

# Lessons Learned from the Laboratories of Democracy: A Critique of Federal Medical Liability Reform

Alexee Deep Conroy

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## NOTE

# LESSONS LEARNED FROM THE “LABORATORIES OF DEMOCRACY”: A CRITIQUE OF FEDERAL MEDICAL LIABILITY REFORM†

*Alexee Deep Conroy*††

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† The phrase “laboratories of democracy” is a reference to Justice Brandeis’s view that individual states can choose to experiment with novel social programs, and, as such, can serve as models for the nation. See *New State Ice v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

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## INTRODUCTION

Echoing sentiments from 2005,<sup>1</sup> President Bush focused on the need for tort reform in his 2006 State of the Union address.<sup>2</sup> According to the White House, the \$250 billion “cost of lawsuits” represents over 2% of our Gross Domestic Product and makes it difficult for the United States to compete globally.<sup>3</sup> U.S. economic expansion, the Administration believes, depends on reducing the “burden” of lawsuits that “weaken our economy” by raising the costs of goods and services and stifling job creation.<sup>4</sup> To that end, the Administration’s 2005 tort reform agenda included class action reform,<sup>5</sup> legislation to halt the initiation of frivolous lawsuits,<sup>6</sup> and legislation aimed to control asbestos litigation.<sup>7</sup> In 2006, the passage of medical liability reform is a top priority.<sup>8</sup>

The President’s medical liability reform initiative rests on the assumption that medical malpractice litigation affects health care costs, as higher medical malpractice premiums and the increased practice of defensive medicine are a function of the frequency of litigation and the increased amount of insurer payouts.<sup>9</sup> The initiative’s supporters hypothesize that rising premiums are passed on to health care consumers through increases in the cost of care.<sup>10</sup> Physicians who cannot increase prices to cover their overhead expenses and malpractice pre-

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<sup>1</sup> President George W. Bush, State of the Union Address, 41 WEEKLY COMP. PRES. DOC. 126, 127 (Feb. 2, 2005), available at <http://www.whitehouse.gov/news/releases/2005/02/20050202-11.html>.

<sup>2</sup> President George W. Bush, State of the Union Address, 42 WEEKLY COMP. PRES. DOC. 145, 150 (Jan. 31, 2006), available at <http://www.whitehouse.gov/stateoftheunion/2006/index.html>.

<sup>3</sup> U.S. Sec’y of Commerce Don Evans, Remarks in a Panel Discussion on the High Cost of Lawsuit Abuse at the White House Conference on the Economy, 40 WEEKLY COMP. PRES. DOC. 2949, 2951 (Dec. 15, 2004), available at <http://www.whitehouse.gov/news/releases/2004/12/print/20041215-11.html>.

<sup>4</sup> *Id.*

<sup>5</sup> Class Action Fairness Act of 2005, Pub. L. No. 109-2, § 1, 119 Stat. 4 (codified as amended at 28 U.S.C. § 1453 (West 2006)). This Act allows national class action lawsuits over \$5 million to move to federal court. Reformers view the legislation as a victory because it prevents state judges from “set[ting] national policies.” Press Release, Am. Tort Reform Ass’n, Class Action Passes U.S. House, ATRA Urges Congress to Continue Momentum on Other Reforms (Feb. 17, 2005), <http://www.atra.org/show/7872>.

<sup>6</sup> Lawsuit Abuse Reduction Act of 2005, H.R. 420, 109th Cong. The Senate has yet to take action on this bill.

<sup>7</sup> Asbestos Compensation Fairness Act of 2005, H.R. 1957, 109th Cong. (2005). The House has yet to take action on this bill.

<sup>8</sup> See Bush, *supra* note 2.

<sup>9</sup> See *infra* notes 45-55.

<sup>10</sup> See Lucinda M. Finley, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 EMORY L.J. 1263, 1267 (2004).

miums close their doors, thus compromising patients' access to care.<sup>11</sup> Furthermore, the Administration postulates that physicians who fear exposure to liability are likely to engage in the practice of "defensive medicine," ordering unnecessary tests to protect themselves from malpractice claims, thereby contributing further to rising health care costs.<sup>12</sup> Citing these concerns, the Administration advocates medical liability reform to "reduce health care costs and make sure patients have the doctors and care they need."<sup>13</sup>

Determined for medical liability reform to gain momentum during his second term, President Bush met with congressional leaders and citizens across the country to discuss his concerns with the medical liability system and to call upon Congress to pass reform in order to "fix a broken medical liability system."<sup>14</sup> In response to the President's calls, the Help Efficient, Accessible, Low-Cost, Timely Health-care (HEALTH) Act of 2005 was introduced in the House and Senate in February 2005.<sup>15</sup> The HEALTH Act, which aims "[t]o improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system,"<sup>16</sup> was passed in the House by a vote of

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<sup>11</sup> See Andrea D. Stailey, Note, *The Health Act's Same Old Story, Different Congress Dilemma: Overhauling the Health Act and Unifying Congress as a Remedy for Tort Reform*, 40 TULSA L. REV. 187, 191-92 (2004).

<sup>12</sup> See Geoff Boehm, *Debunking Medical Malpractice Myths: Unraveling the False Premises Behind "Tort Reform,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 357, 362-63 (2005).

<sup>13</sup> Bush, *supra* note 1, at 127.

<sup>14</sup> President George W. Bush, Remarks Following a Discussion on Medical Liability Reform in Collinsville, Illinois, 41 WEEKLY COMP. PRES. DOC. 9, 10 (Jan. 5, 2005), available at <http://www.whitehouse.gov/news/releases/2005/01/print/20050105-4.html>. President Bush delivered this speech in Madison County, Illinois, a place described by one 2005 report as the nation's worst "judicial hellhole" based on the number of tort related suits filed and allowed to go forward there. See Press Release, Am. Tort Reform Ass'n, President Bush to Discuss Need for Civil Justice Reform from Nation's Worst "Judicial Hellhole®" (Jan. 4, 2005), <http://www.atra.org/show/7848>.

<sup>15</sup> H.R. 534, 109th Cong. (2005). This bill is identical to H.R. 5, 109th Cong. (2005) and S. 354, 109th Cong. (2005). The House and Senate versions of the HEALTH Act differ in some important respects. For the purposes of this Note, however, distinguishing between the bills is unnecessary, as the primary tort provisions in each bill are essentially the same. Therefore, this Note will treat the Senate and House bills as one. The House passed the HEALTH Act for the first time in May 2004, by a vote of 229-197. This bill did not reach the Senate floor during the 108th Congress. See S. 354. Although the reason the bill never reached the Senate floor is unclear, Senate staff predicted in June 2004 that the chamber's full calendar, combined with the reduced number of meeting days as a result of the fall elections, would prevent the Senate from taking up the bill in this legislative session. Thus, the Senate's failure to introduce the bill in 2004 did not emanate from a belief that the bill was likely to fail. See *House Passes HEALTH Act as Senate Leadership Judges Likelihood of Passage in 2004*, HEALTH POL'Y ADVOC. (Am. Med. Dir. Ass'n, Columbia, MD), June 2004, at 15, 15, available at <http://www.amda.com/federalaffairs/newsletters/june2004/printissue.pdf>.

<sup>16</sup> H.R. 534 (statement of purpose).

230–194 on July 28, 2005.<sup>17</sup> The bill has yet to come to the Senate floor.<sup>18</sup>

Politically, medical liability reform is likely to enjoy substantial support. Among the powerful, well-heeled interest groups, only trial lawyers are likely to oppose the initiative. Tort reform initiatives are especially popular among Republicans, because these reforms weaken the financial power, and therefore the political power, of one of the largest contributors to the Democratic party—trial lawyers.<sup>19</sup> Medical liability reform also enjoys significant public support. Fueled by media hype highlighting seemingly exorbitant jury awards and physician office closings,<sup>20</sup> many Americans believe that the health care crisis emanates from the legal system, and they are eager for the government to address the issue.<sup>21</sup>

Yet, we do not have compelling evidence that a medical *liability* crisis exists. Those who oppose medical liability reform attribute rising health costs and the decreasing availability of care to systemic problems within the health care system, the cyclical nature of the insurance industry, and economic factors.<sup>22</sup> As such, these opponents suggest that federal medical liability reform such as the HEALTH Act is unlikely to be an effective solution.<sup>23</sup>

This Note examines the economic and social forces serving as the impetus for the HEALTH Act, and the likelihood that the Act will achieve its objectives. The Note begins by considering whether we need federal medical liability reform. Part I addresses the health care

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<sup>17</sup> 151 CONG. REC. H6974, 7012 (daily ed. July 28, 2005).

<sup>18</sup> GovTrack: S. 354: HEALTH Act of 2005, available at <http://www.govtrack.us/congress/bill.xpd?bill=s109-354> (last visited Mar. 10, 2006).

<sup>19</sup> See Sheryl Gay Stolberg, *Lobbyists on Both Sides Duel in the Medical Malpractice Debate*, N.Y. TIMES, Mar. 12, 2003, at A21 (noting that the American Medical Association, which opposes medical liability reform, contributes mostly to Republicans, and that the Association of Trial Lawyers of America, which supports such reform, contributes mostly to Democrats).

<sup>20</sup> See Finley, *supra* note 10 (“[T]he media has fueled the controversy by publishing highly selective—and thus misleading—accounts of some large tort verdicts that seemed to lend truth to the criticisms.”); *infra* notes 40–44 and accompanying text (describing highly publicized doctor walkouts and office closings); see also *infra* notes 63–69 and accompanying text (discussing the media’s influence on public perceptions of the tort system).

<sup>21</sup> HEALTH COAL. ON LIAB. & ACCESS, AMERICANS SAY HEALTH CARE ACCESS THREATENED BY LIABILITY CRISIS: MOST BELIEVE QUALITY CARE AT-RISK FROM LITIGATION 1 (2004), available at [http://www.hcla.org/factsheets/2004-HCLA-Poll-\(Fact%20Sheet\).pdf](http://www.hcla.org/factsheets/2004-HCLA-Poll-(Fact%20Sheet).pdf) (noting that 82% of Americans believe that litigation costs are driving physicians out of practice, 72% believe that increasing costs of medical liability lawsuits have led to greater health care expenses for all Americans, and 72% want Congress to enact legislation placing caps on noneconomic damages).

<sup>22</sup> See *infra* Part II.B.

<sup>23</sup> See MARTIN D. WEISS ET AL., WEISS RATINGS, INC., MEDICAL MALPRACTICE CAPS: THE IMPACT OF NON-ECONOMIC DAMAGE CAPS ON PHYSICIAN PREMIUMS, CLAIMS PAYOUT LEVELS, AND AVAILABILITY OF COVERAGE 3–4 (2003), available at <http://weissratings.com/MedicalMalpractice.pdf>.

crisis motivating the medical liability reform movement. After briefly describing some of the primary problems in our medical system, such as increasing costs and decreasing access to care, this Part considers the rationale of tort reformers who attribute these problems to a faulty medical liability system. Part II challenges this rationale by exposing several myths about the relationship between the tort system and the health care system. It then argues that our health care crisis results from a confluence of systemic problems unrelated to medical liability and malpractice lawsuits. In sum, there is no medical *liability* crisis.

This Note then looks to the efficacy of current medical liability reform proposals at the state and federal level. That is, if a medical liability crisis exists, will current attempts to remedy the problem be effective? Part III discusses medical liability reform initiatives at the state and federal level. In Part IV, this Note evaluates the effects of current tort reform initiatives by surveying findings of several major studies of these initiatives. This discussion reveals the inefficacy of most tort reform legislation in lowering premium rates or decreasing the number of malpractice claims filed. At the same time, the states' caps on noneconomic damages disproportionately harm vulnerable populations such as women, children, and the elderly. This Part concludes by highlighting the work of a few scholars who postulate that formal changes in state tort laws may have important nonformal consequences by altering public perception and thus the market environment in which the tort system operates.

In Part V, this Note evaluates the reforms to federal law proposed in the HEALTH Act. These findings lend support to the Note's conclusion that the HEALTH Act is unlikely to achieve its stated objectives. Moreover, in light of the potential effects of public perception on the tort system, national tort reform could undermine reformers' efforts by changing popular conceptions of the civil justice system. Observing that little empirical evidence supports the efficacy of the reforms articulated in the HEALTH Act, and recognizing the Act's potential to disproportionately harm vulnerable groups, this Note concludes in Part VI that the Congress should reject the Act. Instead, state governments should continue to implement and monitor reforms and both federal and state governments should engage in systematic efforts to identify factors that adversely affect our health care system. Finally, this Note suggests specific changes at the state level that may reduce medical malpractice and halt the premium rate increase while leaving open the courthouse door to victims of appalling medical harm.

I  
THE CALL FOR FEDERAL MEDICAL LIABILITY REFORM: A  
LITIGATION CRISIS

A. A Health Care System in Crisis

The crisis in our health care system includes the skyrocketing costs of medical care and prescription drugs, a rising number of uninsured persons, sharply escalating malpractice premiums, high rates of medical error, and a widespread perception that access to proper care is becoming increasingly elusive. The United States spent \$1.6 trillion on health care in 2002,<sup>24</sup> more per capita than any other nation in the world,<sup>25</sup> but it consistently has poorer health outcomes than other developed countries.<sup>26</sup> For example, among industrialized countries, the United States ranks 26th in infant mortality rates,<sup>27</sup> and, at any given moment, over 40 million Americans are without health insurance.<sup>28</sup> Health care costs are consuming an increasingly larger portion of household budgets, rising from \$1,300 per capita in inflation-adjusted dollars in 1970 to \$5,450 in 2002,<sup>29</sup> or 14.9% of our Gross Domestic Product.<sup>30</sup> Moreover, pharmaceutical costs are surging, with growth in spending increasing at more than 14% annually between 1997 and 2002.<sup>31</sup>

Of even greater concern is the Institute of Medicine's (IOM) warning in 2000 that our medical system is failing to offer meaningful health care solutions to a significant number of individuals.<sup>32</sup> Specifically, the IOM estimates that preventable medical error kills between 44,000 and 98,000 individuals annually, such that "deaths due to medical errors exceed the number attributable to the 8th leading cause of

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<sup>24</sup> *Health Care Spending and the Uninsured: Before the S. Comm. on Health, Education, Labor, and Pensions*, 108th Cong. 8 (2004) [hereinafter *The Uninsured*] (statement of Douglas Holtz-Eakin, Director, Cong. Budget Office), available at <http://www.cbo.gov/ftpdocs/49xx/doc4989/01-28-HealthTestimony.pdf>.

