

## **Medical Liability Reform - NOW!**

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A compendium of facts supporting medical liability reform  
and debunking arguments against reform.

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## I. Identification of the problem

### A. Recurrence of an old problem?

1. The medical liability insurance system experienced a period of crisis in the early 1970s, when several private insurers left the market because of rising claims and inadequate rates.
2. This exodus of capacity resulted in an availability crisis and created an affordability issue for those physicians and hospitals lucky enough to find insurance.
3. Over the next 15 years, various attempts were made to ease the explosion in claims costs: tort reform, increased diagnostic testing, improved peer review and increased communication between physicians and patients. Aggressive campaigns to reform state laws governing medical liability lawsuits began in the 1970s and were successful in a number of states including California, Louisiana, Indiana and New Mexico.
4. In California, between 1968 and 1974, the number of medical liability claims doubled and the number of losses in excess of \$300,000 increased 11-fold, from three to 34. Losses amounting to \$180 for each \$100 of premium led most commercial insurers to conclude that the practice of medicine was uninsurable, and they refused to provide medical liability insurance at any price. In California, access to care was threatened, and a special session of the California legislature led to enactment of the Medical Injury Compensation Reform Act of 1975 (MICRA).<sup>1</sup>

### B. Second liability crisis: the 1980s

1. During the 1980s, the second crisis—one of affordability—shook the industry, as claim frequency and severity increased again and premiums rose rapidly.
2. The affordability crisis had a dramatic effect. Physicians in specialties such as obstetrics and gynecology cut back on high-risk procedures and high-risk patients to reduce their risks and hold down their premiums.
3. Some physicians closed practices in states where premiums and the risk of being sued were especially high.

### C. The third liability crisis: the 2000s

1. Access to care
  - a. Forty-five percent of hospitals reported that the professional liability crisis resulted in the loss of physicians or reduced coverage in emergency departments.<sup>2</sup>

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<sup>1</sup>Richard E. Anderson, *Commentaries Defending the Practice of Medicine*, 164 ARCHIVE OF INTERNAL MED. 1173, 1173-4 (June 14, 2004).

<sup>2</sup> AM. HOSP. ASS'N., PROF'L LIABILITY INS. SURVEY (2003).

b. According to an American College of Obstetricians and Gynecologists (ACOG) survey, the lack of affordable liability insurance forced 70 percent of OB/GYNs to make changes to their practice. Liability concerns also forced between seven to eight percent of OB/GYNs to stop practicing obstetrics. Finally, close to 90 percent of OB/GYNs have had at least one liability claim filed against them with the average being 2.6 claims per OB/GYN.<sup>3</sup>

c. Residents' and students' concerns: At the height of the recent crisis, residents and students expressed grave concerns about their ability to practice medicine in high risk specialties. With liability concerns steering students and residents away from some of the most needed specialties, shortages in these specialties will only grow worse.

i. Medical residents' growing concerns about liability issues may cause them to avoid high-risk specialties or states with adverse liability climates. Sixty-two percent of medical residents reported that liability issues were their top concern in 2003 - surpassing any other concern, and representing an enormous increase from 2001, when only 15 percent of residents said liability was a concern.<sup>4</sup>

ii. Some medical residents reported that the current medical liability system works against physicians trying to practice evidence-based medicine (EBM). One recent example is from a resident who, despite utilizing the best practices of EBM, watched in horror as he was sued and the plaintiff's attorney portrayed EBM as nothing more than "a cost-saving method," and "the few lives saved were not worth the money." Thus, despite the resident showing how he followed "conscientious, explicit, and judicious use of the current best evidence in making clinical decisions about the care of individual patients," the plaintiff's attorney used it against him. The resident was exonerated, but the residency program was found liable for \$1 million.<sup>5</sup>

iii. Even in states with caps, such as Wisconsin, residents may not be protected from massive damage awards. In October 2004, a loophole in Wisconsin's previous non-economic damages cap was exploited to permit a total award of more than \$26 million against a resident, who was found to be unprotected by the cap because he was not yet a fully licensed physician.<sup>6</sup> (Currently, Wisconsin's cap on non-economic damages is \$750,000, but it has not been challenged in court.)<sup>7</sup>

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<sup>3</sup> The American College of Obstetricians and Gynecologists, November 3, 2006. Available at [http://www.acog.org/from\\_home/publications/press\\_releases/nr11-03-06.cfm](http://www.acog.org/from_home/publications/press_releases/nr11-03-06.cfm) (Accessed on December 18, 2007)

<sup>4</sup> MERITT, HAWKINS & ASSOC., SUMMARY REPORT: 2003 SURVEY OF FINAL YEAR MED. RESIDENTS 5 (2003).

<sup>5</sup> Daniel Merinsein, *Winners and Losers* 291 JAMA 15, 15-6 (2004).

<sup>6</sup> Derrick Nunnally, *Payout in death may be state's biggest— But challenge looms for 'loophole' allowing jury to ignore malpractice cap*, MILWAUKEE J. SENTINEL, Oct. 23, 2004.

