

## Medical Tort: Ranking the 50 States

By John R. Graham

### Key Points:

- States' liability laws drive medical-tort costs, which increase health costs.
- Evidence indicates that medical-tort costs are higher than optimal, with consequences including unfair verdicts, reduced availability of doctors, and increased use of wasteful "defensive" medicine.
- Eight variables contribute to a medical-tort index that measures all 50 states' success at reforming medical-tort laws to mitigate these problems, and provides a partial update to the 2009 *U.S. Index of Health Ownership*.
- Mississippi, Nevada, Michigan, Colorado, and Louisiana have been most successful at reforming medical tort; the least successful include Vermont, Rhode Island, Kentucky, Pennsylvania, and Iowa.

For three years, 2007 through 2009, PRI published the *U.S. Index of Health Ownership*.<sup>1</sup> The *Index* continues to be the only effort to measure the degree to which individuals, whether patients, health professionals, entrepreneurs, or taxpayers, "own" the health care in their states. It quantifies how state laws and regulations affect the liberty of citizens involved in state government health plans (primarily Medicaid), the private health insurance market, and the provision of medical services, as well as the effect of medical tort on people's freedom to engage health services.

Although there will not be a new edition for 2010, new research allows an update of one of the four categories of health ownership: medical tort. Lawrence J. McQuillan and Hovannes Abramyan have recently completed a 2010 edition of the *U.S. Tort Liability Index*, which has a number of measurements included in the *U.S. Index of Health Ownership*. The latest edition of the *U.S. Tort Liability Index* includes 42 variables.<sup>2</sup>

Thirteen of these measure outputs, and 29 measure inputs. McQuillan and Abramyan rank the states by taking a simple average of each type of measurement (but they do not publish a ranking that includes all 42 measurements). Alaska, Hawaii, and North Carolina perform best according to the ranking of outputs, whereas Oklahoma, Texas, and Ohio bested the ranking of inputs.

Eight of the measurements in the *U.S. Tort Liability Index* are relevant to the *U.S. Index of Health*

*Ownership*: one output and seven inputs. The previous edition of the *U.S. Index of Health Ownership* included six measurements of medical tort, but McQuillan and Abramyan have discovered more variables for their 2010 edition of the *Tort Liability Index*, allowing more detailed measurement.

As a partial update of the *U.S. Index of Health Ownership*, this *Health Policy Prescription* calculates a medical-tort index from a simple average of the eight relevant variables:

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**Reducing the burden of medical tort is critical to increasing Americans' health ownership and reducing medical costs that curtail our access to care. Some progress is evident, but states aiming to improve their medical-tort laws still have a long way to go.**

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1. The ratio of medical-malpractice insurance losses per projected personal health expenditures in 2008. The data come from A.M. Best Company and the Centers for Medicare and Medicaid Services.
2. Caps on non-economic-damage awards in medical-malpractice lawsuits. This tracks whether a state has limits on non-economic damages or has increased the negligence standard required for medical malpractice. For example, North Dakota has a \$500,000 limit. McQuillan and Abramyan cite evidence that capping non-economic damages reduces defensive medicine.
3. Caps on punitive-damage awards in medical-malpractice lawsuits. For example, Washington does not allow punitive damages, and Alaska limits them to \$500,000 or three times compensatory damages. McQuillan and Abramyan cite evidence that capping punitive damages lowers medical-malpractice premiums.
4. Attorney-fee limits for medical-malpractice cases. New York, for example, uses a sliding scale: Lawyers can take 30 percent of the first \$250,000 of an award, 25 percent of the next \$250,000, 20 percent for the next \$500,000, 15 percent of the next \$250,000, and 10 percent above \$1.25 million. McQuillan and Abramyan cite evidence that such limits increase the supply of physicians in a state.
5. Pre-trial screening or arbitration in medical-malpractice cases. Pre-trial screenings determine the validity of a case, while arbitration is an alternative to trial. Nebraska, for example, mandates review of medical-malpractice claims by a panel before proceeding to trial. Oregon mandates dispute resolution within 270 days of filing an action, unless both parties waive mediation or arbitration. McQuillan and Abramyan cite evidence that these opportunities reduce the number of meritless cases.
6. Does the state allow a "Food and Drug Administration (FDA) defense" or a "Federal Trade Commission (FTC) defense"? These defenses allow some immunity if the FDA has approved the therapeutic product or the FTC has approved its advertising. For example, West Virginia holds that health providers are not liable for personal injuries caused by an FDA-approved drug. These rules reduce the burden of over-regulation which limits investment by pharmaceutical and medical-device makers.
7. Conditions on the use of expert witnesses in medical-malpractice lawsuits. For example, Minnesota requires that medical-malpractice claimants sign an affidavit if they have consulted with an "expert." Michigan requires "experts" to be licensed and board-certified in the same specialty as the defendant, and that they be engaged in active practice or actually teaching medicine. These rules increase the likelihood of fair verdicts.

8. Statute of limitations on medical-malpractice cases. Kentucky, for example, sets its statute of limitations at one year from the alleged act or reasonable discovery, but no more than five years after the act. McQuillan and Abramyan cite evidence that such rules lower medical costs.

Although other variables included by McQuillan and Abramyan also influence health ownership, these eight are specific to health care alone. Therefore, they comprise the update to the medical-tort component of the *U.S. Index of Health Ownership*. Table 1 shows the results. Mississippi, Nevada, Michigan, Colorado, and Louisiana lead the pack; while Vermont, Rhode Island, Kentucky, Pennsylvania, and Iowa bring up the rear. Even the leaders, however, lag in some measurements.

Mississippi, for example, leads on procedural rules: Pre-trial screening or arbitration and conditions on the use of expert witnesses. However, it does not limit lawyers' ability to abuse their privilege by limiting their share of awards. Colorado and Louisiana also fail to impose limits. Unfortunately, the laggards do not show a similar pattern: The bottom five states perform poorly in all eight measurements.

Reducing the burden of medical tort is critical to increasing Americans' health ownership and reducing medical costs that curtail our access to care. Some progress is evident, but states aiming to improve their medical-tort laws still have a long way to go.

## Endnotes

- 1 John R. Graham, *U.S. Index of Health Ownership*, 3<sup>rd</sup> edition (San Francisco: Pacific Research Institute, 2009).
- 2 Lawrence J. McQuillan and Hovannes Abramyan, *U.S. Tort Liability Index: 2010 Report* (San Francisco: Pacific Research Institute, 2010).

<b>2010 Medical-Tort Index</b>	
<b>State</b>	<b>Medical Tort Rank</b>
Mississippi	1
Nevada	2
Michigan	3
Colorado	4
Louisiana	5
Texas	6
Florida	7
Illinois	8
Oklahoma	9
Kansas	10
California	11
Alaska	12
Montana	13
Idaho	14
West Virginia	15
Massachusetts	16
New Hampshire	17
Nebraska	18
Indiana	19
North Dakota	20
Ohio	21
Arkansas	22
Arizona	23
Georgia	24
Delaware	25
Tennessee	26
Virginia	27
Utah	28
Missouri	29
New Jersey	30
North Carolina	31
Washington	32
Alabama	33
Minnesota	34
Wisconsin	35
South Dakota	36
South Carolina	37
Connecticut	38
Oregon	39
Maine	40
Maryland	41
New Mexico	42
New York	43
Wyoming	44
Hawaii	45
Iowa	46
Pennsylvania	47
Kentucky	48
Rhode Island	49
Vermont	50