<sup>25</sup> BUREAU OF LABOR EDUC., UNIV. OF ME., *THE U.S. HEALTH CARE SYSTEM: BEST IN THE WORLD, OR JUST THE MOST EXPENSIVE?*, at 2-3 (2002) [hereinafter BUREAU OF LABOR EDUC.]; Uwe Reinhardt, *How Healthy Is Our Health Care?*, PRINCETON ALUMNI WKLY., Apr. 10, 2002, [http://www.princeton.edu/~paw/web\\_exclusives/plus/plus\\_041002Reinhardt.html](http://www.princeton.edu/~paw/web_exclusives/plus/plus_041002Reinhardt.html) ("The United States has long been the most expensive health system in the world, and it remains so today . . .").

<sup>26</sup> See BUREAU OF LABOR EDUC., *supra* note 25, at 4-7.

<sup>27</sup> *Id.* at 5.

<sup>28</sup> See *The Uninsured*, *supra* note 24, at 1 (statement of Douglas Holtz-Eakin, Director, Congressional Budget Office) ("From 2000 to 2002, the number of nonelderly people who were uninsured increased from 39.4 million to 43.3 million . . .").

<sup>29</sup> *Id.* at 8.

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

<sup>32</sup> See generally INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (Linda T. Kohn et al. eds., 1999) (reporting on the quality of American health care).

death.”<sup>33</sup> The IOM estimates that these errors cost the nation between \$17 billion and \$29 billion annually.<sup>34</sup> The estimated number of preventable deaths has risen to approximately 195,000, excluding errors in obstetrics.<sup>35</sup>

Since at least the early 1990s, policymakers have been concerned with rising health care costs and the resulting increase in the number of uninsured patients.<sup>36</sup> Despite these warning signs, the mounting crisis in health care did not generate widespread public support for government-sponsored change.<sup>37</sup> The government sought to remedy a system in trouble by attempting national initiatives such as the failed Clinton health care plan,<sup>38</sup> which met with deep public skepticism about the role of government in addressing health care problems.<sup>39</sup>

Public awareness of the health care crisis emerged in 2001, when rising medical malpractice premiums began to burden Americans with health insurance through corresponding increases in health insurance costs, reduced coverage, and the decreasing availability of care.<sup>40</sup> Anecdotal reports of doctors permanently closing their practices or moving to different states because of rising malpractice premiums reinforced the perception of a threat to patients’ access to health care.<sup>41</sup>

Nationally publicized work stoppages in 2003 and walkouts by doctors in hospitals and private practices lent further credence to this perception. For example, in January 2003, a group of West Virginia surgeons whose contracts had expired on December 31, 2002, protested against “soaring medical malpractice costs” by walking out of hospitals.<sup>42</sup> Similarly, in 2003, physicians in southern Florida initiated

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<sup>33</sup> See *id.* at 1.

<sup>34</sup> See *id.*

<sup>35</sup> See Boehm, *supra* note 12, at 357.

<sup>36</sup> See CONG. BUDGET OFFICE, U.S. CONG., RISING HEALTH CARE COSTS: CAUSES, IMPLICATIONS, AND STRATEGIES 28–29, 33–57 (1991) [hereinafter RISING HEALTH CARE COSTS] (discussing the number of uninsured patients and evaluating policies to control health care spending); see also *Testimony Before the S. Subcomm. on Legis. Branch Comm. on Appropriations*, 104th Cong. 4 (1992) (statement of Robert D. Reischauer, Director, Cong. Budget Office) (noting that the Congressional Budget Office “has published six major health care reports in ten months, helping to set the stage for the debate on the future of health care in this country”).

<sup>37</sup> See HAYNES JOHNSON & DAVID S. BRODER, *THE SYSTEM* 534 (1997).

<sup>38</sup> See Derek Bok, *The Great Health Care Debate of 1993–1994*, PUBLIC TALK, Fall 1998, <http://www.upenn.edu/pnc/ptbok.html>.

<sup>39</sup> See JOHNSON & BRODER, *supra* note 37 (“By the nineties, attitudes about government had turned deeply negative. Americans wanted to limit, not expand, government’s role in their lives, as the fate of the health care battle demonstrated so clearly.”).

<sup>40</sup> See Finley, *supra* note 10, at 1267.

<sup>41</sup> See Stailey, *supra* note 11, at 188, 191.

<sup>42</sup> Lauren Elizabeth Rallo, Comment, *The Medical Malpractice Crisis—Who Will Deliver the Babies of Today, the Leaders of Tomorrow?*, 20 J. CONTEMP. HEALTH L. & POL’Y 509, 512 (2004).

a slowdown in the delivery of medical services by gradually refusing to see patients except in emergency cases.<sup>43</sup> Around the same time, thousands of Pennsylvania physicians simultaneously closed their offices for one week.<sup>44</sup> Such upheavals caused Americans to perceive a crisis in their health care system. Many Americans, led astray by a public ethos that linked work stoppages to lawsuits, branded excessive litigation the culprit.

## B. A Solution to the Health Care Crisis: Medical Liability Reform

Tort reformers insist that rising costs and difficulties in obtaining treatment in our health care system stem from high jury awards in medical malpractice cases.<sup>45</sup> In addition to the direct costs associated with a given judgment, reformers argue, high jury awards raise malpractice premiums by encouraging doctors to practice “defensive medicine”<sup>46</sup> and patients to file “frivolous” lawsuits.<sup>47</sup> They further assert that significant financial resources, which otherwise might be put to constructive use, must be set aside to defend against such claims.<sup>48</sup> Finally, tort reformers assert that high malpractice premiums disastrously reduce the availability of care in certain areas and within certain specialties because premium costs are too high for physicians to remain in practice.<sup>49</sup> According to this argument, affected doctors who do not choose to leave medicine altogether will relocate to states with lower malpractice premiums.<sup>50</sup>

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<sup>43</sup> Stailey, *supra* note 11, at 187.

<sup>44</sup> *See id.* at 188.

<sup>45</sup> *See, e.g.*, Am. Tort Reform Ass’n, Medical Liability Reform, <http://www.atra.org/show/7338> (last visited Apr. 4, 2006) (“[The] inequities and inefficiencies of the medical liability system negatively affect the cost and quality of health care as well as access to adequate health care.”).

<sup>46</sup> *See, e.g., id.* (“[T]he practice of ‘defensive medicine’ as a means of reducing or avoiding tort liability is a major contributor to health care cost.”).

<sup>47</sup> *See* Stolberg, *supra* note 19 (“President Bush has been attacking trial lawyers . . . for ‘frivolous lawsuits’ . . .”).

<sup>48</sup> *See* Finley, *supra* note 10, at 1267.

<sup>49</sup> *See* Stailey, *supra* note 11, at 191. Premiums for obstetrics and gynecology are the highest of all specialties and have been rising rapidly. *See id.* One study reported that physicians paid “11.5% more in 2000 than they did in 1999; 9.2% more in 2001 than they did in 2000; and 19.3% more in 2002 than they did in 2001.” *Id.* Because of such increases, one reporter asserted that “in many states it is getting difficult to find doctors who will deliver babies.” *Id.*

<sup>50</sup> *See id.* at 191 (“Reports abound of physicians who are limiting their practices to . . . geographical areas with lower malpractice premiums . . .”). *But see id.* at 192 (citing studies by opponents of tort reform that “have found no evidence to support claims that doctors are leaving certain areas because of high insurance rates; instead, [the studies] indicate that doctors are flooding into many of these states” (quotations omitted)).

Tort reform advocates offer much anecdotal evidence to support their charge that physicians' preoccupation with liability leads them to neglect health care. The following anecdote is a typical example:

Leanne Dyess' . . . husband, Tony Dyess, crashed his car . . . and suffered severe head injuries. But the [closest] hospital did not have a specialist who could put a shunt into Tony Dyess' head to reduce the swelling of his brain. He did not get adequate care until he was airlifted to Jackson's University of Mississippi Medical Center—six hours later.

"I learned there were no specialists on staff that night . . . because rising medical liability costs had forced physicians in that community to abandon their practices," Leanne Dyess said.

Her husband is now permanently brain damaged and under the care of his parents . . .<sup>51</sup>

In addition to such anecdotal evidence, tort reform supporters cite limited empirical evidence in support of their claims of crisis. For example, in eleven states, medical malpractice filings increased 18% from 1993 to 2002.<sup>52</sup> Additionally, physician premiums rose 15% between 2000 and 2002.<sup>53</sup> The American Medical Association (AMA) reports that "more than 26% of health care institutions have reacted to the liability crisis by cutting back on services, or even eliminating some units."<sup>54</sup> In some cases, this has resulted in doctors refusing to perform high-risk surgeries.<sup>55</sup> Additionally, insurance companies may decline to cover some "high-risk" surgeries in states that have been hit hard by the "health care crisis."<sup>56</sup> Other major insurers, such as St. Paul Travelers, have stopped providing medical liability insurance altogether, leaving thousands of customers in search of alternative insurers.<sup>57</sup>

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<sup>51</sup> Ana Radelat, *Mississippian Joins Battle on Capitol Hill over Medical Malpractice*, GANNETT NEWS SERVICE, Feb. 12, 2003, cited in Health Coal. on Liab. & Access, *The Facts*, <http://www.hcla.org/crisis.html> (last visited Apr. 4, 2006).

<sup>52</sup> NAT'L CTR. FOR STATE COURTS, EXAMINING THE WORK OF STATE COURTS: A NATIONAL PERSPECTIVE FROM THE COURT STATISTICS PROJECT, 2003, at 28 (Richard Y. Schauffler et al., eds., 2003) [hereinafter NAT'L CTR. FOR STATE COURTS, 2003], available at [http://www.ncsconline.org/D\\_research/csp/2003\\_Files/2003\\_Main\\_Page.html](http://www.ncsconline.org/D_research/csp/2003_Files/2003_Main_Page.html).

<sup>53</sup> CONG. BUDGET OFFICE, U.S. CONG., LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE 1 (2004) [hereinafter LIMITING TORT LIABILITY], <http://www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf>.

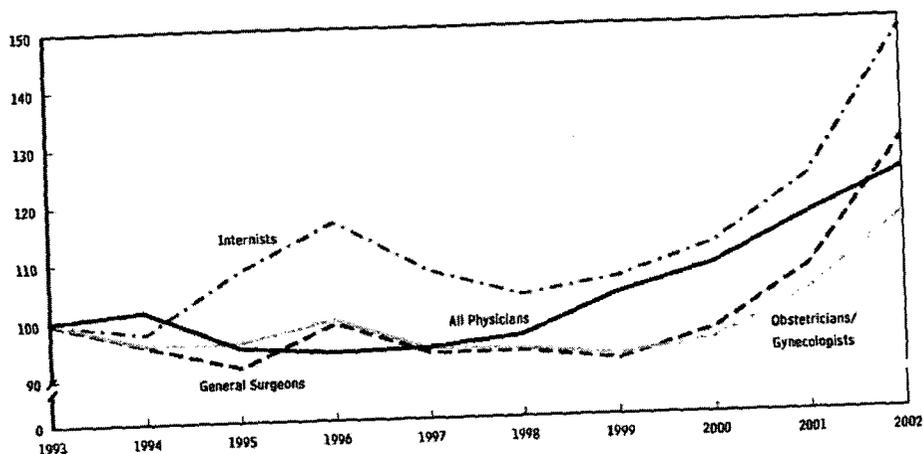
<sup>54</sup> *Assessing the Need to Enact Medical Liability Reform, Hearing on H.R. 5 Before the Subcomm. on Health of the Comm. on Energy and Commerce*, 108th Cong. 122 (2003), quoted in Stailey, *supra* note 11, at 191–92.

<sup>55</sup> See Stailey, *supra* note 11, at 191.

<sup>56</sup> See Health Coal. on Liab. & Access, *supra* note 51 ("Nearly 56% of Blue Cross/Blue Shield plans in the 12 'crisis' states identified by the American Medical Association are refusing some high-risk procedures.").

<sup>57</sup> See *id.* (noting that before withdrawing this coverage, St. Paul insured 42,000 doctors, 750 hospitals, 5,800 health care facilities, and 72,000 health care providers).

FIGURE 1  
TRENDS IN PREMIUMS FOR PHYSICIANS' MEDICAL MALPRACTICE  
INSURANCE, BY TYPE OF PHYSICIAN, 1993-2002



Source: Figure 1 in Congressional Budget Office, *Limiting Tort Liability*, cited in text note 53, at 2 (based on data from the Office of the Actuary at the Centers for Medicare and Medicaid Services and from annual premium surveys conducted by *Medical Liability Monitor*). © Congressional Budget Office. Reproduced with permission.

Although physician practice closings and restrictions on insurance coverage harm all Americans, reformers point to statistics that indicate that women suffer disproportionate injury because the most severely affected specialties, obstetrics and gynecology, cater specifically to women.<sup>58</sup> Doctors in these specialties saw a 22% increase in their premiums between 2000 and 2002.<sup>59</sup> Concerns about physicians closing their doors, insurers pulling out of states, escalating premiums, and harm to women in need of obstetricians and gynecologists, have fueled efforts by tort reform proponents to mitigate the effects of the legal system on patients' access to care.

<sup>58</sup> See *LIMITING TORT LIABILITY*, *supra* note 53, at 1 n.1 (citing data from the Centers for Medicare and Medicaid Services and from annual surveys conducted by *Medical Liability Monitor* newsletter); see also *supra* note 49 (noting rising premiums in obstetrics and gynecology).

<sup>59</sup> *LIMITING TORT LIABILITY*, *supra* note 53, at 1.

## II

CRITIQUING THE CALL FOR MEDICAL LIABILITY REFORM: A  
MEDICAL SYSTEM IN CRISISA. Exposing Myths About the Causal Relationship Between Tort  
Litigation and the Health Care Crisis

Despite the public clamor, those opposed to tort reform believe that no medical *liability* crisis exists.<sup>60</sup> They deny that the tort system has created or could solve the health care crisis. Instead, they assert that the legal system provides groups of medical professionals, such as the AMA, with a scapegoat for the health system's systemic troubles.<sup>61</sup> Moreover, this convenient explanation also allows politicians and tort reform lobbyists to use public persuasion campaigns to change societal beliefs about fairness in our justice system. As some commentators put it:

[Tort] reformers . . . want to affect the way in which the media, intellectuals, key elites, and ultimately the public at large think about the civil justice system. . . . More than just the formal legal changes it seeks, tort reform has always been about altering the cultural environment surrounding civil litigation . . . . The best evidence of this is found in the various public relations campaigns used by the reform interests since at least the 1970s . . . .<sup>62</sup>

Despite evidence that judges believe that juries are generally effective in meting out justice and assigning equitable awards to deserving plaintiffs,<sup>63</sup> headline news stories fuel public skepticism about our justice system and the tort system in particular.<sup>64</sup> The highly publicized case of the plaintiff who received \$2.9 million from McDonald's for spilling hot coffee on herself exemplifies the media's portrayal of a tort system out of control.<sup>65</sup> Media hype in the area of medical mal-

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<sup>60</sup> Many opponents of tort reform do acknowledge, however, that increasing costs and decreasing access to care may have created a health care crisis. See, e.g., Finley, *supra* note 10, at 1268-77 (presenting empirical evidence that increased premiums result not from high tort damages but from economic and systemic forces).

