-home care, may not be covered under the ACA.

58 Of the 93 percent of medical malpractice cases resolved before trial, 61 percent ended favorably for the plaintiff. Some studies show the average settlement award for medical malpractice to be about $462,000.


61 For example, a New York appeals court in 2011 reduced a $60 million medical liability verdict to $600,000, saying it was excessive. Hugh v. Ofodile, 87 A.D.3d 508, 929 N.Y.S.2d 122 (2011).
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