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The Medical Malpractice System and the Payment of Future Medical Damages: On Life Support Elsewhere, Resuscitated in Louisiana

I. INTRODUCTION

Bill and Cheryl entered the hospital looking forward to the birth of their first child. During labor that night, hospital staff noticed that the baby's heart rate slowed significantly during contractions. They called Cheryl's obstetrician (OB/GYN) at home, who ordered that levels of Pitocin, a drug used to quicken the labor process, be increased. Throughout the night, though, the baby's heart rate continued to slow, and hospital staff called the doctor again. The doctor did not come to the hospital.

When the doctor arrived the next morning, she performed a Cesarean Section on Cheryl. The newborn, named Laura, required oxygen to revive her. A CAT scan revealed that she sustained substantial brain damage due to lack of oxygen during the delay in her delivery. The jury in the subsequent medical malpractice trial awarded Bill and Cheryl \$2.7 million to pay for Laura's future medical care.¹ This seemed like more than enough until their attorneys took \$900,000 in contingency fees. Now they do not have enough money to pay for the care Laura will need for the rest of her life. What will they do?

* * *

On September 27, 2006 the Louisiana Third Circuit Court of Appeal found that the statutory cap on medical malpractice damages is too low to properly compensate victims.² While the case has since been vacated and remanded, the court was correct, because the \$500,000 cap, which is still in effect but has lost two-

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1. Although the facts of this hypothetical were extracted from a real medical malpractice scenario, the names and some facts have been altered. See Janet, Jenner & Suggs, LLC, *The MEDLAW Legal Team Recovers \$3.7 Million Jury Verdict in Cerebral Palsy/Medical Malpractice Case, 2007*, <http://www.cerebral-palsy-injury.com/cerebral-palsy-compensation.html>.

2. *Arrington v. ER Physicians Group, APMC*, 940 So. 2d 777, 781 (La. App. 3d Cir. 2006), *vacated*, 947 So. 2d 727 (La. 2007).

thirds of its value since being enacted more than thirty years ago,³ is inarguably Draconian. However, what the court did not note is that Louisiana balances the seeming inequity of the low cap with a unique system for the payment of future medical damages (commonly known as “future medical”). Future medical damages comprise the cost of all future medical care necessitated by medical malpractice.⁴ Louisiana offsets the low cap with the Patient’s Compensation Fund, which compensates malpractice victims better than the standard tort scheme. In Louisiana, Laura’s parents would not have to worry about how to pay for her lifetime of expensive future care.

This paper will demonstrate why the Louisiana system for the payment of future medical damages is superior to others. Part II gives a brief overview of the medical malpractice system and how it generally handles damages. Part III exposes the negative consequences of the traditional method for paying future medical, with an emphasis on inadequate compensation to victims. Part IV explains the relevant portions of the current medical malpractice law in Louisiana and explains its system for paying future medical damages. Part V evaluates this system. The evaluation demonstrates how the system solves many of the inadequacies revealed in Part III. Part VI concludes that while it has its own unique caveats, the Louisiana system for the payment of future medical damages surpasses others in its compensatory abilities and is therefore more just for patients.

II. ANATOMY OF THE MEDICAL MALPRACTICE SYSTEM

Generally, private physicians and other healthcare providers are legally required to maintain professional liability insurance that will cover them in the event of an unfavorable medical malpractice verdict.⁵ A typical policy for physicians will pay malpractice

3. *Id.*

4. See Catherine M. Sharkey, *Caps and the Construction of Damages in Medical Malpractice Cases*, in *MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM* 154, 154 (William M. Sage & Rogan Kersh eds., 2006) [hereinafter *MEDICAL MALPRACTICE*].

5. Michelle M. Mello & David M. Studdert, *The Medical Malpractice System: Structure and Performance*, in *MEDICAL MALPRACTICE*, *supra* note 4, at 11, 13.

victims a maximum of \$1 million per claim, and pay out up to \$3 million in total claims per year.⁶ Some healthcare providers choose to supplement this primary layer insurance policy with excess layer coverage to insure them in a situation where a malpractice judgment exceeds the primary layer limit.⁷ The insurance companies that provide primary and excess insurance are usually private commercial carriers, though the number of physician-owned mutual insurance companies has increased in recent years.⁸

In order to maintain their medical malpractice insurance, providers must pay an annual fee called a premium. Medical malpractice premiums are a function of the degree of risk in the physician's specialty and the expected costs of litigation in the provider's geographic practice area.⁹ Most insurance companies do not base their premiums on individual experience ratings (the number of claims against the healthcare provider) because such ratings are too difficult to calculate accurately.¹⁰ Instead, insurance companies will refuse to provide coverage for those healthcare providers who have had numerous claims against them.¹¹

Once a medical malpractice judgment of liability is rendered, the victim is entitled to damages. Medical malpractice damages include compensatory and punitive damages.¹² Compensatory damages are broken down into economic and non-economic damages. Economic damages include lost wages, rehabilitation expenses, past medical expenses, and future medical care

6. CompHealth, Malpractice Insurance 1, http://www.comphealth.com/pdf/residents/understanding_malpractice_insurance.pdf (last visited Jan. 21, 2008).

7. Mello & Studdert, *supra* note 5, at 14.

8. *Id.*

9. *Id.*

10. *Id.*

11. Edward P. Richards & Thomas R. McLean, *Administrative Compensation for Medical Malpractice Injuries: Reconciling the Brave New World of Patient Safety and the Torts System*, 49 ST. LOUIS U. L.J. 73, 87 (2005).

12. Sharkey, *supra* note 4, at 154. As a general rule, Louisiana does not allow punitive damages. *Killebrew v. Abbott Labs.*, 359 So. 2d 1275, 1278 (La. 1978).

expenses,¹³ which are the focus of this paper. As mentioned above, future medical expenses are those necessitated by medical malpractice.¹⁴ For instance, like other brain-injured babies, Laura will probably need future medical care in the form of twenty-four hour monitoring and a feeding tube, among other things.¹⁵ Non-economic damages are awarded for pain and suffering, physical impairment, inconvenience, anguish, marital loss, and disfigurement.¹⁶

“Traditionally, awards are made in one lump-sum payment, even when the amount awarded is intended to cover future medical expenses and lost earnings.”¹⁷ While most do not, some states mandate that damages rising above a statutorily designated amount must be paid in periodic payments over time.¹⁸ For example, Colorado law mandates that all future medical awards above \$150,000 must be paid in periodic payments.¹⁹ Some argue that periodic payments are better for malpractice victims. They assert that periodic payments help ensure that money needed for future medical expenses remains available.²⁰

III. FLAT LINE: INCORRECT HANDLING OF FUTURE MEDICAL CARE COSTS

The majority of states do not address the payment of future medical damages in a maximally effective way. As noted above, they are usually lumped under the general category of economic damages.²¹ This lack of special treatment is becoming more and more of a problem because damage awards continue to rise, and “it

13. Health Coalition on Liability Access, Ending the Confusion: Economic, Non-Economic and Punitive Damages, <http://www.hcla.org/factsheets/2003-23-Damages.pdf> (last visited Jan. 21, 2008).