<sup>61</sup> See *id.* at 1267.

<sup>62</sup> Stephen Daniels & Joanne Martin, "The Impact That It Has Had Is Between People's Ears:" *Tort Reform, Mass Culture, and Plaintiffs' Lawyers*, 50 DEPAUL L. REV. 453, 453 (2000) [hereinafter Daniels & Martin, *Ears*].

<sup>63</sup> See Boehm, *supra* note 12, at 367-68 (discussing the results of a 2000 judicial survey finding that only 1% of judges give the jury system "low marks," while 90% of judges believe that jurors "show considerable understanding of legal issues involved in the cases they hear" (quotations omitted)).

<sup>64</sup> See Michael McCann et al., *Java Five: Genealogy of a Juridical Icon*, 56 U. MIAMI L. REV. 113, 116 (2001) ("Our own aggregate content analysis . . . shows how news coverage of tort litigation by reports relying on . . . routine institutional conventions produces a consistent portrait of legal action that parallels in form and substance the selective, simplistic anecdotal portrayals of civil legal practice disseminated by tort reformers.").

<sup>65</sup> See generally *id.* (arguing that the publicity surrounding that case profoundly influenced American attitudes toward the tort system).

practice includes unsupported anecdotes of doctors' office closings,<sup>66</sup> skyrocketing jury awards,<sup>67</sup> and "frivolous lawsuits."<sup>68</sup> These media presentations of the tort system as "out of control" erode public understanding of the tort system as a tool for ordinary citizens to redress social wrongs and "hold accountable those with power—including corporations, large institutions, professionals, and even government."<sup>69</sup>

After pointing out that the campaign for tort reform is, in part, an ideological war, those opposed to medical liability reform deny the role of the tort system in causing the problems in the health care system by rebutting several myths espoused by tort reformers. A discussion of these myths and their rebuttal follows.

### 1. *The Medical Liability—National Competitiveness Myth*

Contrary to public perception, medical malpractice spending accounts for less than 2% of all health care spending.<sup>70</sup> Thus, even a 50% reduction in medical malpractice costs would have a negligible effect on the \$1.6 trillion dollars Americans spend annually on health care.<sup>71</sup> This evidence reveals that President Bush's push for medical liability reform as a means of increasing national competitiveness by decreasing allegedly wasteful health care expenditures<sup>72</sup> is drastically overstated, if not spurious. Just as importantly, a reduction in malpractice liability could create a disincentive to invest in error reduction, thus increasing the already high rate of medical error.<sup>73</sup> Malpractice liability is one of the few means by which patients can hold their physicians to high standards of care and encourage health organizations to institute mechanisms to reduce medical error. Thus, not only is medical liability reform likely to have a negligible effect on health care spending, it may also lead to a further decline in the quality of health outcomes.

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<sup>66</sup> See *supra* note 51 and accompanying text.

<sup>67</sup> See Finley, *supra* note 10.

<sup>68</sup> See Boehm, *supra* note 12, at 358–60. Tort reformers are fond of asserting that each U.S. consumer pays a "tort tax" of \$809 per year. See Dan Zegert, *Tort Reform Advocates Play Fast and Loose with the Facts*, 30 MONT. LAW., Feb. 2005, at 30, 30. This figure was arrived at simply by dividing \$233 billion, the supposed cost of the tort system, by the population of the United States. See *id.* at 33. Yet opponents of reform dispute the \$233 billion figure, noting that it includes the total costs of the insurance industry, including not only legal fees but also executive salaries, advertising, and other miscellaneous costs. See *id.* Thus, the actual "tort tax" may be far less than \$809. See *id.*

<sup>69</sup> See Boehm, *supra* note 12, at 366.

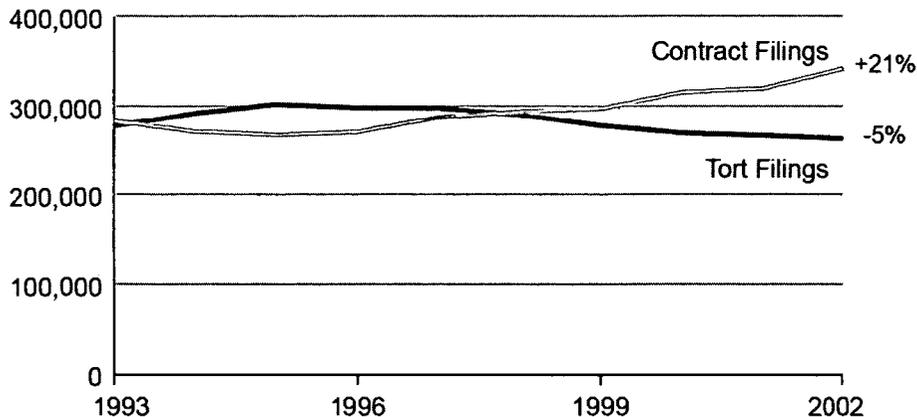
<sup>70</sup> LIMITING TORT LIABILITY, *supra* note 53, at 1.

<sup>71</sup> *The Uninsured*, *supra* note 24, at 8 (statement of Douglas Holtz-Eakin, Director, Congressional Budget Office).

<sup>72</sup> See *supra* notes 1–8 and accompanying text.

<sup>73</sup> See LIMITING TORT LIABILITY, *supra* note 53, at 5.

FIGURE 2  
TORT AND CONTRACT FILINGS IN GENERAL JURISDICTION TRIAL  
COURTS IN 17 STATES, 1993–2002



Source: Figure 1 in National Center for State Courts, *Examining the Work of State Courts: A National Perspective from the Court Statistics Project*, 2003, cited in text note 52, at 23. © National Center for State Courts. Reproduced with permission.

## 2. *The Malpractice Premium–Litigation Myth*

Empirical evidence demonstrates that the rise in malpractice premiums does not result from an increase in litigation. First, tort filings have not increased in recent years.<sup>74</sup> Indeed, between 1993 and 2002, tort filings decreased 5%, compared with a 21% increase in contract filings.<sup>75</sup> Moreover, between 1994 and 2003, tort filings declined 10% overall in fifteen states.<sup>76</sup> Additionally, medical malpractice claims constitute only a small percentage of state tort claims. From 2001 to 2003—“crisis” years according to reform advocates—medical malpractice filings constituted no more than 5% of all tort claims,<sup>77</sup> a rate comparable to that in the early 1990s.<sup>78</sup> Assessments of medical mal-

<sup>74</sup> NAT'L CTR. FOR STATE COURTS, 2003, *supra* note 52, at 23 fig.

<sup>75</sup> *See id.*

<sup>76</sup> NAT'L CTR. FOR STATE COURTS, *EXAMINING THE WORK OF STATE COURTS: A NATIONAL PERSPECTIVE FROM THE COURT STATISTICS PROJECT*, 2004, at 26 fig. (Richard Y. Schauffler et al. eds., 2004), available at [http://www.ncsconline.org/d\\_research/csp/2004\\_Files/EW2004\\_Main\\_Page.html](http://www.ncsconline.org/d_research/csp/2004_Files/EW2004_Main_Page.html). Additionally, between 1993 and 2002, tort filings declined 4% overall in the thirty-five states able to provide data. NAT'L CTR. FOR STATE COURTS, 2003, *supra* note 52, at 23. These states represent 77% of the U.S. population. *Id.*

<sup>77</sup> *See* Finley, *supra* note 10, at 1268. Medical malpractice claims constitute a larger percentage of tort cases actually litigated, however. *See* THOMAS H. COHEN & STEVEN K. SMITH, *CIVIL JUSTICE SURVEY OF STATE COURTS, 2001: CIVIL TRIAL CASES AND VERDICTS IN LARGE COUNTIES, 2001*, at 2 tbl.1 (2004), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/ctcvlc01.pdf> (finding that medical malpractice trials constituted 9.7% of state trials in the largest 75 counties).

<sup>78</sup> *See* NAT'L CTR. FOR STATE COURTS, 2003, *supra* note 52, at 26 (comparing medical malpractice claims in the 75 largest counties in 1992 with automobile claims, which account for 60% of all tort claims, and “slip and fall” claims, which account for 17%).

practice filings over just a few years can be misleading because longitudinal data suggest that filing trends fluctuate over four and five year spans. For example, in eleven states, malpractice claims remained stable for three years between 1996 and 1998, declined in 1999 and 2000, and increased by 10% for two years thereafter.<sup>79</sup> Taken altogether, it appears that medical malpractice filings in those states are growing by approximately 1% annually.<sup>80</sup> Rather than view this slight increase in malpractice filings as reflecting Americans' overly litigious nature, the increase may largely result from the rising per capita consumption of medical services.<sup>81</sup>

Second, even if medical malpractice claims are increasing, medical malpractice trials and insurer payouts are not. Between 1992 and 2001, there was a 14.2% decrease in medical malpractice trials.<sup>82</sup> Additionally, very few of the cases that are filed result in a verdict, let alone a verdict in the plaintiff's favor.<sup>83</sup> Furthermore, despite the increase in medical malpractice filings, the number of large claims paid out by insurers has remained relatively stable.<sup>84</sup>

Third, little evidence supports reformers' assertions that there are too many frivolous lawsuits. While some false claims undoubtedly are filed, research suggests that, in light of the high rate of preventable medical error in the United States,<sup>85</sup> the number of claims filed may be quite low, with only one out of every eight incidents of medical error resulting in a medical malpractice claim.<sup>86</sup>

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<sup>79</sup> *Id.* at 28.

<sup>80</sup> *See id.* That figure includes five additional states that were included for only the last five years of the period studied. *Id.*

<sup>81</sup> *See* Bernard Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988–2002*, 2 J. EMPIRICAL LEGAL STUD. 207, 229–30 (2005) (noting that one should expect medical practice claims to increase along with the increasing consumption of medical care services).

<sup>82</sup> COHEN & SMITH, *supra* note 77, at 9 tbl.10.

<sup>83</sup> *See* Finley, *supra* note 10, at 1268–69 (reporting that less than 5% of all medical malpractice cases that are filed make it to trial); Mitchell J. Nathanson, *It's the Economy (and Combined Ratio), Stupid: Examining the Medical Malpractice Litigation Crisis Myth and the Factors Critical to Reform*, 108 PENN ST. L. REV. 1077, 1107 (2004) (reporting that between 1985 and 1999, only 6.7% of all medical malpractice cases that were filed resulted in a verdict, and only 1.3% favored the plaintiff). The low number of verdicts favoring plaintiffs may be skewed by a "selection effect" on the cases that go to trial. *See infra* note 90.

<sup>84</sup> *See* Black et al., *supra* note 81, at 252 ("For Texas, the frequency of large paid medical malpractice claims, and the per-claim cost of these claims, were relatively stable from 1988 to 2002 . . .").

<sup>85</sup> *See supra* note 35 and accompanying text.

<sup>86</sup> Ashley Stewart, Casenote, *Texas' House Bill Four's Noneconomic Damage Caps Impose the Burden of Supporting the Medical Industry Solely upon Those Most Severely Injured and Therefore Most in Need of Compensation*, 57 SMU L. REV. 497, 503 (2004).

### 3. *The Malpractice Premium–Jury Award Myth*

Empirical evidence also suggests that one cannot attribute the rise in malpractice premiums to higher jury awards. Data from Texas suggest that the value of jury awards to successful plaintiffs has remained stable over the past fifteen years.<sup>87</sup> Moreover, less than 5% of all medical malpractice claims actually make it to trial.<sup>88</sup> When they do, juries tend to favor defendants.<sup>89</sup> For example, plaintiffs won only 27% of cases in 2001.<sup>90</sup> Furthermore, very few successful plaintiffs receive awards for noneconomic damages in excess of the proposed cap of \$250,000.<sup>91</sup>

Additionally, despite all of the publicity, large jury awards constitute only 4% of insurers' payouts because many large awards are never paid.<sup>92</sup> Instead, many plaintiffs enter "high-low" agreements in advance of the jury verdict.<sup>93</sup> These agreements establish an upper and lower limit for damages, such as \$1 million and \$3 million.<sup>94</sup> If the verdict favors the plaintiff, then, regardless of the actual jury award, the defendant will pay no more than \$3 million; if the verdict favors

<sup>87</sup> See Black et al., *supra* note 81 (analyzing Texas closed claims data from 1988 to 2002). *But see* COHEN & SMITH, *supra* note 77, at 9 tbl.11 (finding that, although median awards in all state civil trials decreased 43.1%, median jury awards in medical malpractice cases increased 70.4% between 1992 and 2001); Black et al., *supra* note 81, at 212 (citing a study by Neil Vidmar et al. that found that median payouts in Florida substantially increased between 1990 and 2003).

<sup>88</sup> See Finley, *supra* note 10, at 1268–69.

<sup>89</sup> See *id.* at 1269.

<sup>90</sup> COHEN & SMITH, *supra* note 77, at 4 tbl.5. This statistic includes verdicts from bench and jury trials (including those with defendants in default), directed verdicts, and judgments notwithstanding the verdict. See *id.* Contrary to popular perception, research shows that plaintiffs in tort cases are more likely to be successful before a judge than a jury. See *id.* at 3 tbl.2. This finding, along with the statistics cited above revealing plaintiffs' success in jury trials, must be considered in conjunction with the "selection effect" recognized among academics as affecting the number and type of cases tried:

Cases only go to trial when the parties substantially disagree on the predicted outcome of trial . . . . These unsettled close cases fall more or less equally on either side of the legal standard, regardless of both that standards' position and the underlying distribution of disputes. Thus, even if the legal standard highly favors plaintiffs, one might not observe a plaintiff trial win rate well above 50%.

Kevin M. Clermont & Theodore Eisenberg, *Trial by Jury or Judge: Transcending Empiricism*, 77 CORNELL L. REV. 1124, 1129 (1992). Because of this phenomenon, statistics indicating the frequency of plaintiff wins may be misleading.

<sup>91</sup> See Stewart, *supra* note 86, at 502.

