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Does tort reform affect physician supply? Evidence from Texas☆,☆☆,☆☆☆,★

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ABSTRACT

Does state tort reform affect physician supply? Tort reformers certainly believe so. Before Texas adopted tort reform in 2003, proponents claimed that physicians were deserting Texas in droves. After tort reform was enacted, proponents claimed there had been a dramatic increase in physicians moving to Texas due to the improved liability climate. We find no evidence to support either claim. Physician supply was not measurably stunted prior to reform, and it did not measurably improve after reform. This is true for all patient care physicians in Texas, high-malpractice-risk specialties, primary care physicians, and rural physicians.

1. Introduction

The United States recently completed its third medical malpractice ("med mal") crisis in the last forty years. As with previous crises, a precipitous increase in malpractice premiums prompted a push for tort reform, especially in states that had not already enacted caps on non-economic or total damages ("damage caps"). Both sides deployed the standard mélange of anecdotes, slogans, talking points, and heartfelt appeals to larger principles. As in prior crises, physicians often had the upper hand, with nine states adopting new damage caps between 2002 and 2006, and seven more adopting caps on punitive damages or other reforms intended to limit malpractice suits.[1]

We focus on Texas, which adopted a strict cap on non-economic ("non-econ") damages and other reforms in 2003. These reforms contributed to a drop in total payouts on med mal claims of over 70% from 2003 to 2009. Physician supply issues played a prominent role in the tort reform debate in Texas. Proponents argued that physicians were fleeing Texas because of lawsuit risk and high insurance premiums, but would stop leaving if the state adopted tort reform. After the reforms took effect, they claimed that the reforms also brought new physicians to the state in droves—a more impressive result than the original prediction, which was only that doctors already in Texas would stay put.

In a previous article, we examined the number of physicians practicing in Texas post-tort reform.[2] Using active, direct patient-care (DPC) physicians per 100,000 Texas residents as a measure, we found no evidence of a pre-2003 decline and no evidence of a post-reform improvement. To the contrary, the rate of increase in Texas DPC physicians per capita was lower after reform. We did not suggest that tort reform caused the slowdown, which seems implausible. Instead, we hypothesized that physician supply is driven primarily by other factors, such as economic growth and the size of Texas' population of insured patients.

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☆☆ University of Illinois, Program in Law, Behavior and Social Science Research Paper No. LE12-12.
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[1] States adopting new damage caps were Florida, Georgia, Illinois, Mississippi, Nevada, Ohio, Oklahoma, South Carolina, and Texas. The caps in Georgia and Illinois have since been invalidated by the state courts. Arizona, Idaho, Missouri, and Montana adopted punitive damage caps; Pennsylvania and West Virginia adopted other reforms; and Alaska reduced the level of its existing cap on non-economic damages.
[2] Silver et al. (2008).

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Our prior study was tentative. We had data on DPC physicians for only four post-reform years (2004–2007). Moreover, the Texas Medical Board ("TMB") had reported a large increase in applications from doctors wanting to practice in the state. Texas' physician population could have grown rapidly in later years, perhaps reflecting a delayed impact of tort reform.

In this article, we extend our analysis through 2011—sufficient time to have a clearer view of the connection between Texas' tort reforms and patients' access to physicians. The bottom line: There is no evidence that the number of active Texas physicians per capita is larger than it would have been without tort reform. Any effect of tort reform is too small for us to measure, against the background of other, larger forces affecting physician supply, both in Texas and nationally. This "non-result" is consistent with other studies, most of which find that state-level tort reforms increase physician supply modestly, if at all. When we focus on three high-malpractice risk specialties highlighted by tort reform advocates – neurosurgeons, orthopedic surgeons, and ob-gynecologists – we again find no evidence of a relative increase in Texas after tort reform. We also find no increase in primary care physicians or rural physicians.

Our findings offer a counterpoint to the multi-state studies that do report statistically significant (albeit modest in magnitude) effects for high-risk specialties and/or rural physicians. Tort reform may not meaningfully affect physician supply in any individual state, even one which, like Texas, adopts far-reaching reform. In subsequent work, we study all none states that adopted damage caps in the early 2000x, and find no evidence of an increase in physician supply, whether total, patient care, high-risk, or rural.[3]

Part II briefly reviews prior research on the connection between liability risk and physician supply, describes the tort reforms enacted by Texas in 2003, and details how those reforms affected liability risk. Part III details the claims made by proponents, both before and after tort reform, about the impact of tort reform on physician supply. Part IV assesses the merits of those claims. Part V discusses our findings. Part VI concludes.