14. Sharkey, *supra* note 4, at 154.

15. See *Kelty v. Brumfield*, 633 So. 2d 1210 (La. 1994).

16. Sharkey, *supra* note 4, at 154–55.

17. Emily V. Cornell, *Addressing the Medical Malpractice Insurance Crisis*, NGA CTR. FOR BEST PRACTICES, Dec. 5, 2002, at 6, <http://www.nga.org/Files/pdf/1102MEDMALPRACTICE.pdf>.

18. See Ronen Avraham, *Database of State Tort Law Reforms* (Nw. Law & Econ. Research, Working Paper No. 06–08, 2006), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=902711#PaperDownload.

19. *Id.* at 25.

20. Cornell, *supra* note 17, at 6.

21. Sharkey, *supra* note 4, at 154.

is clear that the rising value of payouts has been caused by an increase in economic damages, not awards for [non-economic damages like] pain and suffering.”²² In fact, awards for future medical care are rising at a faster rate than total damages.²³ Since future medical damages make up such a large proportion of awards, the general failure to address the issue has several dangerous consequences, especially—and most importantly—for patients. The most glaring examples of these consequences are in the area of obstetrics and gynecology, particularly in Florida in the 1970s and 1980s.

A. Consequences for Physicians and Private Insurers

The consequences of inefficient systems for the payment of future medical damages are highly intertwined for all those in the healthcare system, but especially physicians and private medical malpractice insurers. There are two basic, unfavorable effects on insurers that in turn affect physicians. First, insurance companies must raise their premiums. Since “awards drive premiums,”²⁴ insurance companies raise the annual premiums they charge in order to keep up with claims payouts,²⁵ or leave the state medical market altogether.²⁶ In response to high claims payouts, Florida’s private medical malpractice insurers raised their premiums for OB/GYNs by 395 percent between 1980 and 1986.²⁷ In 1986,

22. *Id.* at 164.

23. Kenneth E. Thorpe, *The Medical Malpractice ‘Crisis’: Recent Trends and the Impact of State Tort Reforms*, HEALTH AFF., Jan. 21, 2004, at W4-23, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.20v1>.

24. Alexander Tabarrok & Amanda Agan, *Medical Malpractice Awards, Insurance, and Negligence: Which Are Related?*, MANHATTAN INST. LEGAL POL., May 2006, at 2, http://www.manhattan-institute.org/pdf/cjr_10.pdf (providing a detailed discussion of statistical analysis of the relationship between premiums and awards).

25. *Id.*

26. Donald J. Palmisano, *The 20-Year Anniversary of the Louisiana Medical Malpractice Act of 1975, “Act 817 of 1975”: “A Rescue From Danger”: A Tribute to John C. Cooksey, MD*, 147 J. LA. STATE MED. SOC. 481, 484 (1995). As of 1975, after four others left, the Hartford Insurance Company and the St. Paul Fire and Marine Insurance Company were the only medical malpractice insurers left in the state. *Id.*

27. Jill Horwitz & Troyen A. Brennan, *No-Fault Compensation for Medical Injury: A Case Study*, 14 HEALTH AFF. 164, 166 (1995) (citing U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: SIX STATE CASE STUDIES SHOW

OB/GYN premiums were \$59,537.²⁸ Such a premium rise places a financial strain on physicians. This strain may be so large that medical students “opt out of high-risk specialties”²⁹ and doctors relocate to states with lower premiums.³⁰ Additionally, physicians may choose to retire early to avoid the costs associated with malpractice insurance.³¹

The second effect of large future medical awards is that private insurers may be forced to leave the medical market and stop writing malpractice policies altogether.³² As mentioned above, sometimes insurers cannot keep up with increasingly high economic damages awards.³³ Between 1970 and 1975, over twenty private medical malpractice insurers left the Florida market as a result of high claims payouts, making it difficult for doctors to find coverage.³⁴

B. Consequences for Patients

Deficient systems for the payment of future medical damages have the dangerous consequence of unjustly leaving malpractice victims inappropriately compensated. Often, those patients who have been hurt the most by malpractice and need the most care do not get it because of the limits private malpractice insurers place on claims payouts.³⁵ These limited amounts must be enough to pay for all financial consequences of the malpractice, including lost earnings and complete medical care.³⁶ Often, verdicts that would exceed insurers’ limits are settled for the maximum allowable amounts. For instance, a commonly litigated malpractice claim is against OB/GYNs for brain injuries caused to

CLAIMS AND INSURANCE COSTS STILL RISE DESPITE REFORMS, Pub. No. GAO/HRD-87-21, at 4 (1986)).

28. *Id.*

29. F. Dean Griffen, *Opportunity for Change*, LPCF Q., March 2006, at 1, available at http://www.lapcf.louisiana.gov/Website_ActiveFiles/NewsLetter/NewsLetter.htm (follow March 2006, “PDF” hyperlink).

30. *Id.*

31. Thorpe, *supra* note 23, at W4-27.

32. Cornell, *supra* note 17, at 1.

33. Palmisano, *supra* note 26, at 484.

34. Horwitz & Brennan, *supra* note 27, at 166.

35. Richards & McLean, *supra* note 11, at 75-76.

36. *Id.* at 75.

babies like Laura during delivery.³⁷ Verdicts for this kind of injury represent the highest in medical malpractice, with a median award of \$2,050,000.³⁸ Given the common \$1 million limit that private insurers place on payouts, it is almost impossible for severely injured patients like Laura to get the care they need. It is in suits against institutional healthcare providers like hospitals that large damages are actually paid.³⁹ However, “[r]elying on institutional providers to pay large claims further limits the cases where adequate compensation is available.”⁴⁰

Most states do not specifically mandate that economic damages be paid in periodic payments but instead allow for lump sum payments.⁴¹ Two of the main problems with lump sums are their speculative nature and the possibility that patients might “misallocate” funds.⁴² Lump sums are based on many variables and thus are seldom precisely accurate as to how much money the patient’s care will require.⁴³

Misallocation occurs when patients use lump sums to pay for things other than medical care and then exhaust their funds before the necessity for care fully diminishes.⁴⁴ When this happens, those states that do not effectively handle the payment of future medical damages place themselves in a precarious position. Patients who exhaust their funds may have to fall back on the public system and become “wards of the state.”⁴⁵ It is the state’s taxpayers, then, that bear the burden of paying for the malpractice victim’s medical care.⁴⁶ The issue of misallocation of funds is also prevalent when

37. David M. Studdert et al., *The Jury Is Still In: Florida’s Birth-Related Neurological Injury Compensation Plan After a Decade*, 25 J. HEALTH POL. POL’Y. & L. 499, 502 (2000).

38. News Release, The American College of Obstetricians and Gynecologists, “*Who Will Deliver My Baby?*” *Ob-Gyns, Patients Push US Senate for Tort Reform* (Apr. 28, 2003).

39. Richards & McLean, *supra* note 11, at 76.

40. *Id.*

41. *See generally* Avraham, *supra* note 18.

42. Samuel A. Rea, Jr., *Lump-Sum Versus Periodic Damage Awards*, 10 J. LEGAL STUD. 131, 132 (1981).

43. *Id.* at 133.

44. *Id.* at 141–42.

45. W.E. Sedgwick & William C. Judge, *The Use of Annuities in Settlement of Personal Injury Cases*, 41 INS. COUNSEL J. 584, 584 (1974).