<sup>92</sup> Joseph T. Hallinan, *Suit Wrinkle: In Malpractice Trials, Juries Rarely Have the Last Word*, WALL ST. J., Nov. 30, 2004, at A1; see also Melissa Patterson, Note, *The Medical Malpractice Crisis: The Product of Insurance Companies and a Threat to Women's Health*, 8 QUINNIPIAC HEALTH L.J. 109, 128–29 (2004) (noting that insurers' payouts have risen at the same pace as medical inflation for 30 years).

<sup>93</sup> See Hallinan, *supra* note 92; see also Steven R. Gabel, *High/Low Settlement Agreements: Method for Dispute Resolutions*, 73 MICH. B.J. 74, 74 (1994) (discussing the advantages and disadvantages of high-low agreements).

<sup>94</sup> See Hallinan, *supra* note 92.

the defendant, however, then the plaintiff is guaranteed to receive \$1 million. Parties enter such agreements to hedge their bets against losing at trial and to avoid costly appeals.<sup>95</sup> These agreements are confidential; thus, their frequency and effect on reducing insurer payouts are not fully known.<sup>96</sup> Professor Neil Vidmar conservatively estimates that high-low agreements reduce at least 44% of jury awards.<sup>97</sup> Professor Vidmar estimates that, on average, plaintiffs receive 62% of their jury awards; moreover, this figure can drop below 10% of the jury award when the awards are unusually large.<sup>98</sup> These estimates further support data showing that jury payouts constitute only a small percentage of insurer costs and thus cannot be primarily responsible for rising malpractice premiums. Even if, as reformers suggest, caps alter the bargaining-power dynamics in settlement discussions, the small number of jury awards in excess of statutory caps<sup>99</sup> suggests that these caps will have a negligible effect on settlement discussions in most cases.

Those opposed to tort reform explain today's higher jury awards as corresponding to the rate of medical inflation, which reflects the increasing cost of medical care.<sup>100</sup> According to the National Practitioner Data Bank, between 1997 and 2001, the median physician payout to malpractice claimants rose less than the rate of medical inflation.<sup>101</sup> Specifically, a comparison of median jury awards in 1992 and 2001 reveals a 70% increase in jury verdicts, yet the 51.7% increase in medical costs and the general inflation of 26.2% could explain most of this increase.<sup>102</sup> The increasing severity of the claims that reach the jury further explains the increasing jury verdicts.<sup>103</sup>

#### 4. *The Malpractice Premium—Access to Care Myth*

Those opposed to tort reform point to empirical evidence that suggests that the rise in malpractice premiums has not generally led to

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<sup>95</sup> See *id.*

<sup>96</sup> See *id.* "In 2000, Pennsylvania reported three of the largest medical-malpractice verdicts in its history, all of them rendered in Philadelphia: one for \$100 million, another for \$55 million and a third for \$49.6 million." *Id.* Ultimately, however, "[t]he \$55 million case settled for \$7.5 million, according to the lawyer for the plaintiff. The \$49.6 million case settled for \$8.4 million, according to court documents. And the \$100 million case settled for an undisclosed sum . . . significantly less than \$100 million." *Id.*

<sup>97</sup> Neil Vidmar et al., *Jury Awards for Medical Malpractice and Post-Verdict Adjustments of Those Awards*, 48 DEPAUL L. REV. 265, 298 (1998).

<sup>98</sup> See *id.* at 298.

<sup>99</sup> See *supra* note 91 and accompanying text.

<sup>100</sup> See Finley, *supra* note 10, at 1269.

<sup>101</sup> *Id.* at 1270.

<sup>102</sup> *Id.* at 1269.

<sup>103</sup> *Id.* ("[I]n 2001, 90% of medical malpractice trials involved plaintiffs who suffered the most severe injuries of death or permanent disability, and damage awards are the highest in these types of cases.")

a decrease in the availability of care.<sup>104</sup> In fact, the General Accounting Office reported that “there has not been any documentable adverse effect on access to health care, except in some scattered, often rural areas, where factors other than malpractice premiums contribute to the access issues.”<sup>105</sup> Furthermore, some states singled out by the AMA as suffering from a decrease in the availability of care experienced an *increase* in the number of physicians per capita.<sup>106</sup>

### 5. *The Litigation–Defensive Medicine Myth*

Finally, those in favor of tort reform advocate reform to reduce the practice of “defensive medicine.”<sup>107</sup> Physicians order unnecessary tests, so the argument goes, for fear of exposing themselves to liability.<sup>108</sup> Yet, an Office of Technology Assessment study showing that “less than eight percent of all diagnostic procedures result primarily from liability concerns” proves these concerns to be exaggerated greatly at best.<sup>109</sup> Similarly, the Congressional Budget Office found that “savings from reducing defensive medicine would be very small.”<sup>110</sup>

## B. An Alternative Explanation for the Origins of Our Health Care Crisis: Systemic Problems, Insurance Cycles, and the Economy

### 1. *Systemic Problems, Not Litigation, Are at the Root of Our Health Care Crisis*

Opponents of medical liability reform believe that the U.S. health care crisis of increasing costs and decreasing availability reflects a number of underlying concerns that do not stem from medical malpractice litigation. Instead, systemic problems call for narrowly tailored solutions. These problems include the uninsured, the underinsured, rapidly rising prescription drug costs, the tying of health insurance to employment, market failures in the health care system, the increasing consumption of health services, the proliferation of new and expensive medical technologies, and the absence of

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<sup>104</sup> See *id.* at 1271. But see WEISS ET AL., *supra* note 23, at 3 (“Soaring premiums on medical malpractice insurance . . . are . . . threatening the availability of care.”).

<sup>105</sup> See Finley, *supra* note 10, at 1271.

<sup>106</sup> *Id.*

<sup>107</sup> See LIMITING TORT LIABILITY, *supra* note 53, at 6; Randall R. Bovbjerg & Laurence R. Tancredi, *Liability Reform Should Make Patients Safer: “Avoidable Classes of Events” Are a Key Improvement*, 33 J.L. MED. & ETHICS 478, 481 (2005) (reporting that doctors believe the current system causes the practice of defensive medicine).

<sup>108</sup> See A.C. Hoffman, *Governmental Studies on Medical Malpractice: The Implications of Rising Premiums for Healthcare and the Allocation of Health Resources*, 24 MED. & L. 297, 304 (2005).

<sup>109</sup> Boehm, *supra* note 12, at 363.

<sup>110</sup> See LIMITING TORT LIABILITY, *supra* note 53, at 6.

federal regulation in the insurance market. Capping noneconomic and punitive damage awards in the hope of reducing medical malpractice premiums and discouraging the practice of defensive medicine will not solve these problems. Even if medical liability reform is successful in reducing malpractice premiums in the short term, these gains will remain temporary as the system continues to absorb the increasing costs of other aspects of care. Problems endemic to the health care system require systemic solutions; tort reform cannot provide anything more than a temporary one.

2. *An Explanation for Escalating Premiums: Insurance Cycles and the Economy*

Because of conflicting data and the politicization of tort reform, separating fact from fiction is difficult in this debate. Commentators disagree over the facts and even the existence of a crisis, making it difficult to evaluate or craft reform agendas. Yet discerning agreed-upon facts is critical to moving forward. The only significant undisputed fact in the malpractice reform debate seems to be that premiums have been rising sharply since 2001.<sup>111</sup> While disagreement persists over the origins of this premium increase, the explanations for rising premium costs offered by advocates of tort reform remain unsubstantiated. In fact, some evidence suggests that escalating premiums are mostly attributable to economic and investment cycles.<sup>112</sup>

The General Accounting Office and Weiss Ratings<sup>113</sup> independently researched the effects of tort reform at the state level and attempted to determine the cause of escalating medical malpractice insurance premiums.<sup>114</sup> Both groups found that damage caps do not lead to lower insurance premiums for doctors.<sup>115</sup> Similarly, a report by Americans for Insurance Reform found that, while jury awards and physicians' payouts are correlated strongly with medical inflation, medical malpractice premiums are not correlated with these payouts "in any direct way."<sup>116</sup> Instead, the cost of malpractice insurance is correlated strongly with the highs and lows of insurance companies' profit margins and investment health.<sup>117</sup> Thus, rather than suggesting

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<sup>111</sup> See, e.g., *id.* at 1; Finley, *supra* note 10, at 1267.

<sup>112</sup> See *supra* Part II.B.2.

<sup>113</sup> Weiss Ratings is an independent agency that provides ratings of insurance and financial institutions. See About Weiss Ratings, [http://weissratings.com/about\\_weiss.asp](http://weissratings.com/about_weiss.asp) (last visited Apr. 4, 2006).

<sup>114</sup> See Finley, *supra* note 10, at 1271–74.

<sup>115</sup> *Id.* at 1271–72.

<sup>116</sup> AMS. FOR INS. REFORM, MEDICAL MALPRACTICE INSURANCE: STABLE LOSSES/UNSTABLE RATES 4 (2002), <http://insurance-reform.org/StableLosses.pdf> (quoted in Finley, *supra* note 10, at 1274).

<sup>117</sup> WEISS ET AL., *supra* note 23, at 3–4; Finley, *supra* note 10, at 1274 (citing AMS. FOR INS. REFORM, *supra* note 116).

that high jury awards increase malpractice premiums, the empirical findings support the hypothesis that the cyclical nature of the insurance market, correlating with the economy and investment success, is most responsible for fluctuations in medical malpractice premiums.<sup>118</sup> According to the Director of Insurance for the Consumer Federation of America:

[T]he amounts charged for premiums do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums.<sup>119</sup>

Weiss Ratings concluded that the current increase in medical malpractice premiums results primarily from six factors:

- (1) medical inflation,
- (2) the cyclical nature of the insurance market,
- (3) the need to shore up reserves for policies already in force,
- (4) declining investment income,
- (5) overall financial safety concerns, and
- (6) the supply and demand of coverage.<sup>120</sup>

These six factors—rather than excessive litigation, the practice of defensive medicine, or escalating jury verdicts—are most likely responsible for the increase in medical malpractice premiums.<sup>121</sup> Therefore, reform measures aiming to reduce escalating premiums should concentrate on one or more of these factors.

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<sup>118</sup> See WEISS ET AL., *supra* note 23, at 3–4; Finley, *supra* note 10, at 1273 (“[I]t was the combination of two powerful forces—under-reserving throughout most of the 1990s *plus* the rapid fall in investment income in the 2000s—that largely drove the unusually rapid premium increases . . . in medical malpractice . . .” (quoting WEISS ET AL., *supra* note 23, at 10)).

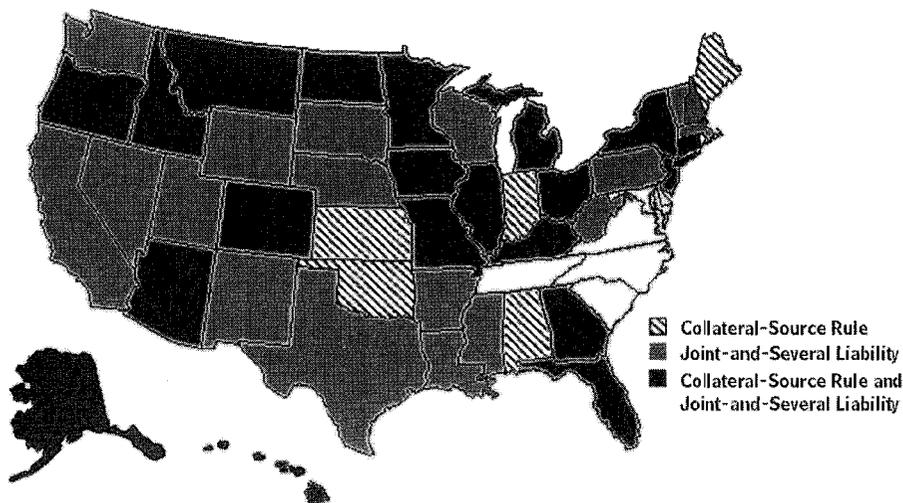
<sup>119</sup> Finley, *supra* note 10, at 1273–74.

<sup>120</sup> WEISS ET AL., *supra* note 23, at 3–4.

<sup>121</sup> See *id.*

III  
 MEDICAL LIABILITY REFORM: STATE ENACTMENTS AND  
 PROPOSED FEDERAL LEGISLATION

FIGURE 3  
 STATES THAT HAVE ENACTED REFORMS TO JOINT-AND-SEVERAL  
 LIABILITY AND THE COLLATERAL-SOURCE RULE SINCE 1986



Source: Figure 1 in Congressional Budget Office, *The Effects of Tort Reform: Evidence from the States*, cited in text at note 122, at 5. © Congressional Budget Office. Reproduced with permission.

A. Tort Reforms Enacted at the State Level

State tort reform initiatives began in the 1970s and continue today.<sup>122</sup> Although many state reform statutes solely address medical malpractice liability, the plans vary and consist of one or more of the following four reform initiatives.<sup>123</sup> First, over the past two decades, thirty-eight states have passed statutes reforming joint and several liability, the common law doctrine under which each liable party is individually responsible for the entire obligation to pay damages, regardless of a party's actual degree of culpability.<sup>124</sup> Forty-two states currently limit joint and several liability in some fashion.<sup>125</sup> This reform aims to reduce the incentives for plaintiffs to join peripheral de-

<sup>122</sup> See CONG. BUDGET OFFICE, U.S. CONG., *THE EFFECTS OF TORT REFORM: EVIDENCE FROM THE STATES* 3 [hereinafter *EVIDENCE FROM THE STATES*], available at <http://www.cbo.gov/ftpdoc.cfm?index=5549&type=1>.

<sup>123</sup> For a description of additional tort reform initiatives, see *id.* at 8. While many states have experimented with measures such as restricting contingent fees, setting up victim compensation funds, and providing for alternative dispute resolution, the effects of such reforms have not been empirically analyzed yet. See *id.*

<sup>124</sup> *Id.* at 4.