2. Background: Prior research and the Impact of Texas' 2003 reforms

2.1. Prior research

A number of prior multi-state studies have examined the extent to which tort reform influences physician supply. We summarize these studies here, but relegate details to Appendix A. The stronger multi-state studies use a difference-in-differences (DiD) research design. Taken as a whole, these studies provide evidence that damage caps, on average, have a small positive impact on physician supply in rural areas and some specific specialties, but mixed evidence for statewide physician counts. One recent review reports evidence of "modest improvement in physician supply" after cap adoption.[4] Another concludes, more equivocally, that research "has not convincingly established what role, if any, liability pressure plays in determining the size of the physician workforce, particularly within individual physician specialties".[5] Helland and Seabury (also published in this issue), study "third-wave" reforms, and find evidence of a post-reform rise in high-risk specialists, but our own study of these reforms finds no such evidence.[6] Given these modest multi-state findings, it would be surprising if tort reform advocates' claims of large effects (as described in Part III) were true.

We are aware of two Texas-specific studies (one unpublished) of the impact of tort reform on physician supply. The published study finds that the number of licensed physicians in Texas (whether engaged in patient care or not) increased modestly faster than Texas' population during the post-reform period (which we find as well, see Figs. 3 and 5). The authors found a 46% increase in physicians in metro areas v. a 9% increase in non-metro areas. This study does not compare Texas to national trends.[7] For the unpublished study, we have the text but not the supporting figures and tables. This study reports mixed evidence on whether reform affected the number of physicians engaged in patient care, but argues (relying on a prior study) that Texas physicians are likely to be working more hours as a result of tort reform.[8]

2.2. Tort reform, Texas style

In mid-2003, Texas enacted a package of med mal litigation reforms. The core reform was a cap on non-econ damages in cases filed after September 1, 2003. The cap limits non-econ damages against physicians and other individual licensed health care providers to $250,000 (nominal, not adjusted for inflation) for all of these individuals together. A separate $250,000 cap applies to each hospital or other licensed health care facility, with total non-econ damages capped at $500,000 for all health care facilities. Thus, the cap will be $250,000 if there is one liable defendant, but can be as high as $750,000 if there are multiple liable defendants.[9] The 2003 tort reforms also included a variety of less significant provisions.[10]

Post-reform, med mal claim rates and payouts dropped sharply.[11] As Fig. 1 reflects, from 1990 to 2003, per capita claim frequency and payouts were generally stable. We measure claim frequency as the number of "large" paid claims – those that closed with payments exceeding $25,000 – per 100,000 Texas residents that closed in a given year, and payout as the sum of all payments on these claims. (All amounts in this article are in 2008 dollars unless specified otherwise.)

Post-reform, large paid claims per 100,000 residents fell by 61% from 2003 to 2009, and the average payout per large paid claim dropped by 45%, for a combined drop of over 75% in total payouts. Payout per Texas resident dropped from $24.39 to $5.27.

Insurance premiums also fell. The largest insurer, Texas Medical Liability Trust, reported in 2009 that the 2003 reforms "dropped the cost of medical liability insurance by 50%" for its policyholders.[12] The Texas Tort Reform Association reported that other med mal carriers also reduced prices substantially.

To what extent did this transformation of the malpractice environment affect access to health care, proxied by the number of patient care physicians per capita in Texas? Part III reviews the claims made by reform proponents, both before and after reform.

[3] Paik, Black, and Hyman (2015).
[4] Kachalia and Mello (2011), at 1568.
[5] Yang et al. (2008), at 30.
[6] Helland and Seabury (2015); Paik, Black, and Hyman (2015).
[7] Stewart et al. (2013).
[8] Magee (2010) (relying on Helland and Showalter 2008).
[9] Texas Civil Practice and Remedies Code § 74.301.
[10] Other reform components include making the separate cap on damages in death cases apply per claim, rather than per defendant, higher evidentiary standards for cases involving emergency room care, a requirement that plaintiffs file an expert report within 120 days of suit with regard to each defendant's negligence (by a practicing physician, if the defendant is a physician), and a ten year statute of repose.
[11] Paik et al. (2012a,b).
[12] Texas Medical Liability Trust, 2009 Annual Report, p. 4. This is in nominal dollars; the decline would be larger if adjusted for inflation.