46. *Id.* at 584.

the victims of malpractice are very old or very young, like Laura.⁴⁷ There is the risk that the caretakers of these patients will utilize the money awarded for future medical care for themselves.⁴⁸ If Laura's parents were in debt, for instance, they might use the money awarded for her future care to pay off that debt instead of directing it exclusively to Laura's care. This risk is slightly tempered, though, by the fact that many states require or permit the appointment of a guardian *ad litem* for a minor's property in the case of large damages awards,⁴⁹ thus providing a degree of protection.⁵⁰

Even if malpractice insurers did not place limitations on the amounts they will pay out and damages were not awarded in lump sums, patients still would not be fully compensated because of attorney contingency fees and transaction costs. Laura and her parents encountered the problem of attorney contingency fees. Usually, if an attorney wins a malpractice case, he or she takes a large portion of the award as payment.⁵¹ This amount is usually about one-third of the total award,⁵² but can reach fifty percent if the case is appealed.⁵³ If the parents of a brain injured baby win a malpractice claim against the delivering OB/GYN for \$1 million in damages, and the verdict is not appealed, approximately \$333,333 will go to the attorney. While this system allows lawyers to earn large sums of money by litigating a very narrow class of cases, it is clearly unfair to patients.

Some states, like California, have capped contingency fees.⁵⁴ The California system allows attorneys to collect forty percent of the first \$50,000 of the award, thirty-three and one-third percent of the second \$50,000, twenty-five percent of the next \$500,000, and fifteen percent of any amount that exceeds \$600,000.⁵⁵ In California, if the parents of a brain injured baby recover \$1 million

47. See generally Ellen S. Pryor, *After the Judgment*, 88 VA. L. REV. 1757 (2002).

48. *Id.* at 1804.

49. *Id.* at 1793.

50. Note, *The Uniform Gifts to Minors Act: A New Method of Giving Money and Securities*, 45 IOWA L. REV. 390, 392 (1959).

51. PAUL C. WEILER, *MEDICAL MALPRACTICE ON TRIAL* 62 (1991).

52. *Id.*

53. Richards & McLean, *supra* note 11, at 77.

54. *Id.*

55. CAL. BUS. & PROF. CODE § 6146 (2005).

in damages, the attorney's fee will be approximately \$221,665. While such a cap reduces the degree of under-compensation, it still allows a large portion of the award to go to attorneys' fees.

Transaction costs include case investigation fees, among other things.⁵⁶ Case investigation involves many costly preparations, the expenses of which are passed on to clients.⁵⁷ Travel expenses, copying records, and the payment of expert witnesses all subtract from the malpractice victim's ultimate compensation.⁵⁸ These costs can total as much as \$50,000 to \$100,000.⁵⁹ Contingency fees, transaction costs, and lump sums all mean that in order to be fully compensated for all necessary future care, a patient must recover more than he or she will need for actual medical bills.⁶⁰

The aforementioned costs all leave patients under-compensated and without the care they need. The standard system, though, does little to remedy these issues. In the 1980s, Louisiana instituted a fairer system that would tackle the issue of proper compensation for medical malpractice.

IV. "PADDLES PLEASE!": THE LOUISIANA MEDICAL MALPRACTICE SYSTEM

In the mid 1970s, the number of malpractice claims was increasing, insurance premiums were rising, and both healthcare providers and private malpractice insurers were leaving the medical market.⁶¹ Like many other states, Louisiana found itself in the midst of these troubling circumstances.⁶² In an effort to address this situation, the state adopted a new medical malpractice system.⁶³

56. Richards & McLean, *supra* note 11, at 77.

57. *Id.*

58. *Id.*

59. *Id.* at 78.

60. WEILER, *supra* note 51, at 62.

61. Forest Dean Griffen, *A Message from the Chairman*, LPCF Q., Sept. 2005, at 2, <http://www.lapcf.louisiana.gov/newsletter/issue1/PCF%20newsletter%209-8-2005.pdf>.

62. Palmisano, *supra* note 26, at 481.

63. *See generally id.*

A. The Louisiana Medical Malpractice Act: Initial Incarnation

In 1975, ophthalmologist John C. Cooksey introduced a new Louisiana medical malpractice law to the state legislature that was patterned after a recently passed Indiana law.⁶⁴ The Indiana law created a Patient Compensation Fund⁶⁵ and capped all damages at \$500,000.⁶⁶ Cooksey garnered the support of the Louisiana State Medical Society and urged the legislature to pass House Bill 1465, which would become known as the Louisiana Medical Malpractice Act (LMMA).⁶⁷ Citing the support of the state's physicians as an influence in his decision, Governor Edwards signed the bill into law in 1975.⁶⁸

The LMMA sought to remedy the problems that plagued medical malpractice systems during the 1970s.⁶⁹ Limits on recoverable damages for medical malpractice suits and the creation of the Patient's Compensation Fund, which is essentially state-run excess medical malpractice insurance for private healthcare providers, were the solutions.⁷⁰ The LMMA applies to hospitals, physicians, and other medical entities that fall within the statutory definition of "healthcare provider."⁷¹ As initially created, the primary function of the Patient's Compensation Fund was to pay medical malpractice damages in excess of the healthcare provider's

64. *Id.*; see also IND. CODE § 34-18-14-3 (2007).

65. IND. STATE MED. ASS'N, A HISTORY OF THE MEDICAL LIABILITY ISSUE: INDIANA COMPENSATION ACT FOR PATIENTS (INCAP) (2003), http://www.ismanet.org/pdf/INCAP_White_Paper.pdf.

66. § 34-18-14-3. The damage cap has been raised to \$1,250,000 for all malpractice occurring after July 1, 1999. *Id.*

67. Palmisano, *supra* note 26, at 481.

68. *Id.* at 482; see also 1975 La. Acts No. 817.

69. Palmisano, *supra* note 26, at 481.

70. 1975 La. Acts No. 817.

71. LA. REV. STAT. ANN. § 40:1299.41(A)(1) (2007) ("Health care provider" means a person, partnership, limited liability partnership, limited liability company, corporation, facility, or institution licensed or certified by this state to provide health care or professional services as a physician, hospital, nursing home, community blood center, tissue bank, dentist, registered or licensed practical nurse or certified nurse assistant, offshore health service provider, ambulance service under circumstances in which the provisions of R.S. 40:1299.39 are not applicable, certified registered nurse anesthetist, nurse midwife, licensed midwife, pharmacist, optometrist, podiatrist, chiropractor, physical therapist, occupational therapist, psychologist, social worker, licensed professional counselor, licensed perfusionist, or any nonprofit facility considered tax-exempt . . .").

personal \$100,000 liability up to the \$500,000 cap.⁷² The Fund will be discussed in greater detail later in this paper.