<sup>125</sup> *Id.*

fendants in hopes of taking advantage of the defendants' "deep pockets."<sup>126</sup>

Second, twenty-three states have abolished or changed the common law "collateral source" rule, which prohibits a defendant from introducing evidence at trial that a plaintiff has already received compensation for the injury in question from another source.<sup>127</sup> Under this rule, damages cannot be reduced by the amount of that compensation.<sup>128</sup> The reform aims to prevent victims who have received compensation from other sources, such as from medical insurance settlements, from being overcompensated.<sup>129</sup>

Third, thirty-four states have enacted reforms restricting punitive damage awards.<sup>130</sup> Limitations include requiring a higher standard of proof of malicious intent before such damages can be awarded, imposing a maximum amount of punitive damages that a victim can recover, and, in some jurisdictions, banning punitive damages altogether.<sup>131</sup>

Fourth, because of the perception that "unpredictable and extravagant judgments" often result from claims of emotional harm, twenty-three states have passed tort reforms placing caps on noneconomic damage awards.<sup>132</sup> The maximum amount varies from \$250,000 in Kansas<sup>133</sup> to \$750,000 in Texas.<sup>134</sup> Five states did strike down these caps as unconstitutional,<sup>135</sup> but the remaining eighteen states consider the caps justified.<sup>136</sup>

Although substantial reforms have taken place at the state level, advocates of federal tort reform legislation argue that the patchwork of individual state laws and the variability in their application hinders efficiency by imposing unnecessary costs on businesses and patients.<sup>137</sup> Proponents of federal tort reform emphasize the benefits of uniformity, citing the potential savings for businesses that provide goods and services in multiple states,<sup>138</sup> and arguing that reform will eliminate venue shopping in medical malpractice cases.<sup>139</sup>

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<sup>126</sup> *See id.*

<sup>127</sup> *Id.* at 5 fig.1.

<sup>128</sup> *Id.*

<sup>129</sup> *Id.* at 6.

<sup>130</sup> *Id.* at 7.

<sup>131</sup> *Id.* at 7-8.

<sup>132</sup> *Id.* at 6.

<sup>133</sup> *Id.*

<sup>134</sup> *Id.*; Jean Hellwege, *Med-Mal Caps in Two States Don't Reduce Insurance Rates*, TRIAL, FEB. 2004, at 14, 15.

<sup>135</sup> EVIDENCE FROM THE STATES, *supra* note 122, at 6 n.16.

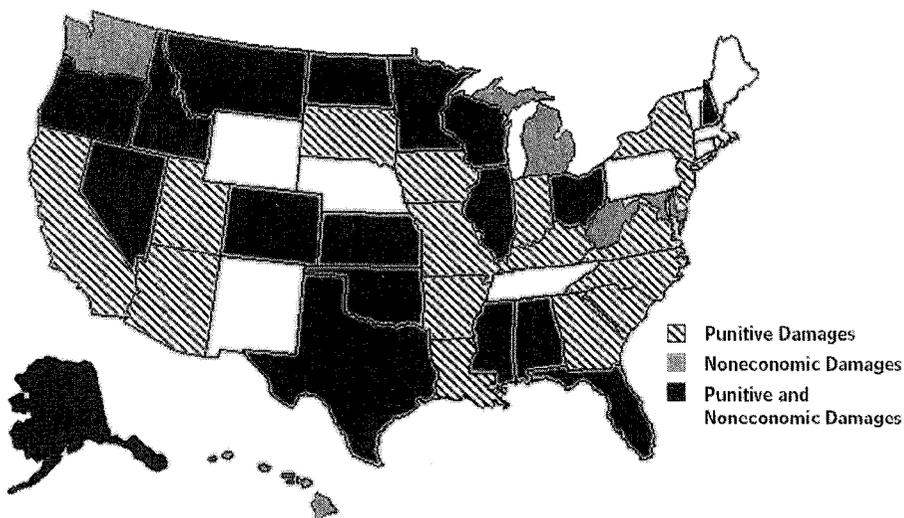
<sup>136</sup> *Id.* at 6.

<sup>137</sup> *Id.* at 2.

<sup>138</sup> *Id.* at 3.

<sup>139</sup> *Id.*

FIGURE 4  
STATES THAT HAVE ENACTED CAPS ON DAMAGES SINCE 1986



Source: Figure 7 in Congressional Budget Office, *The Effects of Tort Reform: Evidence from the States*, cited in text at note 122, at 7. © Congressional Budget Office. Reproduced with permission.

#### B. Proposed Federal Reform: The HEALTH Act

Growing out of the belief that medical malpractice costs are adversely affecting patients' access to care and increasing the cost of health care, the reform initiatives of the proposed federal HEALTH Act of 2005 aim to achieve the following objectives:

- Improve access to care
- Reduce physicians' practice of "defensive medicine"
- Reduce medical malpractice premiums for physicians
- Ensure equitable compensation for injury
- Enhance information sharing to reduce malpractice<sup>140</sup>

To accomplish these objectives, the Act will implement the following policies:

- (1) Set the statute of limitations at "3 years after the date of manifestation of the injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first"<sup>141</sup>
- (2) Cap damages for noneconomic loss at \$250,000<sup>142</sup>
- (3) Limit lawyers' contingency fees<sup>143</sup>

<sup>140</sup> See Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2005, H.R. 534, 109th Cong. § 2(b) (2005).

<sup>141</sup> *Id.* § 3.

<sup>142</sup> *Id.* § 4(b).

<sup>143</sup> *Id.* § 5(a).

- (4) Abolish joint and several liability, adopting a proportionate liability standard instead<sup>144</sup>
- (5) Abolish the collateral source rule<sup>145</sup>
- (6) Eliminate the recovery of punitive damages except for certain intentional torts,<sup>146</sup> and specify the exclusive factors to be considered in determining an appropriate amount of punitive damages<sup>147</sup> not to exceed \$250,000 or “two times the amount of economic damages awarded, whichever is greater.”<sup>148</sup>

Although the Act states that its provisions preempt applicable state laws,<sup>149</sup> it provides an exception for state laws that “specif[y] a particular monetary amount of compensatory or punitive damages . . . that may be awarded . . . , regardless of whether such monetary amount is greater or lesser than is provided for under this Act . . . .”<sup>150</sup>

#### IV

#### EVALUATING THE EFFECTS OF STATE TORT REFORM INITIATIVES

Notwithstanding the significant disagreement about whether the medical liability system is in crisis, the passage of the HEALTH Act in the House clearly indicates that at least some members of Congress sense a need for a national medical liability reform package. Assuming, despite the foregoing discussion to the contrary, that a medical *liability* crisis does in fact exist, this Part will assess whether the HEALTH Act will be an effective solution to this crisis. This inquiry will begin by analyzing the efficacy of comparable state reforms.

##### A. State Reform Initiatives: General Findings from Major Tort Reform Studies, 1993–2005

The results from state-level reforms are mixed. Despite the imposition of caps on damages, insurance premium rates have increased in Florida and Texas.<sup>151</sup> National research supports these results by find-

<sup>144</sup> *Id.* § 4(d).

<sup>145</sup> *Id.* § 6. In the Senate version, this limitation allows collateral source agents to recover money from the plaintiff if such action is not barred by state law. *See* S. 354, 109th Cong. § 7 (2005).

<sup>146</sup> H.R. 534, § 7(a). The exception applies only if the tortfeasor “acted with malicious intent to injure the claimant” or “deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. *Id.*

<sup>147</sup> *Id.* § 7(b)(1).

<sup>148</sup> *Id.* § 7(b)(2). The House version of the Act also states that punitive damages will not be awarded for products that comply with FDA standards. *Id.* § 7(c).

<sup>149</sup> *Id.* § 11(a).

<sup>150</sup> *See id.* § 11(c)(1).

<sup>151</sup> *See* Hellwege, *supra* note 134, at 16 (citing two 2003 studies, one conducted by Weiss Ratings, and another conducted by the U.S. General Accounting Office).

ing that medical malpractice premiums rose faster in states with caps than in those without.<sup>152</sup> Moreover, in Texas, higher premium rates have been accompanied by reduced insurance coverage and increased deductibles.<sup>153</sup> Yet the AMA reports that upon implementing tort reform, the “crisis” states of Texas, West Virginia, and Ohio have witnessed “less dramatic premium increases” and “some of the results they hoped for” following the implementation of tort reform measures.<sup>154</sup> The AMA also observes that improvements in access to care in specialties such as obstetrics in Texas have mitigated the increased insurance premiums.<sup>155</sup> Despite these findings, however, significant problems remain.<sup>156</sup>

In recent years, several studies have assessed the impact of state-level tort reforms.<sup>157</sup> Yet several factors limit the applicability of these studies’ results. Studies restricted to a particular kind of tort claim do not necessarily apply universally.<sup>158</sup> For example, findings of the effects of tort reform on automobile injury cases do not necessarily apply to medical malpractice cases.<sup>159</sup> Additionally, the effects of specific reform measures are often uncertain because isolating one reform’s effects from those of other reforms or economic forces is

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<sup>152</sup> See Stewart, *supra* note 86, at 501–02 (citing WEISS ET AL., *supra* note 23).

<sup>153</sup> See Hellwege, *supra* note 134, at 16 (citing anecdotal evidence).

<sup>154</sup> Mike Norbut, *Three Crisis States Show Improvement Since Tort Reform*, AM. MED. NEWS, Mar. 28, 2005, at 1.

<sup>155</sup> See *id.*

<sup>156</sup> See *id.* (citing an Ohio Department of Insurance report finding that “rising insurance costs are still having an adverse effect on doctors and patients”).

<sup>157</sup> See Black et al., *supra* note 81, at 210 (arguing that “no crisis involving medical malpractice claims occurred” in Texas and that the rise in premiums is more likely the result of “insurance market dynamics” than of “litigation dynamics”); Patricia H. Born & W. Kip Viscusi, *The Distribution of the Insurance Market Effects of Tort Liability Reforms*, 1998 BROOKINGS PAPERS ON ECON. ACTIVITY: MICROECONOMICS 55; Mark J. Browne & Robert Puelz, *The Effect of Legal Rules on the Value of Economic and Non-Economic Damages and the Decision to File*, 18 J. RISK & UNCERTAINTY 189 (1999); Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?* 111 Q.J. ECON. 353 (1996) (finding a 5 to 9% reduction in medical expenditures “without substantial effects on mortality or medical complications” and concluding that tort reform can reduce the practice of defensive medicine); Han-Duck Lee et al., *How Does Joint and Several Tort Reform Affect the Rate of Tort Filings? Evidence from the State Courts*, 61 J. RISK & INS. 295 (1994) (conducting a regression analysis based on nineteen states in the 1980s and finding a surge in tort filings in the year prior to the implementation of tort reform and weak evidence of a reduction after the reforms); W. Kip Viscusi et al., *The Effect of 1980s Tort Reform Legislation on General Liability and Medical Malpractice Insurance*, 6 J. RISK & UNCERTAINTY 165 (1993); Albert Yoon, *Damage Caps and Civil Litigation: An Empirical Study of Medical Malpractice Litigation in the South*, 3 AM. L. & ECON. REV. 199, 203 (2001) (concluding that from 1987 to 1999, damage awards in Alabama decreased by roughly \$20,000 after caps were imposed and then increased by roughly \$40,000 when the caps were lifted); Kenneth E. Thorpe, *The Medical Malpractice “Crisis”: Recent Trends and the Impact of State Tort Reforms*, 4 HEALTH AFF. (WEB EXCLUSIVE), W4-28, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.20v1.pdf> (concluding that capping awards would result in lower premiums than if awards were not capped).

<sup>158</sup> See EVIDENCE FROM THE STATES, *supra* note 122, at vii.

<sup>159</sup> See *id.*

difficult, if not impossible.<sup>160</sup> Finally, researchers often use incomplete data sets, leading to highly uncertain conclusions.<sup>161</sup> These limitations led the Congressional Budget Office, after reviewing many of the studies cited here,<sup>162</sup> to state that “the findings [across states] are not sufficiently consistent to be considered conclusive.”<sup>163</sup>

The next section will review the findings of major tort reform studies between 1993 and 2005, discussing what effect, if any, punitive damage caps, changes to the collateral source rule, and the elimination of joint and several liability may have on achieving the reform objectives. Because of the breadth of research on noneconomic damage caps, an assessment of the effects of those caps will occur separately, following the discussion of the effect of other reforms.

### 1. *Limitation of Punitive Damage Caps*

The effect of punitive damage caps on the rate of medical malpractice claims and insurer payouts remains indeterminate. Some research finds that caps on punitive damage awards led to a significant reduction in premiums for general liability insurance, but not for medical malpractice insurance in particular.<sup>164</sup> Other research does not isolate the effect of punitive damage caps from the effects of other reforms that yielded an increase in the insurer’s profitability and a reduction of malpractice premiums.<sup>165</sup> A final study, whose data set consisted solely of automobile injury claims, finds that punitive damage caps led to an increase in both the number of claims filed and economic damages, but a decrease in noneconomic damages.<sup>166</sup>

The automobile study, however, is likely to be minimally useful here because studies have demonstrated that medical malpractice claims sometimes follow a different trend from other types of tort claims.<sup>167</sup> Indeed, a study of the nation’s seventy-five largest counties in 2001 found that while fifty-four plaintiffs in automobile cases in state courts recovered punitive damages, only fifteen plaintiffs in medical malpractice cases in the same sampling received such awards.<sup>168</sup> Moreover, only four of those medical malpractice plaintiffs received jury awards over \$250,000 in 2001.<sup>169</sup> Finally, the actual payouts are

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<sup>160</sup> See *id.* at viii.

<sup>161</sup> See *id.*

<sup>162</sup> The Congressional Budget Office reviewed all the studies cited in note 157 *supra*, except the study by Black and coauthors, *supra* note 81. See *id.* at viii.

<sup>163</sup> *Id.* at vii.

<sup>164</sup> *Id.* at x (citing Viscusi et al., *supra* note 157).

<sup>165</sup> See *id.* at x (citing Born & Viscusi, *supra* note 157). These other reforms include noneconomic damages, discussed *infra* Part IV.B.

<sup>166</sup> *Id.* at xi (citing Browne & Puelz, *supra* note 157).

<sup>167</sup> See *id.* at x (citing Viscusi et al., *supra* note 157).

<sup>168</sup> COHEN & SMITH, *supra* note 77, at 6.

<sup>169</sup> *Id.*

likely to be substantially less than \$250,000 because "high-low agreements" cap defendant payouts in advance of trial.<sup>170</sup> Although tort reformers argue that the presence of caps enhances the defense's bargaining power in setting "high-low agreements," thereby resulting in lower negotiated payouts when caps are in place,<sup>171</sup> that argument carries minimal weight in light of the low number of punitive damage awards over \$250,000 even without caps.

### 2. *Joint and Several Liability Reform*

Despite several studies,<sup>172</sup> researchers have been unable to conclusively determine what effect, if any, joint and several liability reform has had on malpractice premiums. One researcher found that joint and several liability reform lowered premiums for *general* liability insurers, but only reforms enacted in one of the three years studied had a significant effect on *malpractice* premiums.<sup>173</sup> Another researcher studying general tort filings noted that filings surged immediately *before* the reform took effect, but that the reforms themselves had no significant impact.<sup>174</sup> A survey of automobile injury claims concluded that joint and several liability reform led to an increase in the value of noneconomic damages, but did not significantly affect the number of claims filed.<sup>175</sup> Other researchers either did not isolate the effect of joint and several liability reform from other reforms<sup>176</sup> or found no statistically significant effect.<sup>177</sup>

### 3. *Elimination or Reform of the Collateral Source Rule*

Research on the effect of the collateral source rule on malpractice premiums is also largely inconclusive. Some studies simply failed to isolate the effect of such reform from the effects of other reforms.<sup>178</sup> One study, focused exclusively on automobile injury claims, finds that reform of the collateral source rule correlates to a decrease in the value of economic and noneconomic claims, although it has no significant effect on the number of claims filed.<sup>179</sup> Another study, focused exclusively on medical malpractice claims, finds that "discre-

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<sup>170</sup> See Hallinan, *supra* note 92.