The LMMA also created medical review panels. Before a patient can bring a malpractice suit against a healthcare provider in court, the patient must present the claim to a panel,⁷³ which is comprised of three healthcare providers and one attorney.⁷⁴ The review panel then decides if the evidence shows that the defendant healthcare provider failed to act with the necessary standard of care.⁷⁵

In order to be eligible for the LMMA's benefits of claims coverage and limitation on damages, healthcare providers must meet specific qualifications. Each provider must provide proof of "financial responsibility"⁷⁶ and pay an annual surcharge to the Patient's Compensation Fund.⁷⁷ If a healthcare provider does not meet these requirements, it is not covered by the fund.⁷⁸ Each provider must demonstrate that it has a primary layer of malpractice insurance—financial responsibility—of at least \$100,000.⁷⁹ This primary layer of insurance can be from a private insurer or the provider may be self-insured. Those who self-insure must demonstrate financial responsibility of at least \$125,000.⁸⁰

Each provider must also pay an annual surcharge to the Patient's Compensation Fund.⁸¹ This surcharge payment is based on a "reserve" system, as opposed to a "pay-as-you-go" system, which other states with patient compensation funds utilize.⁸² When healthcare providers pay the surcharge into the Louisiana Patient's Compensation Fund, they are creating a reserve with

72. 1975 La. Acts No. 817.

73. LA. REV. STAT. ANN. § 40:1299.47(B) (2007).

74. § 40:1299.47(C).

75. § 40:1299.47(G).

76. § 40:1299.42(A)(1).

77. § 40:1299.42(A)(2).

78. § 40:1299.42(A)(1)–(2).

79. § 40:1299.42(E).

80. *Id.*

81. § 40:1299.42(A)(2).

82. REPORT OF THE JOINT INTERIM COMMITTEE ON MISSOURI HEALTH CARE STABILIZATION FUND, MISSOURI GENERAL ASSEMBLY 11 (2005) [hereinafter REPORT ON MISSOURI FUND].

which the claims in the coming year will be paid.⁸³ In a pay-as-you-go system, providers are paying for previous years' claims.⁸⁴

The Louisiana Insurance Rating Commission determines the amount of the surcharge.⁸⁵ Providers are placed into one of several classes determined by specialty, and the surcharge is assessed based on those classes.⁸⁶ At the end of each calendar year, when all claims have been paid, if the Patient's Compensation Fund exceeds \$15 million, the Insurance Rating Commission can lower the surcharge.⁸⁷ However, the LMMA also mandates that the fund must maintain a thirty percent surplus at all times.⁸⁸ If it does not, the Insurance Rating Commission cannot lower the surcharge.⁸⁹

The LMMA places a \$500,000 limit on an award of damages for medical malpractice.⁹⁰ Initially, the statute stated that this \$500,000 was the "total amount recoverable," meaning that it accounted for both economic and non-economic damages.⁹¹ Future medical damages have since been excluded from the cap though, and this exclusion will be addressed later.⁹² Providers are only liable for up to \$100,000 of the damages award.⁹³ Their primary layer (private insurance) pays this sum. If the award is higher than \$100,000 the Patient's Compensation Fund pays the remainder up to the \$500,000 cap.⁹⁴

This \$500,000 cap on damages is strikingly low compared to other states' caps. For example, Indiana's Medical Malpractice Act, after which the LMMA was modeled, now caps damages at \$1,250,000.⁹⁵ Additionally, many other states distinguish between

83. *Id.*

84. *Id.*

85. § 40:1299.44(A)(2) (2007).

86. See LOUISIANA PATIENT'S COMPENSATION FUND, RATE MANUAL (2006), <http://www.lapcf.state.la.us/rateman/2004/PCF%20Rate%20Manual%202004.doc> [hereinafter RATE MANUAL] (classifying providers based on their specialty as designated by their primary insurance). See also E-mail from Lorraine LeBlanc, Executive Director, Louisiana Patient's Compensation Fund, to author (Nov. 7, 2006, 02:21 CST) (on file with author).

87. § 40:1299.44(A)(6).

88. § 40:1299.44(A)(6)(a).

89. § 40:1299.44(A)(6)(b).

90. § 40:1299.42(B)(1).

91. 1975 La. Acts No. 817.

92. § 40:1299.43(D) (2007).

93. § 40:1299.42(B)(2).

94. § 40:1299.42(B)(3)(a).

95. IND. CODE ANN. § 34-18-14-3(a)(3) (West 2005).

economic and non-economic damages when imposing limitations. These states generally limit only non-economic damages.⁹⁶

Until very recently, the \$500,000 cap on damages endured and courts even expressly held it constitutional.⁹⁷ However, on September 27, 2006, in *Arrington v. ER Physicians Group, APMC*, the Louisiana Third Circuit Court of Appeal found that the cap no longer provides an adequate remedy.⁹⁸ In reaching its decision, the court reasoned that since the value of the dollar has depreciated since 1975 when the legislature first capped damages, the \$500,000 cap is actually a \$160,000 cap by today's standards.⁹⁹

The propensity for change has also made its way into the legislative branch of the Louisiana state government. A bill has been introduced into the legislature that would amend the LMMA to exclude all economic damages from the \$500,000 cap.¹⁰⁰ While change may be in the cap's future, the LMMA's success, and particularly the success of the portion dealing with the payment of future medical damages, indicates that the remaining provisions will endure.

B. The Louisiana Medical Malpractice Act: Reincarnation with Future Medical

In 1984, the Louisiana legislature made a revolutionary amendment to the LMMA with respect to future medical damages.¹⁰¹ The purpose of this amendment was twofold. One purpose was "to grant severely injured malpractice victims, who have been deprived by the cap of compensation for any necessary

96. See CAL. CIV. CODE § 3333.2 (West 2005); MICH. COMP. LAWS ANN. § 600.1483 (West 2005).

97. *Butler v. Flint Goodrich Hosp. of Dillard Univ.*, 607 So. 2d 517 (La. 1992); *LaMark v. NME Hosp., Inc.*, 542 So. 2d 753 (La. App. 4th Cir. 1989); *Williams v. Kushner*, 524 So. 2d 191 (La. App. 4th Cir. 1988).

98. 940 So. 2d 777, 781 (La. App. 3d Cir. 2006), *vacated*, 947 So. 2d 727 (La. 2007). The cap remains in tact, despite this case's procedural posture. § 40:1299.42(B)(1).

99. *Arrington*, 940 So. 2d at 781.

100. H.B. 1228, 32nd Reg. Sess. (La. 2006). If the legislature does remove the cap from economic damages, as long as the LMMA still mandates that all future medical must be paid exclusively from the Patient's Compensation Fund, the fund will remain an invaluable part of the Louisiana medical malpractice system.

101. 1984 La. Acts No. 435.

medical service, a speedy, convenient, and inexpensive administrative remedy for the payment of actually incurred medical expenses, without limit except as tailored to the patient's needs."¹⁰² The other purpose was "to provide cost-effective, actuarially sound methods for financing and delivering compensation for medical services necessitated by medical malpractice."¹⁰³

The original 1975 version of the law lumped future medical damages under the \$500,000 cap.¹⁰⁴ The amended law now excludes the cost of "future medical care and related benefits"¹⁰⁵ from the \$500,000 cap on damages and mandates that future medical damages be paid by the Patient's Compensation Fund.¹⁰⁶ According to the LMMA, "future medical care and related benefits" are "all reasonable medical, surgical, hospitalization, rehabilitation, and custodial services and includes drugs, prosthetic devices, and other similar materials reasonably necessary in the provision of such services, incurred after the date of the injury."¹⁰⁷

A patient who wishes to be compensated through the fund must file a claim with the Patient's Compensation Fund Oversight Board, and a medical review panel then reviews the claim before it goes to trial.¹⁰⁸ Juries that sit on medical malpractice trials are given a specific interrogatory asking if the victim needs future medical and the approximate cost of such future medical expenses.¹⁰⁹ If the jury finds that a victim is in need of future medical care, these costs are separated from the remainder of damages and paid by the Patient's Compensation Fund; all other damages must fall under the \$500,000 cap.¹¹⁰ It is important to note that Louisiana follows the collateral source rule, which states that "a tort-feasor may not benefit, and an injured plaintiff's tort recovery may not be diminished, because of benefits received by the plaintiff from sources independent of the tort-feasor's

102. *Kelty v. Brumfield*, 633 So. 2d 1210, 1216-17 (La. 1994).

103. *Id.*

104. 1975 La. Acts No. 817 (enacted as LA. REV. STAT. ANN. § 40:1299.42(B)(2007)).

105. LA. REV. STAT. ANN. § 40:1299.42(B).

106. *Id.*

107. § 40:1299.43(B)(1).

108. § 40:1299.47(A).

109. § 40:1299.43(A)(2).

110. § 40:1299.43(A)(4).

procurement or contribution.”¹¹¹ This means that the healthcare provider being sued cannot seek to decrease the damages award by introducing evidence that the victim has already received compensation from sources other than the healthcare provider, like the victim’s own health insurance.¹¹²

The method in which the Patient’s Compensation Fund pays future medical is what makes the Louisiana system notable. Instead of taking the cost of future medical damages recommended by the jury and giving the victim a lump sum in that amount, the Patient’s Compensation Fund pays the cost of future medical “as incurred and presented for payment” from the time the malpractice occurred.¹¹³ The fund is then either billed directly by the healthcare provider treating the patient or it reimburses the patient.¹¹⁴ This means, for instance, that Laura’s parents would receive no money until her care has actually begun. The Fund also pays for any medical costs incurred as a result of malpractice, but before the judgment has been rendered.¹¹⁵ In order to ensure that patients are not claiming payment for unnecessary medical expenses, the Patient’s Compensation Fund can require medical checkups of the patient’s needs every six months, and more often with a court order.¹¹⁶

C. Jurisprudence Clarifying Issues Related to the Patient’s Compensation Fund

Since its inception, Louisiana courts have helped to clarify the functions and workings of the fund. A major case related to the LMMA and the Patient’s Compensation Fund is *Kelty v. Brumfield*.¹¹⁷ This case helped to clarify the purpose of the Patient’s Compensation Fund. It stated that the goal of the

111. *Williamson v. St. Francis Med. Ctr., Inc.*, 559 So. 2d 929, 934 (La. App. 2d Cir. 1990).

112. David Schap & Andrew Feeley, (Much) More on the Collateral Source Rule (Coll. of Holy Cross Dept. of Econ. Faculty Research Series, Paper No. 06-05, 2006), http://www.holycross.edu/departments/economics/RePEc/Schap_Collateral1.pdf (last visited Sept. 7, 2007).

113. § 40:1299.43(A)(4).

114. E-mail from Lorraine LeBlanc, *supra* note 84.

115. *Id.*

116. § 40:1299.43(G).

117. 633 So. 2d 1210, 1218 (La. 1994).

legislation was to “remedy . . . the damage cap’s harsh tendency to prune recovery inversely to the injury”¹¹⁸

The *Kelty* case also held that non-medical professional parents could make claims to the fund for services they rendered in caring for a child victim of malpractice.¹¹⁹ For compensation, the parent must show that there is a need for the services, establish the reasonableness of the fee, and must show the extent and duration of the services.¹²⁰ The Keltys’ daughter, Anne Mary, suffered from a lack of oxygen during delivery.¹²¹ As a result, she was severely brain-damaged and physically handicapped.¹²² The Keltys undertook to care for Anne Mary themselves instead of placing her in a facility or hiring outside caretakers.¹²³ She required four feedings a day through a gastrointestinal tube, with the first feeding at 8:45 a.m. and the last ending at 2:10 a.m.¹²⁴ The Keltys provided physical and occupational therapy and bathed her once a day, which required the help of both parents.¹²⁵ The Keltys also monitored Anne Mary’s gag reflex twenty-four hours a day to prevent her from lethally aspirating vomit.¹²⁶ The court used the standard rate paid to nurses and other caretakers in order to calculate how much compensation the Keltys should receive.¹²⁷

Hall v. Brookshire Brothers, Ltd. held that the principle of comparative fault applies to awards from the Patient’s Compensation Fund.¹²⁸ When there are multiple causes of a plaintiff’s injury, and medical malpractice is one of those causes, the fund is only responsible for paying for the healthcare provider’s percentage of that fault if it rises above \$100,000.¹²⁹ The plaintiff in *Hall* sued both her doctor and pharmacy for malpractice which contributed to a permanently debilitating

118. *Id.* at 1217.

119. *Kelty v. Brumfield*, 691 So. 2d 242, 245 (La. App. 4th Cir. 1997), *writ denied*, 693 So. 2d 800 (La. 1997).

120. *Id.* at 247.

121. *Id.* at 244.

122. *Id.*

123. *Id.* at 246.

124. *Id.*

125. *Id.*

126. *Id.*

127. *Id.* at 247.

128. 848 So. 2d 559, 568 (La. 2003).

129. *Id.* at 567.

disorder.¹³⁰ The jury found that her doctor was eighty-five percent at fault and the pharmacist was ten percent at fault.¹³¹

V. FUTURE MEDICAL RESUSCITATED: THE LOUISIANA SYSTEM

In implementing the Patient's Compensation Fund and providing for the separate treatment of future medical damages, Louisiana has set itself apart from the forty-nine other states. While twelve other states have patient's compensation funds,¹³² none pay for future medical care necessitated by medical malpractice the way that Louisiana does.¹³³ In implementing this unique system, Louisiana has successfully addressed the issues that other states struggle with, and, most importantly, has addressed the issue of patient compensation.

A. Consequences of the Louisiana System for Physicians and Private Insurance Companies

The Louisiana system for the payment of future medical damages has several favorable effects for both physicians and private insurance companies. By removing the burden of paying future medical damages from private insurance companies, those companies are able to keep their insurance premiums stable.¹³⁴ By virtue of the cap and the fund's payment of future medical damages, private insurers know that they will only be responsible for up to \$100,000.¹³⁵ This means that they can more accurately predict what their future expenditures will be. As a result, private insurers can keep annual premiums relatively low and stable for

130. *Id.* at 562.

131. *Id.* at 563.

132. Griffen, *supra* note 61, at 2. The Pennsylvania fund is currently being phased out. GEORGE COPPOLO & KEVIN MCCARTHY, OLR RESEARCH REPORT NO. 2003-R-0606: PATIENT COMPENSATION FUNDS AND REINSURANCE FOR MEDICAL MALPRACTICE INSURANCE 2 (2003), available at <http://www.cga.ct.gov/2003/olrdata/ins/rpt/2003-R-0606.htm>.