<sup>171</sup> See *id.*

<sup>172</sup> See *supra* note 157 (listing studies).

<sup>173</sup> EVIDENCE FROM THE STATES, *supra* note 122, at 17 (citing Viscusi et al., *supra* note 157).

<sup>174</sup> *Id.* at 12 (citing Lee et al., *supra* note 157).

<sup>175</sup> *Id.* at 12 (citing Browne & Puelz, *supra* note 157).

<sup>176</sup> See *id.* at x (citing Born & Viscusi, *supra* note 157); *id.* at xi (citing Kessler & McClellan, *supra* note 157).

<sup>177</sup> See *id.* at xi (citing Thorpe, *supra* note 157).

<sup>178</sup> See *id.* at x-xi (citing Born & Viscusi, *supra* note 157; Kessler & McClellan, *supra* note 157).

<sup>179</sup> *Id.* at xi. (citing Browne & Puelz, *supra* note 157).

tionary" collateral source offsets<sup>180</sup> enhance insurer profitability but have no significant effect on premiums.<sup>181</sup>

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Although the above studies<sup>182</sup> assessed the consequences of capping punitive damages, abolishing joint and several liability, and changing the collateral source rule, most of the results were inconclusive. The only reform to yield positive results was that of the collateral source rule. Yet even that reform led only to greater profits for insurers and not to a significant decrease in premiums.<sup>183</sup> Thus, insurers captured all the benefit of the only successful reform without passing that benefit on to consumers.

#### B. State Reform Initiatives: Findings on Noneconomic Damage Caps, 1993–2005

Tort reformers have seen positive, albeit limited, results in reforms capping noneconomic damages. This type of reform is the most frequent subject of study and one of the most contentious areas of debate. Reformers promise that caps will bring substantial savings to our health care system, while opponents of caps deny those promises, instead emphasizing the harmful effects of caps on select subpopulations. This subpart will focus on the impact of noneconomic damage caps on the number of claims filed, plaintiffs' recovery, the practice of defensive medicine, access to care, insurer profitability, premiums, and vulnerable populations.

##### 1. *The Effect of Noneconomic Damage Caps on Number of Claims, Plaintiffs' Recovery, the Practice of Defensive Medicine, and Access to Care*

Tort reformers' claims that capping noneconomic damages will reduce the number of claims filed contradict the existing empirical research.<sup>184</sup> In fact, one study supports the conclusion that *no relation* exists between caps on noneconomic damages and the number of

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<sup>180</sup> "Discretionary" collateral source offsets here are "those considered at a judge's discretion." *Id.* (citing Thorpe, *supra* note 157).

<sup>181</sup> *Id.* (citing Thorpe, *supra* note 157).

<sup>182</sup> Cited *supra* note 157.

<sup>183</sup> See EVIDENCE FROM THE STATES, *supra* note 122, at 13 (citing Thorpe, *supra* note 157).

<sup>184</sup> Although one study found that noneconomic damage caps decreased the number of claims filed, see Browne & Puelz, *supra* note 157, at 211, its data set consisted exclusively of automobile accidents, *id.* at 191, rendering any comparison to medical liability highly speculative.

claims filed.<sup>185</sup> Another study reports a decrease in plaintiffs' recoveries in medical malpractice cases when Alabama instituted noneconomic damage caps.<sup>186</sup>

Additionally, although reformers argue that noneconomic damage caps will reduce the practice of defensive medicine, leading to cost savings in health care,<sup>187</sup> only one of the surveyed studies corroborated this assertion.<sup>188</sup> Yet even that study's conclusion—that tort reform led to cost savings without adverse health consequences in the treatment of patients with ischemic heart disease—could not be reproduced on a larger scale.<sup>189</sup> Furthermore, the Congressional Budget Office reports that it “has found no evidence that tort reforms reduced medical spending.”<sup>190</sup>

Moreover, tort reformers' predictions that tort reform will enhance access to care<sup>191</sup> erroneously presuppose that the current levels of care are inadequate. In fact, despite the public perception that a problem exists and the media hype surrounding a few physician office closings,<sup>192</sup> empirical evidence does not support the existence of a crisis in either access to or availability of care.<sup>193</sup> Specifically, the General Accounting Office's study of physician access in several communities revealed that access to care has not been affected.<sup>194</sup> Noneconomic damage caps cannot be touted as a solution to a problem that has not been proven to exist.

## 2. *The Effect of Noneconomic Damage Caps on Insurer Profitability and Premiums*

While studies suggest that damage caps may enhance insurer profitability,<sup>195</sup> this effect is likely to be much smaller than the effects from other reform efforts or natural fluctuations in the insurance market. Although several studies support the conclusion that damage caps enhance insurer profitability by decreasing premiums and lower-

<sup>185</sup> See OFFICE OF TECH. ASSESSMENT, U.S. CONG., IMPACT OF LEGAL REFORM ON MEDICAL MALPRACTICE COSTS 64, available at <http://www.wws.princeton.edu/ota/disk1/1993/9329/9329.PDF>.

<sup>186</sup> EVIDENCE FROM THE STATES, *supra* note 122, at 15 (citing Yoon, *supra* note 157).

<sup>187</sup> See *supra* notes 107–08.

<sup>188</sup> See Kessler & McClellan, *supra* note 157; see also studies cited *supra* note 157.

<sup>189</sup> EVIDENCE FROM THE STATES, *supra* note 122, at 19 (citing Kessler & McClellan, *supra* note 157).

<sup>190</sup> *Id.*

<sup>191</sup> See Finley, *supra* note 10, at 1267.

<sup>192</sup> See Stailey, *supra* note 11, at 188, 191.

<sup>193</sup> See Finley, *supra* note 10, at 1271.

<sup>194</sup> See *supra* note 105 and accompanying text (“[T]here has not been any documentable adverse effect on access to health care, except in some scattered, often rural areas, where factors other than malpractice premiums contribute to the access issues.”).

<sup>195</sup> See EVIDENCE FROM THE STATES, *supra* note 122, at 17–18 (citing Born & Viscusi, *supra* note 157; Thorpe, *supra* note 157; Viscusi et al., *supra* note 157).

ing insurer loss ratios,<sup>196</sup> some of these studies may be unreliable because they use old data,<sup>197</sup> or because the results may be due to other reform efforts, such as the elimination of the collateral source rule.<sup>198</sup> Additionally, the majority of the studies do not engage the alternative theory that premium fluctuations reflect the cyclical nature of the insurance market and economic fluctuations, rather than an increasing number of claims or larger jury awards.<sup>199</sup> This alternate theory is supported by a 2005 study that found a “weak connection between claims-related costs and short-to-medium-term fluctuations in insurance premiums.”<sup>200</sup> The authors of that study inferred that the insurance premium spike likely resulted from “insurance market dynamics, not litigation dynamics.”<sup>201</sup>

Moreover, findings from states that impose noneconomic damage caps on jury verdicts show that these caps have failed to decrease or stabilize medical malpractice premiums. For example, after the Nevada Legislature passed a tort reform bill in 2002 that included caps on noneconomic damages of \$350,000, three of the state’s major insurance companies requested rate increases.<sup>202</sup> More generally, Weiss Ratings found that premiums grew faster in states that had enacted tort reform statutes than in states that did not enact such initiatives.<sup>203</sup> Furthermore, they found that damage awards comprised only a fraction of the premium costs.

Professor Lucinda Finley notes that insurers themselves rarely claim that caps on damages will reduce or stabilize malpractice premiums.<sup>204</sup> Indeed, the President of the American Tort Reform Association has “cautioned that the reason to pass tort reform [was not] to reduce insurance rates.”<sup>205</sup> This may be because, as major insurers in Florida discovered, most jury awards and settlements occur below the statutory caps.<sup>206</sup> When considering a damage cap of \$450,000, these insurance companies realized that the cap would affect very few of

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196 See *supra* note 195.

197 See EVIDENCE FROM THE STATES, *supra* note 122, at 17 (citing Viscusi et al., *supra* note 157, who cite data from 1985 to 1988).

198 See *id.* at 18 (citing Thorpe, *supra* note 157, who finds that the change in the collateral source rule led to a 13.3% lower insurer’s loss ratio than other states experienced).

199 See WEISS ET AL., *supra* note 23, at 9.

200 Black et al., *supra* note 81, at 210.

201 *Id.*

202 See Finley, *supra* note 10, at 1276–77.

203 See WEISS ET AL., *supra* note 23, at 7–8.

204 See Finley, *supra* note 10, at 1275.

205 *Id.* at 1276 (quotation omitted).

206 See *id.* at 1275 (referring to St. Paul’s determination that a proposed cap in Florida would have affected only 4 of 313 claims).

their claims<sup>207</sup> and concluded that it would have “no effect” on medical malpractice premium rates.<sup>208</sup>

### 3. *The Effect of Noneconomic Damage Caps on Vulnerable Populations*

In addition to arguing that noneconomic damage caps fail to solve the problem of rising medical malpractice premiums, Professor Finley also argues that caps disproportionately harm certain classes of tort victims.<sup>209</sup> Professor Finley’s empirical analysis of jury verdicts in California demonstrates that a greater proportion of jury damage awards given to women and elderly individuals are noneconomic damages; by contrast, economic damages are more likely to compensate the dominant wage earners, younger men, adequately.<sup>210</sup> This proves especially true for many classically “female” injuries, such as the grief and emotional harm resulting from rape or from obstetrical-gynecological and reproductive problems that are compensated only in noneconomic damages because they generally do not entail lost wages.<sup>211</sup> Even in the elderly population, which is less likely to incur significant wage loss, elderly women receive a greater proportion of their damages as noneconomic than elderly men.<sup>212</sup> Caps on noneconomic damages will thus disproportionately affect women, the elderly, and other populations whose damages are more likely to be apportioned for emotional harms rather than lost wages.<sup>213</sup>

Recent studies show that noneconomic damage caps have draconian consequences for those who suffer the most devastating injuries or significant loss to their quality of life.<sup>214</sup> The caps prevent the most deserving plaintiffs from receiving equitable compensation for their injuries.<sup>215</sup> For example, the parents of a child killed because of medical malpractice will not be able to recover more than the \$250,000 statutory cap on noneconomic damages, despite the gravity of the loss.<sup>216</sup> Caps also discourage plaintiffs’ lawyers from representing members of vulnerable populations in the first place, further limiting these groups’ ability to receive compensation for their harm.<sup>217</sup> A tort system limited by caps on noneconomic damages perpetuates societal

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<sup>207</sup> *See id.*

<sup>208</sup> *Id.* at 1276 (quotation omitted).

<sup>209</sup> *See id.* at 1283.

<sup>210</sup> *See id.* 1283–84.

<sup>211</sup> *See id.*

<sup>212</sup> *See id.* at 1283.

<sup>213</sup> *See id.* at 1283–84.

<sup>214</sup> *See Boehm, supra* note 12, at 360.

<sup>215</sup> *See id.* at 360 & n.16.

<sup>216</sup> *See Finley, supra* note 10, at 1313.

<sup>217</sup> *See id.* at 1284, 1313.

injustice by disproportionately reducing or eliminating compensation for members of vulnerable populations.<sup>218</sup>

### C. The Impact of Tort Reform on Public Perception and the Tort System

In recent years, some scholars have begun to study the impact of public perception on tort filings and jury verdicts. These scholars postulate that the tort reform movement is, at root, a message to society about the proper contours of our civil justice system in compensating individuals for harms. Thus, the public's views about the effectiveness of the justice system in compensating deserving individuals fairly and equitably are critical.<sup>219</sup>

Although there is little conclusive evidence, a few scholars have attempted to measure the impact of public perception on changes in litigation dynamics.<sup>220</sup> Some have analyzed media messages, advertising campaigns, and similar platforms for public expression in order to expose the messages underlying these public campaigns, and to better understand their effects on the public.<sup>221</sup> This research reveals the numerous strategies tort reform advocates employ to spread their message, as well as the way American notions of individual responsibility and independence make American audiences receptive to reformers' messages.<sup>222</sup> For example, the manner in which the media discussed and mocked the highly publicized McDonald's coffee cup case is paradigmatic of public campaigns that seek to highlight the overly litigious nature of the tort system, runaway jury verdicts, and the financial burdens that a supposedly out-of-control legal system places on ordinary Americans.<sup>223</sup>

In other efforts, Professors Stephen Daniels and Joanne Martin designed empirical research studies in order to quantify the nonformal impact of tort reforms.<sup>224</sup> This nonformal impact consists of the effect of public perception on the "market" environment of tort

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<sup>218</sup> See *id.* at 1313.

<sup>219</sup> See Daniels & Martin, *Ears*, *supra* note 62, at 491; see also Shari Seidman Diamond et al., *Juror Judgments About Liability and Damages: Sources of Variability and Ways to Increase Consistency*, 48 DEPAUL L. REV. 301, 309 (1998) (finding that the strongest predictor of juror liability decisions was the jurors' beliefs about "whether plaintiffs generally receive too much or too little in a lawsuit"), discussed in Daniels & Martin, *Ears*, *supra* note 62, at 456 n.11.

<sup>220</sup> See, e.g., Daniels & Martin, *Ears*, *supra* note 62; Stephen Daniels & Joanne Martin, *The Strange Success of Tort Reform*, 53 EMORY L.J. 1225 (2004) [hereinafter Daniels & Martin, *Success*]; McCann et al., *supra* note 64.

<sup>221</sup> See McCann et al., *supra* note 64, at 115–16.

<sup>222</sup> See *id.* at 116–17.

<sup>223</sup> See *id.* at 113–15.