133. See generally REPORT ON MISSOURI FUND, *supra* note 82. The other states with patient compensation funds pay future medical damages in the same way that states without funds pay them—in either capped or uncapped lump sum payments. COPPOLO & MCCARTHY, *supra* note 132, at 6.

134. REPORT ON MISSOURI FUND, *supra* note 82, at 15.

135. LA. REV. STAT. ANN. § 40:1299.44(A)(6) (2007).

healthcare providers.¹³⁶ For example, the Government Accounting Office found that the average increase in private insurance premiums for states with caps like Louisiana's was just nine percent between 2001 and 2002, compared to a twenty-nine percent increase in states with limited reforms.¹³⁷ While some premium increases may be inevitable, it is clear that Louisiana's reforms make a large impact on relative premium stability.

The ability to predict future claims expenditures also means that private insurers are more likely to stay in the medical market.¹³⁸ The presence of the state-run Patient's Compensation Fund helps to ensure the availability of excess layer insurance for doctors. Since it is run by the state and established by law, the fund does not leave the medical market during a malpractice crisis the way private insurance companies do.¹³⁹

Critics may argue that since physicians are essentially paying two premiums, one to their primary private insurer and one in the form of a surcharge to the Patient's Compensation Fund,¹⁴⁰ the fund does not truly address the issue of malpractice insurance affordability.¹⁴¹ However, because the fund pays for all future medical expenses without limit, it removes a significant financial burden from physicians and other providers. Since private insurers place limits on the amount they will pay out, physicians may be forced to purchase private excess layer insurance to protect themselves from damage awards that exceed their primary layer limits.¹⁴² This excess layer insurance is often more expensive than the surcharge paid to the fund.¹⁴³ So, if doctors are going to

136. REPORT ON MISSOURI FUND, *supra* note 82, at 15.

137. *Medical Malpractice Insurance: Testimony Before the Subcommittee on Wellness and Human Rights, Committee on Government Reform, House of Representatives*, GAO-04-128T, at 11 (2003) (statement of Richard J. Hillman, Director Financial Markets and Community Investment, and Kathryn G. Allen, Director Health Care—Medicaid and Private Health Insurance Issues). "States with caps like Louisiana's" refers to the eight states used in the GAO study that have \$500,000 damage caps on non-economic damages.

138. REPORT ON MISSOURI FUND, *supra* note 82, at 15.

139. Frank A. Sloan et al., *Public Medical Malpractice Insurance: An Analysis of State-Operated Patient Compensation Funds*, 54 DEPAUL L. REV. 247, 265 (2005).

140. § 40:1299.42(A)(2).

141. REPORT ON MISSOURI FUND, *supra* note 82, at 15.

142. Mello & Studdert, *supra* note 5, at 14.

143. *Id.*

purchase excess layer insurance and pay two premiums anyway, it is actually more cost-effective for them to purchase it from the Patient's Compensation Fund rather than from a private insurer. Additionally, since healthcare providers can self-insure for only \$125,000,¹⁴⁴ there is an incentive for private malpractice insurers to keep their premiums low so that providers will buy primary coverage from them instead of self-insuring.

B. Consequences of the Louisiana System for Patients

The greatest accomplishment of the Louisiana system for the payment of future medical damages is most certainly its level of justice, exemplified by the fact that victims are properly compensated for their injuries. By excluding the cost of future medical care from the \$500,000 cap and paying it from the fund, victims get all of the money they need to pay for the care necessitated by medical malpractice. This is particularly important for severely injured patients or those patients who are injured at a young age, like Laura, as they require the most, and therefore most expensive, care.

In order to ensure that patients can pay for the care they need, the Louisiana regime essentially protects patients from themselves. By taking lump sum amounts for future medical damages out of the system and instead paying these damages "as incurred and presented for payment,"¹⁴⁵ the system prevents victims from using the money designated for medical care for other things.¹⁴⁶ Additionally, this system protects the most vulnerable patients from greedy caretakers. The very young and elderly are susceptible to the theft of their lump sum awards; these medical malpractice victims might not even be aware that sometimes life-sustaining funds are being taken from them by those in whom they place ultimate trust.¹⁴⁷ If she were born in Louisiana, there would be no danger of Laura's parents using the money needed for her future care to pay off debts.

144. See *supra* note 80 and accompanying text.

145. § 40:1299.43(A)(4).

146. Rea, *supra* note 42, at 141–42.

147. See *supra* Part III.B.

In addition to ensuring that patients are not under-compensated, the Louisiana system for the payment of future medical damages also ensures that they are not over-compensated, thereby wasting valuable funds. If a very elderly or severely injured malpractice victim is awarded a large lump sum for future medical damages, there is a chance that he or she may not live long enough to utilize the full amount.¹⁴⁸ In such a case, the victim's survivors might get windfalls in the form of an unutilized portion of the lump sum.¹⁴⁹ This windfall is wasted money. Since the Patient's Compensation Fund pays future medical expenses as they are incurred, it eliminates the windfall problem. This aspect of the system also demonstrates its true justice—it not only ensures that patients get enough compensation, but only the compensation they need.

Another negative consequence of the traditional system that Louisiana avoids is that of exorbitant contingency fees for attorneys.¹⁵⁰ Since there is no lump sum awarded for future medical, attorneys cannot take large proportions of those awards as their payment and patients are fully compensated. To ensure payment, Louisiana malpractice attorneys make alternate fee arrangements. For example, some attorneys only charge a fee on the portion of the patient's award that is not designated for future medical.¹⁵¹ Under such arrangements, malpractice victims are still completely able to fund their future medical care. The lack of large contingency fees also helps to eliminate the problem of "ambulance chasers" in search of large payouts for themselves. Again, if she were born in Louisiana, Laura's parents would not have to worry about insufficient funds for their daughter's care because of high contingency fees.

The Louisiana Patient's Compensation Fund does not place an economic strain on the state in the way the standard system for the payment of future medical care does. Even though it is an arm of

148. Rea, *supra* note 42, at 143.

149. *Id.*

150. See *supra* Part III.B.

151. E-mail from Jennifer Willis, Attorney, Cater and Willis, A Professional Law Corporation, to author (December 6, 2006, 10:31 CST) (on file with author).

the state, the fund is completely financed by those enrolled in it.¹⁵² While other states are forced to pay for the expensive future medical care of those that have fallen into the public system and become “wards of the state,”¹⁵³ Louisiana barely needs to concern itself with this issue. In Louisiana, taxpayers who had nothing to do with the patient’s harm are not forced to unjustly pay for a doctor’s malpractice. Since the legislature created it, the fund has fully paid out all claims.¹⁵⁴

C. Comparative Evaluation

While the above argument demonstrates the success of the LMMA in patient compensation, it is very theoretical. A concrete way to demonstrate the law’s effectiveness is to compare it to another system. While the LMMA is unique in that it covers future medical care necessitated by all malpractice in all practice areas, Virginia and Florida have compensation funds that cover future medical care only for babies who sustain brain injuries during delivery.¹⁵⁵ Malpractice suits for these injuries are brought against the delivering OB/GYNs. A look at the effects of the Florida Neurological Injury Compensation Association (NICA) affords the chance to evaluate the Louisiana Patient’s Compensation Fund against a similar system.

Florida instituted the NICA plan in 1988 in order to reform the state’s medical malpractice system with regard to those cases involving birth related neurological injuries.¹⁵⁶ The NICA plan provides no fault compensation to the families of brain injured babies. Those families that wish to receive the compensation provided by the plan cannot sue the negligent OB/GYN in tort.¹⁵⁷ Like the Louisiana Patient’s Compensation Fund, the NICA plan

152. Ken Schnauder, *\$100 Million Dollar Claims Budget, the Norm?*, LPCF Q., July 2006, at 2, available at http://www.lapcf.louisiana.gov/Website_ActiveFiles/NewsLetter/Newsletter.htm (follow “PDF” hyperlink under “July 2006”).

153. Sedgwick & Judge, *supra* note 45, at 584.

154. *Economic Viability of the Fund*, LPCF Q., Mar. 2006, at 6, available at http://www.lapcf.louisiana.gov/Website_ActiveFiles/NewsLetter/Newsletter.htm (follow “PDF” hyperlink under “March 2006”).

155. Saul Spigel, Virginia and Florida Child Brain Injury Compensation Funds (Sept. 11, 2003), <http://biotech.law.lsu.edu/policy/2003-R-0620.htm>.

156. Studdert et al., *supra* note 37, at 502.

157. Horwitz & Brennan, *supra* note 27, at 168.

requires that covered physicians pay an annual fee of \$5,000.¹⁵⁸ Unlike the Louisiana system, though, this fee is not the plan's only source of funding. It also levies a \$250 fee on all Florida physicians for licensure, private hospitals must pay \$50 per live birth, and the state made a one-time grant to the NICA.¹⁵⁹

Claims made to the NICA are reviewed for OB/GYN substandard care by the Division of Administrative Hearings, which determines if a baby's injury is covered by the NICA.¹⁶⁰ In order to be covered, the injury must meet seven criteria. It must be

(1) to the brain or spinal cord of a (2) live infant (3) weighing at least 2,500 grams at birth. It must be (4) caused by oxygen deprivation or mechanical injury and (5) occur in the course of labor, delivery, or resuscitation in the immediate post delivery period The birth must take place (6) in a hospital. Finally, as a consequence of the injury, the infant must have been (7) rendered permanently and substantially mentally and physically impaired.¹⁶¹

If the injuries are covered, the NICA pays for all necessary future care exclusive of that covered by private insurance or government programs and pays up to \$100,000 in pain and suffering to the baby's parents and attorney's fees.¹⁶²

Since Florida instituted the NICA, fewer obstetricians have stopped practicing and fewer have decreased the number of deliveries they perform.¹⁶³ In fact, once the state implemented the NICA, the rate of OB/GYNs dropping out of practice in Florida dropped to fifty percent of the overall U.S. OB/GYN drop-out rate.¹⁶⁴ More than eighty percent of Florida OB/GYNs participate in the NICA plan.¹⁶⁵

Most importantly, the NICA has proven to provide necessary money, and therefore care, to patients and their families.¹⁶⁶ One of

158. *Id.* at 169.

159. *Id.*

160. *Id.* at 168.

161. Studdert et al., *supra* note 37, at 503.

162. Spigel, *supra* note 155.

163. Horwitz & Brennan, *supra* note 27, at 175.

164. *Id.*

165. *Id.* at 177.

166. Kenney Shipley, NICA, An Alternative That Works for OBGYN, <http://www.flobgyn.org/se/2110.php> (last visited Sept. 7, 2007).

the major tests facing any system of this nature is its actuarial soundness. As of 2002, the NICA had accepted 161 claims at approximately \$1.85 million per claim.¹⁶⁷ At that time the NICA had \$299 million in reserves to pay for those claims.¹⁶⁸ To date, the NICA's reserves have been enough to pay for all accepted claims, but should it ever need to, the NICA can access an extra \$20 million from an Insurance Regulatory Trust Fund.¹⁶⁹ Also, if the NICA's liability for existing claims reaches eighty percent of its assets, it reserves the ability to cut off applications for new claims.¹⁷⁰

Since one of the central purposes of any tort system should be compensation, this microcosm of a tort system should compensate as well as possible. However, even though it deals with a narrow class of victims, there is evidence that the NICA plan does not meet this central purpose. While those that are permitted to file claims under the NICA are well compensated, the system does not allow all of those who deserve compensation to file claims.¹⁷¹ The ultra-narrow seven part test ensures that cases involving blatant negligence by physicians are not compensated if they do not meet all of the criteria.¹⁷²

For instance, if Laura's severe brain injury was caused by something other than oxygen deprivation during delayed delivery, the NICA would not compensate her. One study shows that of the birth-related injury cases it examined, only one-sixth met the statutory criteria, whereas one-third involved sub-standard medical care.¹⁷³ Additionally, since the NICA plan reserves the right to cut off claims applications at any time, there is a constant risk that even those who meet the narrow criteria will not be compensated. Given these figures, the NICA plan has done only a modest job of compensating birth-related brain injuries.¹⁷⁴

Since the NICA plan gives claimant families the option of pursuing a tort remedy or a no-fault remedy, it has not eliminated

167. Spigel, *supra* note 155.

168. *Id.*

169. *Id.*

170. *Id.*

171. Studdert et al., *supra* note 37, at 519.

172. *Id.*

173. *Id.*

174. *Id.* at 517.

the problem of high jury awards for birth related neurological injuries from Florida's tort system.¹⁷⁵ The strict criteria for compensation make it difficult for claimants to get compensation through the NICA plan, so they turn to the traditional tort system.¹⁷⁶ This means that the problems associated with the traditional payment of future medical care still plague Florida.

Given its design, the Louisiana Patient Compensation Fund should accomplish the goal of keeping OB/GYNs in the state at least as well as the NICA plan does for Florida. The percentage of OB/GYNs in Florida is twelve percent, which is larger than or equal to the percentage in thirty-one other states.¹⁷⁷ The percentage of OB/GYNs in Louisiana is fifteen percent, which is larger than or equal to the percentage in forty-nine other states.¹⁷⁸ Louisiana is also one of fifteen states with between 500 and 1,100 OB/GYNs, and Florida is one of eleven states with over 1,100 OB/GYNs.¹⁷⁹ These figures demonstrate Louisiana's success because it has accomplished both the goals of keeping OB/GYNs in the state and of compensating victims with greater success than Florida, a state with a specialized fund that exclusively covers OB/GYNs, and it did so using a fund that covers all qualified healthcare providers.

Even though Louisiana is charged with providing future medical care for all victims of medical malpractice, and not just a narrow class of victims like Florida, the Louisiana system is much more adept at providing appropriate compensation. First, by allowing compensation for all classes of victims and not utilizing a stringent and exclusive set of criteria, Louisiana ensures that those in need of compensation get it. Florida, by contrast, leaves a significant number of malpractice victims uncompensated; these victims include brain injured babies who do not meet the criteria.¹⁸⁰ Second, since all other malpractice victims and many brain injured babies must rely on the traditional tort scheme for

175. *Id.*

176. *Id.* at 523.

177. StateHealthFacts.org, Distribution of Nonfederal Primary Care Physicians by Field, 2006, <http://www.statehealthfacts.org/comparebar.jsp?ind=433&cat=8> (last visited Sept. 7, 2007).