<sup>224</sup> Daniels & Martin, *Ears*, *supra* note 62; Daniels & Martin, *Success*, *supra* note 220.

claims.<sup>225</sup> Professors Daniels and Martin studied tort reform initiatives in Texas from the mid 1980s to 2003, and hypothesized that those initiatives changed behavior in ways that were unrelated to the specific reform elements.<sup>226</sup> They conclude that, as the public perception of the need for and impetus behind tort reform heightens, public belief in tort reformers' arguments ultimately alters the power dynamics among litigants, the caseload, and the composition of the plaintiffs, independently of formal changes in the law.<sup>227</sup>

When considering the Daniels and Martin research in light of Black and his coauthors' observation that filings in Texas and jury awards changed little during a similar period,<sup>228</sup> one might conclude that public perception affects plaintiffs' lawyers' client base and case load, but does not significantly affect the system overall. On the other hand, tort filings have been declining nationally since 1995, even without state or national measures to curb such filings.<sup>229</sup> Accordingly, one may argue that tort reformers' public campaign has affected public perception about the need for tort reform and consequently changed behavior.

If changes in perception affect the tort market, then the strategy of tort reformers is apt to change drastically. To prove more definitively this perception hypothesis, however, the Daniels and Martin study must be repeated in states that have not enacted tort reform initiatives. Until then, the effects of the nonformal mechanisms of public perception on the tort market remain largely speculative.

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<sup>225</sup> Daniels & Martin, *Success*, *supra* note 220, at 1262.

<sup>226</sup> *See id.* at 1228. The study focused on automobile injury tort claims rather than medical malpractice claims. *Id.* Yet, Daniels and Martin chose to study automobile cases precisely because such claims had *not* been the target of reform. *See id.* The authors hypothesize that tort reform alters public perceptions so broadly that the market environment changes even for torts that were not directly reformed. *Id.* The study thus provides a useful theoretical framework with which to analyze the impact of the tort reform movement on public perception.

<sup>227</sup> For example, they found that plaintiffs' lawyers in Texas believed that media campaigns, which favored tort reform, hindered their chances to receive favorable jury verdicts. *See id.* at 1242–44. In light of this perception of jury sympathy, plaintiffs' lawyers surmised that insurance companies would be less likely to settle in advance of trial. *See id.* at 1242–43. As a result, attorneys tightened their gatekeeping function, choosing to take only those cases that they strongly believed would be successful in front of a jury. *See id.* at 1229. Consequently, clients whom juries are likely to disfavor—such as criminals, unemployed individuals, or individuals on welfare—are now less able to have their cases taken up by plaintiffs' lawyers, who believe they are unlikely to recover their fees through success in jury trials. *See id.* at 1257–59. On the other hand, changing perceptions about the importance of tort reform have led to an increase in the number of medical malpractice specialists. *See id.* at 1253. One medical malpractice lawyer explained that reform increases the demand for specialists “because it makes it so hard for marginal or medium-sized firms that don’t specialize in it and who don’t know all the traps, and who can’t handle the expense.” *See id.* at 1254.

<sup>228</sup> *See* Black et al., *supra* note 81 (studying claims from 1988 to 2002).

<sup>229</sup> *See* Daniels & Martin, *Success*, *supra* note 220, at 1226.

## V

EVALUATING PROPOSED FEDERAL MEDICAL LIABILITY REFORM  
LEGISLATION: THE HEALTH ACT

Certain that we are in the midst of a medical liability crisis, reform advocates crafted the HEALTH Act in an effort to reduce premium increases, curb the filing of medical malpractice lawsuits, and increase the availability of care.<sup>230</sup> Opponents of reform do not believe that the current health care crisis reflects problems in our legal system, deny reports of shortages of care, and attribute current premium increases to the state of the economy and the cyclical nature of the insurance market.<sup>231</sup> Although both sides agree that premiums have been escalating rapidly in the past few years, the reasons for this trend remain in dispute.

Considering these conflicting views of the facts, legislators must decide whether to adopt a national reform package such as the HEALTH Act or leave the states to adopt reform packages in response to their own problems, while gathering data on the effects of those reforms. This Note postulates that the latter approach is preferable.<sup>232</sup>

## A. The HEALTH Act: Forecasting the Effectiveness of Reform Proposals

Regardless of whether a medical liability crisis actually exists, rising premiums and anecdotal accounts of shortages in medical care have led to calls for reform. But empirical evidence of the failure of tort reform at the state level reveals that the Act will fail to meet many of its objectives. First, the effect that caps on punitive damage awards will have on plaintiffs' recovery is uncertain.<sup>233</sup> Indeed, one study found that these caps would actually *increase* tort filings.<sup>234</sup> Moreover, because few juries award punitive damages, such caps might not significantly reduce insurers' overall costs.<sup>235</sup> Second, state-level changes to

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<sup>230</sup> Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2005, H.R. 534, 109th Congress (2005).

<sup>231</sup> See *supra* Part II.

<sup>232</sup> An analysis of the constitutional implications of federal government action in tort reform is beyond the scope of this Note. For a brief discussion of constitutional concerns raised by conservatives, see RANDOLPH W. PATE & DEREK HUNTER, HERITAGE FOUND., EXECUTIVE SUMMARY BACKGROUNDER NO. 1908, CODE BLUE: THE CASE FOR SERIOUS STATE MEDICAL LIABILITY REFORM (2006), available at <http://www.heritage.org/research/healthcare/bg1908.cfm>.

<sup>233</sup> See EVIDENCE FROM THE STATES, *supra* note 122, at 12-13.

<sup>234</sup> See *id.* at 15 (citing Browne & Puelz, *supra* note 157) ("Caps on punitive damages . . . increased the likelihood that a claim would be filed—from 2.7 percent to 4 percent.")

<sup>235</sup> See COHEN & SMITH, *supra* note 77, at 2 tbl.7 (reporting that punitive damages were awarded in only fifteen cases in the seventy-five largest counties in 2001). Although me-

joint and several liability have yielded no discernible consequences.<sup>236</sup> Third, only one study supports reforming the collateral source rule to allow for discretionary collateral source offsets in order to decrease insurer loss ratios, and even that study found that such reform yields no corresponding reduction in premiums.<sup>237</sup> Fourth, despite evidence from a study that caps on noneconomic damages can enhance insurer profitability, the same study revealed that this enhanced profitability did not result in lower malpractice premiums for physicians.<sup>238</sup> Fifth, despite an objective to increase information sharing, the HEALTH Act does not incorporate any specific steps to meet this objective.<sup>239</sup> Finally, the HEALTH Act's opt-out provision, which allows states to set their own noneconomic and punitive damage caps,<sup>240</sup> limits the benefits that would flow from a uniform federal policy.

In general, empirical findings from state-level tort reforms suggest that the HEALTH Act will not decrease tort filings, reduce overall health costs, reduce plaintiffs' net recoveries, or increase access to care. Moreover, rather than making the system more equitable so that "persons with meritorious health care injury claims receive fair and adequate compensation,"<sup>241</sup> the HEALTH Act could enhance insurer profitability at the expense of members of vulnerable populations.<sup>242</sup> By implementing changes that are unlikely to remedy large-scale problems in our health care system while having a strong potential to affect many individuals adversely, the HEALTH Act assaults the fundamental precept of the tort system: to fairly and equitably compensate victims who have suffered injuries or death.

## B. The Unintended Consequences of Reform: Changes in Public Perception

Defining the elements of the HEALTH Act is an exercise in Orwellian doublespeak. The Act is phrased artfully to lead unsuspecting readers to false conclusions. For example, the Act states that the

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dian punitive damage awards for medical malpractice are \$187,000 *when awarded, id.*, the infrequency of punitive damage awards limits the potential savings available to insurance companies because of caps. While insurance companies might see some savings because of caps, those savings are likely to be small.

<sup>236</sup> See EVIDENCE FROM THE STATES, *supra* note 122, at 12–13 (citing Browne & Puelz, *supra* note 157; Lee et al., *supra* note 157; Thorpe, *supra* note 157).

<sup>237</sup> See *id.* at 13 (citing Thorpe, *supra* note 157); *supra* Part IV.A.3.

<sup>238</sup> See *id.* (citing Viscusi et al., *supra* note 157). *But see id.*

<sup>239</sup> See Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2005, H.R. 534, 109th Congress (2005).

<sup>240</sup> *Id.* § 11(c)(1).

<sup>241</sup> *Id.* § 2(b)(3).

<sup>242</sup> See *supra* Part IV.B.3 (discussing the disproportionate effect of noneconomic damage caps on vulnerable populations).

hard cap on noneconomic damages allows plaintiffs to recover “as much as \$250,000,”<sup>243</sup> rather than “not more than \$250,000.” Similarly, the statute of limitations in the Act occurs underneath the heading “Encouraging Speedy Resolution of Claims,”<sup>244</sup> instead of a more accurate title such as “Limiting the Timeframe for Claim Filing.” Thus, the drafters seem to understand the effect of public perception on the tort movement and have used this artful language to further their message.<sup>245</sup> Rather than appearing to take damages away from those who most deserve them, the Act is phrased to imply an intent to deliver “fair and adequate compensation” to all who deserve it.<sup>246</sup>

While touting the HEALTH Act as a reform package aimed at stemming the tide of out-of-control jury awards and an unmanageable litigation system may serve reformers’ goals in the short term, a national initiative such as the HEALTH Act and its accompanying public relations spin could *hinder* tort reformers’ objectives. Reformers who aim to affect the hearts and minds of potential jurors may win the public relations battle but lose the courtroom war. In the absence of national legislation, and with varied reform provisions across the various states, tort reformers have decried the harmful effects of an unchecked legal system gone amok due to frivolous lawsuits and outrageous jury awards. Professors Daniels and Martin hypothesize that these media campaigns constrict the tort system by informally changing the market environment in which litigation occurs.<sup>247</sup>

Once a national tort reform measure is passed, however, the pleas of these reformers are likely to fall upon deaf ears. The public—particularly jurors—may not believe that the legal system is out of control because the publicity following the passage of national tort reform initiatives will likely portray excessive jury awards as a problem solved. Ironically, such publicity may cause jurors to be less vigilant in keeping awards low and to feel less responsible for policing their own actions. If jurors believe that tort reform has fixed the problems in our civil justice system, then jurors will be less likely to worry about contributing to unmeritorious awards or windfalls for plaintiffs. Thus, the pressure that the public climate currently exerts on plaintiffs’ attorneys to try only the most meritorious claims may subside. Consequently, if the Daniels and Martin thesis about the effects of perception on the tort system is correct, jurors’ increasing tendency to side with plaintiffs will boost plaintiffs’ attorneys confidence in their ability to win, thus causing the very changes in the tort market that

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<sup>243</sup> See H.R. 534, § 4(b) (emphasis added).

<sup>244</sup> *Id.* § 3.

<sup>245</sup> Cf. *supra* Part IV.C. (discussing attempts to shape public perception as a critical goal of tort reform).

<sup>246</sup> H.R. 534, § 2(b)(3).

<sup>247</sup> See Daniels & Martin, *Ears*, *supra* note 62, at 491–92.

tort reformers criticize, such as an increase in the number of claims filed.

## VI

### RECOMMENDATIONS FOR ADDRESSING THE HEALTH CARE CRISIS

This Note calls into question the existence of a medical *liability* crisis, postulating instead that problems in our health care system may be attributable to a variety of other factors, including insurance cycles fluctuating with the economy and systemic problems in the design of our health care payment and delivery systems. Even if one believes, however, that the current crisis in health care emanates from an out-of-control tort system, current tort reform proposals are unlikely to present an effective solution. Data from state-level reforms provide an uncertain picture of the benefits and drawbacks of tort reform initiatives, with most initiatives seeming to have little effect. Rather than adopting a national reform whose outcome is, at best, uncertain, the most appropriate course of action is to develop greater certainty over which measures will be effective. Therefore, this Note argues that national medical liability reforms such as the HEALTH Act should not be adopted; instead, states should engage in broad-based monitoring of tort reform measures and, when necessary, initiate modest state-level reforms geared toward tempering the rise in litigation defense costs, slowing premium rate increases, and decreasing the rate of claims of medical malpractice. This Note delineates specific suggestions for state-level reforms below.

#### A. Research and Monitor Reform Initiatives and Other Factors Affecting the Interaction Between the Medical and Legal Systems

Above all, states should implement systematic efforts to monitor the effects of their reform initiatives. This monitoring should include assessments of both the formal and nonformal impacts of tort reform measures. Such assessments could test the theory that public perception affects the market environment of tort claims.<sup>248</sup> Moreover, researchers should closely study alternative factors affecting the relationship between the medical and legal systems, such as rising defense costs, to determine the truth of claims that rising litigation defense costs are driving premium rate increases.<sup>249</sup> Research on these questions could provide greater clarity as to the path that any reform effort should take, if needed.

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<sup>248</sup> See *supra* Part IV.C.

<sup>249</sup> See, e.g., Nathanson, *supra* note 83, at 1078.

## B. Initiate Systemic Change: Reducing Medical Error

Our health care system is in trouble. Rising costs, increasing numbers of uninsured, the proliferation of new and expensive technologies, and widespread poor health outcomes demand broad systemic change.<sup>250</sup> Ambitious policy proposals for overhauling the health care system are beyond the scope of this Note. The health care system can take steps to reduce its exposure to medical liability, however, by implementing systemic change at the state level to reduce the rate of medical error.<sup>251</sup> One possible change would be to institute a risk management program to review hospital practices, resolve instances of medical error, and design safety programs to lower the risk of error.<sup>252</sup> Reducing medical error may reduce the number of medical malpractice claims filed because, absent medical error, a malpractice claim is unlikely to survive a motion for summary judgment.<sup>253</sup>

## C. Screen Malpractice Claims to Reduce Frivolous Lawsuits

Because the early detection of frivolous claims may reduce the number of claims filed, states should require every plaintiff in a malpractice action to file a certificate of their claim with an expert who will verify that the claim is meritorious.<sup>254</sup> This will reduce insurance companies' expenditures on defending frivolous claims.<sup>255</sup> As of 2004, approximately fifteen states required such certificates.<sup>256</sup> In Maryland, malpractice filing rates dropped 36% in the year after these certificates became mandatory.<sup>257</sup> One major benefit of this reform is that it targets one of the very concerns that animates current calls for tort reform: frivolous lawsuits.<sup>258</sup> Additionally, unlike other efforts to reduce claims, such as caps on noneconomic or punitive damages, this reform is likely to reduce malpractice claims without disparately disadvantaging those who suffer primarily from emotional harms.<sup>259</sup>

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<sup>250</sup> See *supra* notes 24–36 and accompanying text.

<sup>251</sup> For a discussion of the prevalence of medical error, see *supra* notes 33–35 and accompanying text.

<sup>252</sup> See COUNCIL OF STATE GOV'TS, MEDICAL MALPRACTICE CRISIS 15 (2003), available at <http://www.csg.org/NR/rdonlyres/ek7ao3dfatxcgh656amm6wnlw2owndpku4rp3xhss32rzech5ggb4j4mbwdozh4zsobfboqxyz3bnp5corc6rrae/Medical+Malpractice+%28May+Revised%29.pdf>.

<sup>253</sup> Cf. *id.* at 14 (“One overlooked aspect of [the] medical malpractice insurance situation is the existence of medical malpractice.”).

<sup>254</sup> See Nathanson, *supra* note 83, at 1111.

<sup>255</sup> See *id.*

<sup>256</sup> *Id.*

<sup>257</sup> *Id.*

<sup>258</sup> See *id.*

<sup>259</sup> See *supra* Part IV.B.3.

#### D. Abolish the Collateral Source Rule

States may consider abolishing the common law collateral source rule in certain cases, instead adopting a discretionary collateral source rule that allows the judge to exercise discretion in allowing parties to present information about payments from a collateral source into evidence.<sup>260</sup> This proposal was one of the few reforms that studies revealed has some potential to reduce loss ratios (though even this reform has not led to reduced premiums in states in which it has been enacted).<sup>261</sup> The discretion inherent in this rule would allow judges to properly balance equity and efficiency in accordance with the needs of individual cases.

#### E. Allow Physicians to Self-Insure

Another means of shielding physicians from exorbitant premium rate increases set by insurance companies is to allow physicians to self-insure. For example, in 2003, members of the Florida Congress proposed removing a legislative provision that prohibited doctors from self-insuring.<sup>262</sup> Such a reform would allow doctors to group together to establish their own insurance pool. Florida Senator Daniel Webster estimates that if 40,000 doctors contributed \$25,000 annually in premiums to a self-insurance fund, they would collect \$1 billion annually.<sup>263</sup> Because Florida medical malpractice insurers paid out only \$352 million in 2002, such an insurance fund would be more than adequate to cover malpractice liability.<sup>264</sup> Furthermore, as one Florida lawyer put it, “[T]he creation of a self-insurance trust fund . . . was the single piece of legislation that solved the ‘insurance crisis’ back in the 1970’s.”<sup>265</sup> Such a measure thus holds great promise for solving the crisis of rising health care costs and decreasing availability of care today.

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<sup>260</sup> Discretionary collateral source rules have been adopted in Idaho, Indiana, and Oregon. See Am. Tort Reform Ass’n, Collateral Source Rule Reform, <http://www.atra.org/show/7344> (last visited Apr. 4, 2006). Collateral source evidence is admissible as evidence and as an offset in these ten states, although exclusions may apply: Alabama, Alaska, Colorado, Connecticut, Florida, Iowa, New Jersey, New York, North Dakota, and Ohio. *Id.* The following eight states make some provisions for the introduction of collateral source evidence, albeit with numerous varying restrictions: Arizona, Hawaii, Illinois, Kentucky, Michigan, Minnesota, Missouri, and Montana. *Id.*

<sup>261</sup> See EVIDENCE FROM THE STATES, *supra* note 122, at 18 (citing Thorpe, *supra* note 157).

<sup>262</sup> See Diane Hirth, *California Gives Insight on Medical Malpractice*, TALLAHASSEE DEMOCRAT, June 8, 2003, at A1.

<sup>263</sup> Paige St. John, *Florida Doctors Will Pay Higher Insurance Rates*, GANNETT NEWS SERVICE, Apr. 12, 2003, available at <http://www.floridacapitalnews.com/legislature2003/stories/041403insurance.htm>.

<sup>264</sup> See *id.*

<sup>265</sup> Hellwege, *supra* note 134, at 16 (quoting Neal Roth, a lawyer who lobbied against damage caps).

## F. Reduce Litigation Defense Costs

Professor Mitchell Nathanson insists that the key to addressing medical malpractice insurer insolvency is creating solutions to curb rising defense costs.<sup>266</sup> He agrees with reformers that the economy and the insurance market's cyclical nature alone cannot explain rising insurance premiums,<sup>267</sup> but he disagrees with most tort reform proposals, such as capping noneconomic damages.<sup>268</sup> Instead, he asserts that insurance companies should focus on curbing litigation defense costs to enhance insurer profitability.<sup>269</sup> He reasons that medical malpractice insurers suffer 40% of their losses in defense costs, in contrast with other types of insurers, whose defense costs account for approximately 12 to 13% of their losses.<sup>270</sup>

Professor Nathanson's proposal is compelling in light of the empirical evidence on litigation defense costs. From 1986 to 2002, defense costs increased approximately 8% annually, with average costs per claim rising from \$8,000 to \$27,000.<sup>271</sup> Although only 5% of medical malpractice cases go to trial each year,<sup>272</sup> and defendants win 73% of the time,<sup>273</sup> insurance companies expend 40% of their total losses on defense costs.<sup>274</sup> Even a case that the parties settle before trial, or one that the insurance company wins, costs a significant amount of money to defend. The Congressional Budget Office reports that in 2002, insurers spent \$22,000 defending claims that did not result in payouts and \$39,000 in claims that did.<sup>275</sup> These defense costs are in addition to settlement and jury award payouts.<sup>276</sup> Thus, the mere filing of claims significantly affects defense costs, independently of how often plaintiffs recover damages.

Additionally, one study's findings that defense costs rose 4.4% per large claim per year in Texas between 1988 and 2002 demonstrated that the number of large claims can significantly raise insurers' costs.<sup>277</sup> On the other hand, the number of large claims, as well as the mean and median payouts for large claims, remained relatively stable

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<sup>266</sup> See Nathanson, *supra* note 83, at 1091.

<sup>267</sup> See *id.* at 1086.

<sup>268</sup> See *id.* at 1092.

<sup>269</sup> See *id.*

<sup>270</sup> See *id.* at 1091-92.

<sup>271</sup> LIMITING TORT LIABILITY, *supra* note 53, at 4.

<sup>272</sup> Finley, *supra* note 10, at 1268-69.

<sup>273</sup> See COHEN & SMITH, *supra* note 77, at 4 (providing data for the nation's seventy-five largest counties in 2001).

<sup>274</sup> Nathanson, *supra* note 83, at 1091.

<sup>275</sup> LIMITING TORT LIABILITY, *supra* note 53, at 4 n.6.

<sup>276</sup> The National Practitioner Data Bank reports that in 2000, the median payout was \$125,000 when the parties settled and \$235,000 when a judgment was rendered. See Stewart, *supra* note 86, at 502.

<sup>277</sup> Black et al., *supra* note 81, at 244.

over the 15-year period, while the number of small claims declined significantly,<sup>278</sup> leading the researchers to conclude that the change in the number or cost of malpractice claims did not cause the spike in malpractice insurance premiums in Texas.<sup>279</sup> They further state that “[n]o sudden rise in . . . defense costs preceded or accompanied the premium spike that occurred in Texas after 1998.”<sup>280</sup>

These researchers are likely correct that rising defense costs alone cannot explain the post-2001 premium spikes; however, their conclusion does not foreclose the possibility that rising defense costs—especially for large claims—raised insurers’ loss ratios and could have contributed to rising premium costs. At the very least, the data suggest that defense costs could significantly affect malpractice premiums. Future studies should seek to support or disprove this hypothesis so that reform measures can take into account defense costs.

### G. Regulate Insurance Companies

Some scholars assert that more robust state regulation of insurance companies will prevent exponential premium rate increases that adversely affect physicians.<sup>281</sup> Many also view California’s passage of strong insurance regulations in 1988, including a 20% rollback of insurance rates, as a model of effective insurance regulation because premium rate increases in California have remained lower than in other states.<sup>282</sup> This leveling of premium rate increases occurred only after the passage of state insurance regulation in 1988, rather than following the enactment of tort reforms in 1975, suggesting that insurance regulation, rather than tort reform, is the driving force controlling insurance premiums.<sup>283</sup>

Weiss Ratings’ 2003 study, which found that noneconomic damage caps were ineffective in controlling premium rate increases, supports this proposal.<sup>284</sup> Under the McCarran-Ferguson Act, which prohibits federal regulation of insurance carriers, increasing regulation of the insurance industry must occur at the state level.<sup>285</sup> Because

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<sup>278</sup> See *id.* at 252.

<sup>279</sup> See *id.* at 255.

<sup>280</sup> *Id.*

<sup>281</sup> See Boehm, *supra* note 12, at 368.

<sup>282</sup> See Diane Hirth, *California Gives Insight on Medical Malpractice*, TALLAHASSEE DEMOCRAT, June 8, 2003, at A1; Janice F. Mulligan, *The “New” Medical Malpractice Insurance Crisis: Are California Reforms Good for the Nation? Maybe, But Not the Ones You Have Been Hearing Most About*, Presentation to the Health Law Section of the American Bar Association (Feb. 21, 2003), available at [http://www.janmulligan.com/new\\_malpractice\\_crisis.pdf](http://www.janmulligan.com/new_malpractice_crisis.pdf).

<sup>283</sup> See Mulligan, *supra* note 282.

<sup>284</sup> WEISS ET AL., *supra* note 23.

<sup>285</sup> 15 U.S.C. § 1012 (2000).

the insurance industry reported record profits in 2004,<sup>286</sup> regulation aimed at curtailing insurance industry profit-margins is unlikely to jeopardize the industry's financial health.<sup>287</sup> The Center for Justice & Democracy notes that "[d]espite a weak economy and soaring medical costs, U.S. health insurers have raked in earnings at a far greater pace than the rest of corporate America, with annual profits and margins doubling in the last four years."<sup>288</sup>

In July of 2004, a coalition of public interest groups united as Americans for Insurance Reform, together with the Center for Justice & Democracy, sent letters to state insurance commissioners requesting that they initiate the following insurance reform efforts:

- (1) Undertake a review of rate levels to determine if rates are excessive in any line of insurance . . . .
- (2) Initiate an investigation into anti-competitive behavior of insurance companies in making statements and other acts to hold off competition . . . .
- (3) If any insurer files a rate request in excess of current inflation for that line of insurance, a rate hearing should be called . . . .
- (4) [B]egin the process of careful analysis as to what led to this most recent cycle, and your department's role in it[,] by allowing rates to fluctuate between excessive (such as now at the end of the hard market) and inadequate (such as right before the turn in the market from soft to hard). . . .
- (5) Review successes from other states in averting the same sort of price spikes you may have endured over the last two years.<sup>289</sup>

Additionally, in March of 2005, the Center for Justice & Democracy recommended that state insurance commissioners implement these reforms:

- [Perform a] full and thorough investigation of the insurance companies' data to determine if there are errors in the data and over-reserving, and whether their business and investment practices present unacceptable financial risks for insurance consum-

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<sup>286</sup> Press Release, Ctr. for Justice & Democracy, Mythbuster: New 2004 Data Shows Insurance Industry Profits are the Highest Ever (Oct. 20, 2004), available at <http://centerjd.org/free/mythbusters-free/InsProfitsHighestEver.pdf>.

<sup>287</sup> See Boehm, *supra* note 12, at 368.

<sup>288</sup> Ctr. for Justice & Democracy, *supra* note 286 (quoting Russ Britt, *Health Insurers Getting Bigger Cut of Medical Dollars*, INVESTOR'S BUS. DAILY, Oct. 15, 2004, available at <http://investors.com/breakingnews.asp?journalid=23544168&brk=1>).

<sup>289</sup> Letter from J. Robert Hunter, Dir. of Ins., Consumer Fed'n of Am., & Birny Birnbaum, Exec. Dir., Ctr. for Econ. Justice, to Ins. Comm'rs of 50 States & D.C. 6 (May 11, 2004), available at [http://insurance-reform.org/AIR\\_Ins\\_Comm\\_04.pdf](http://insurance-reform.org/AIR_Ins_Comm_04.pdf), quoted in Boehm, *supra* note 12, at 369. The letter also requested that the state insurance commissions "[a]lert [their] legislature[s] to the end of the hard market and advise them that there is no need to rush into legislative fixes, such as legal limits on victims' rights." *Id.*, quoted in Boehm, *supra* note 12, at 369.

ers and shareholders by failing to take into account cyclical economic downturns . . . .

- [Perform] annual audits of insurance companies to ascertain whether the companies are engaging in questionable accounting practices . . . .
- [Regulate the e]xcessive prices . . . charged by insurers today . . . .
- [Allow] the public . . . the opportunity to participate in rate hearings . . . .
- [Require m]edical malpractice insurers [to] use claims history as a rating factor, and . . . give that factor significant weight . . . .
- [Establish a] state consumer advocate . . . in the Insurance Commissioner's office to monitor insurance industry waste, inefficiencies and price-gouging.<sup>290</sup>

States should initiate some or all of these reform efforts.

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The proposals discussed above reflect the practical conclusion that fewer claims, reduced premiums, and lower litigation costs will reduce costs in the system as a whole. This targeted approach to state-level cost reduction recognizes the need for cost containment in our health care system while preserving the role of the tort system as a vehicle for compensating those who are wrongly injured.

#### CONCLUSION

Tort reformers and those who stand opposed to reform can find common ground in the recognition that the current system of medical care in the United States appears to be in trouble. Disagreement arises, however, over the origins of the problem, and thus an effective solution. Presenting evidence that the supposed relationship between the tort system and problems in health care cost and access is more myth than reality, this Note argues that the crisis in medical care emanates from a broken *health* care system, not a broken *legal* one. Reducing medical liability will not increase national competitiveness or decrease health care costs, as the tort system constitutes only two percent of overall health spending. Moreover, there is little evidence that reform measures will achieve meaningful savings through a reduction in the practice of defensive medicine. Additionally, there is little evidence that reducing the number of medical malpractice cases filed annually or capping jury awards will contribute to a decline in malpractice premiums.

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<sup>290</sup> Press Release, Ctr. for Justice & Democracy, *Mythbuster: What's the Answer? Insurance Regulation* (Mar. 19, 2005), available at <http://centerjd.org/RegAnswer.pdf>.

Finally, even if a medical liability crisis does exist, evidence from state-level reforms suggests that current tort reform proposals will be inadequate to solve the problems identified. Accordingly, federal medical liability reform is not yet appropriate; rather, in states where premiums continue to soar and anecdotal evidence of the decreasing availability of care flourishes, state legislators should develop and refine tort reform packages as necessary to address their particular states' needs. In order for these state experiences to prove valuable, well developed empirical studies must be designed and implemented to track state initiatives. Such studies will inform policymaking by presenting data of successful or unsuccessful reforms, and will assist subsequent states in reproducing successful results. If premiums continue to rise nationally, and if better evidence emerges that this premium increase is responsible for reducing the availability of health care, then it may be appropriate to reconsider federal tort reform legislation. At such a point, reform initiatives by states acting as "laboratories of democracy"<sup>291</sup> will provide guidance to federal policymakers about how best to achieve reform objectives and quell the mounting crisis in our health care system.

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<sup>291</sup> *New State Ice v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) ("It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.").