178. *Id.*

179. *Id.*

180. Studdert et al., *supra* note 37, at 519.

compensation,¹⁸¹ they may fall back on the state to pay for their care.¹⁸² As discussed above, Louisiana avoids this problem by funding all care. Third, Louisiana eliminates the issue of under-compensation because of attorney fees for all patients, and not just a very small class of them, like Florida.¹⁸³

The Louisiana system also has positive effects beyond patient compensation that the Florida system does not. The NICA plan does not necessarily function to keep private malpractice insurers in the state. Since NICA only covers care for a narrow class of victims, private insurers are left to deal with all other malpractice awards by themselves and with no state assistance.¹⁸⁴ Additionally, the NICA plan does not make claims expenditures more predictable for private insurers because it only shifts the burden of a small class of victims.¹⁸⁵ Both of these things can result in private insurers leaving the market. Louisiana, though, makes claims payouts predictable for private insurers, thereby keeping malpractice insurance stable and available.¹⁸⁶

A comparison to Florida's NICA plan reveals just how effective the Louisiana Patient Compensation Fund is at compensating malpractice victims. The NICA addresses the issue of compensation for brain-injured babies that meet the seven criteria, but it leaves all other claims to the traditional tort system.¹⁸⁷ While it may have a functional design and is actuarially sound, the NICA plan falls short of satisfying true compensatory goals.

D. Clots in Louisiana's System?

Even in spite of its successes, the Patient's Compensation Fund does have its own unique caveats. First, since the fund must provide coverage to all doctors who meet the statutory criteria,

181. *Id.* at 523.

182. Sedgwick & Judge, *supra* note 45, at 584.

183. Spigel, *supra* note 155. Since the NICA only applies to a narrow class of victims, it is only their attorney fees that are paid. See generally Studdert et al., *supra* note 37.

184. Shipley, *supra* note 166 (“[P]roblems in the insurance arena have again increased.”).

185. See *id.*

186. REPORT ON MISSOURI FUND, *supra* note 82, at 6.

187. Studdert et al., *supra* note 37, at 523.

there are necessarily bad doctors participating who account for a large numbers of claims.¹⁸⁸ Those doctors for whom the fund has paid out two or more claims over a five year period are assessed an increase in their individual surcharges.¹⁸⁹ This increase is a percentage of the surcharge and cannot exceed fifty percent.¹⁹⁰ By only increasing the amount they pay and not denying them coverage, the law ensures that bad doctors will always be a part of the Louisiana system. Clearly, this is also a negative consequence for patients.

Second, while the reduction in high contingency fees helps ensure that patients are fully compensated, this reduction may also make it more difficult for poorer malpractice victims to find legal representation. Contingency fee systems provide access to legal representation for those who would not otherwise be able to pay a fixed fee;¹⁹¹ under these systems, victims get representation and lawyers get paid—handsomely. Without the possibility of a large payout for themselves, lawyers may be less likely to take on any cases other than those that are sure winners. This means that those victims who have suffered actual, but difficult to prove, harm from malpractice may be left without a means for remedy against their mal-practicing physicians. “To the extent that contingent fees give the poor and middle class greater access to the courts, contingency fees are a useful part of our legal system.”¹⁹² While Louisiana’s reduction in contingent attorney fees better compensates those that do actually get verdicts against tortfeasors, one downfall is that it may actually prevent some victims from ever getting to court. There is also the possibility that those with less than “sure fire” cases who do find attorneys will get sub-par representation due to the unlikelihood of a large verdict.

Third, while the Patient’s Compensation Fund has been solvent since its inception and looks as though it will remain solvent in the future,¹⁹³ the Louisiana system is not as fiscally efficient as others. By nature, a system that is open-ended and allows for the indefinite

188. REPORT ON MISSOURI FUND, *supra* note 82, at 17.

189. RATE MANUAL, *supra* note 86.

190. *Id.*

191. Angela Wennihan, Comment, *Let’s Put the Contingency Back in the Contingency Fee*, 49 SMU L. REV. 1639, 1649 (1996).

192. *Id.* at 1649.

193. *Economic Viability of the Fund*, *supra* note 154, at 6.

payment of damages drags the claims process out, unlike a system that awards a lump sum and closes the case. Since the fund is run by the state, the state is then forced to remain involved in claims indefinitely. This flaw, though, is necessary to the fund's construction, and the legislature should not attempt to "cure" it; the very thing that makes the Patient's Compensation Fund fiscally successful is its open ended nature and the lack of lump sum payments.

VI. CONCLUSION: STABLE VITAL SIGNS?

As demonstrated above, Louisiana far surpasses other systems in its ability to properly compensate victims of even the most debilitating malpractice. However, it strikes a tenuous balance between two issues that are at the center of the medical malpractice system: justice and efficiency. The Louisiana system for the payment of future medical damages is extremely just because it carries out one of the most central goals of the medical malpractice system: appropriate patient compensation.

It is in the areas of fiscal soundness and efficiency, though, that Louisiana could make improvement. Even though it already maintains a surplus, the Patient's Compensation Fund's future could be better solidified if the state followed the NICA plan and established an "emergency" fund—something that the fund could access in the event of an unforeseeably large number of claims with unforeseeably large dollar amounts that would otherwise leave it insolvent. Such an emergency account would ensure that compensation is always available to Louisiana malpractice victims, even in economically uncertain times.

Another aspect in which the Fund can improve is its pool of doctors. As discussed above, since it gives coverage to all those who meet the statutory requirements, there are bad doctors included within the system's coverage.¹⁹⁴ Unlike the temporal inefficiency, this is not a necessary evil. The Fund could eliminate this problem by denying coverage to doctors with large numbers of claims against them even if they meet the statutory criteria. This

194. REPORT ON MISSOURI FUND, *supra* note 82, at 17.

would both give an incentive to doctors to improve their practices and protect patients.

The weight of the Fund's very minimal inefficiency and the problem of bad doctors must be considered in light of what is most important in a medical malpractice system. Justice in full and appropriate patient compensation is of the utmost importance, and though it may be inefficient time-wise, the Louisiana system is highly efficient in compensating patients. Compensation, after all, is one of the cornerstones of the Louisiana, and any, tort system.¹⁹⁵

"Sound lawmaking requires matching the characteristics of a social issue with the characteristics of legal institutions to see which institution[] . . . is most likely to deal with the issue[] most satisfactorily."¹⁹⁶ In matching the medical malpractice system's goal of appropriate patient compensation with the characteristics of the Patient's Compensation Fund, Louisiana has successfully revolutionized the payment of future medical damages and has created a wake of positive effects for the state medical malpractice system as a whole.¹⁹⁷ Given its success in comparison to the traditional system, the rest of the states should play a similar "matching game," and look to Louisiana as an inspiration for remodeling their systems the way that Louisiana looked to Indiana over thirty years ago.¹⁹⁸

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195. See LA. CIV. CODE ANN. art. 2315 (2007).

196. Roger B. Dworkin, *The Process Paradigm: Rethinking Medical Malpractice*, 41 WAKE FOREST L. REV. 509, 510 (2006).

197. See *supra* Part V.

198. Palmisano, *supra* note 26, at 481.

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