<sup>7</sup> Wis. Stat. § 655.017 (2006).

iv. Students, too, are affected by the liability crisis. In fact, half of the respondents of an AMA survey indicated the current medical liability environment was a factor in their specialty choice.<sup>8</sup>

v. Thirty-nine percent said the medical liability environment was a factor in their decision about a state in which they would like to complete residency training.<sup>9</sup>

vi. Sixty-one percent of students reported they are extremely concerned the current medical liability environment is decreasing physicians' ability to provide quality medical care.<sup>10</sup>

vii. Forty-eight percent of students in their third or fourth year of medical school indicated that the liability situation was a factor in their specialty choice.<sup>11</sup>

## 2. Costs

### a. Trends in jury awards and settlements:

i. Recent data from the Physician Insurers Association of America illustrate the problem as it exists today.

(a). The median medical liability jury award in medical liability cases more than tripled from 1997 to 2006, increasing from \$157,000 to \$487,500. The average award increased from \$347,134 in 1997 to \$637,134 in 2006.<sup>12</sup>

(b). Settlements have also grown in size. Median and average settlements increased from \$100,000 to \$204,500, and from \$212,861 to \$335,847 between 1997 and 2006, respectively.<sup>13</sup>

(c). Overall, 74 percent of medical liability claims in 2004 were closed without payment to the plaintiff. Plaintiffs lost the majority of the cases that went to a jury. Of the six percent of claims that went to a jury verdict, the defendant won 91 percent of the time.<sup>14</sup>

(d). However, physicians who win at trial still have large fees to pay for their defenses. Average defense costs were \$94,284 per claim in cases where the defendant prevailed at trial. And in

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<sup>8</sup> DIV. OF MKT. RESEARCH & ANALYSIS, AM. MED. ASS'N, AMA SURVEY: MED. STUDENTS' OPINIONS OF THE CURRENT MED. LIABILITY ENV'T (2003).

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> PHYSICIAN INSURERS ASS'N OF AM., PIAA CLAIM TREND ANALYSIS: 2006 ed. (2007).

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

cases where the claim was dropped or dismissed, costs to defendants averaged \$18,887.<sup>15</sup>

ii. In 2007, the Bureau of Justice Statistics issued a Special Report in which it reviewed 2000-2004 closed claim data available from a number of states. Its analysis of that data showed that 17 percent of paid claims in Illinois and Massachusetts and 8.5 percent of paid claims in Nevada resulted in payouts at or above \$1 million.<sup>16</sup>

b. Total tort costs:

i. According to a 2007 study released by Towers Perrin, medical liability represents a large and growing component of total U.S. tort costs. Medical liability went from 5.8 percent of total tort costs in 1975 to 12.2 percent in 2006. Annual cost growth since 1975 has averaged 11.1 percent per year for medical liability, and 8.4 percent per year for other torts. Between 2005 and 2006, when U.S. tort costs fell by 5.5 percent, medical liability costs were still rising by almost three percent.<sup>17</sup>

ii. Moreover, data show that 40 percent of closed claims were filed with no merit: 37 percent did not involve a medical error, and another three percent did not involve an injury.<sup>18</sup>

c. Premium levels: The *Medical Liability Monitor* tracks medical liability premiums from many of the leading medical liability insurance carriers. In October of each year, the *Medical Liability Monitor* publishes its annual rate survey.

i. According to the latest rate survey, the good news is that medical liability premiums continue to stabilize in many states; however, the bad news is that the rates are stabilizing at or near all time highs. According to the survey, of the 815 non-compensation fund rates reported in its annual survey, the most common results are “no change” or a slight decrease.<sup>19</sup>

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<sup>15</sup> *Id.*

<sup>16</sup> Bureau of Justice Statistic, *Medical Malpractice Insurance Claims in Seven States, 2000-2004*, Department of Justice (March 2007) available at <http://www.ojp.gov/bjs/pub/pdf/mmicss04.pdf> (Viewed last on December 19, 2007)

<sup>17</sup> Towers Perrin. 2007 Update on U.S. Tort Cost Trends (2007), at 15, available at [http://www.towersperrin.com/tp/getwebcachedoc?webc=TILL/USA/2007/200712/tort\\_2007\\_1242007.pdf](http://www.towersperrin.com/tp/getwebcachedoc?webc=TILL/USA/2007/200712/tort_2007_1242007.pdf) (last visited December 13, 2007).

<sup>18</sup> David M. Studdert, et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 N. ENG. J. MED. (2024-2033) 2006.

<sup>19</sup> *Medical Liability Monitor* Rate Survey Edition (October 2007)

## Medical Liability Monitor Rate Survey Issue Results

Number of Rate Changes	Increase or Decrease	Percent Change
5	Increase	More than 100
5	Increase	70 to 99.9
3	Increase	50 to 69.9
4	Increase	25 to 49.9
48	Increase	10 to 24.9
69	Increase	0 and 9.9
426	-	No rate change
172	Decrease	0.1 to 9.9
53	Decrease	10.0 to 19.9
19	Decrease	20.0 to 29.9
11	Decrease	30 or more

ii. The next chart displays the rapid escalation in premiums since 2000 in several key states.<sup>20, 21</sup>

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<sup>20</sup> *Id.*

<sup>21</sup> The rates in the table above are examples of manual rates for professional liability insurance. These rates were selected by the AMA from a comprehensive rate report of insurers in all 50 states by the Medical Liability Monitor, an independent Chicago-based publication. This table does not include all the rates reported for the geographic areas selected above, nor the premiums paid by physicians in other areas of the country, which may be higher or lower. These rates reflect the manual rates for one of the state's marketshare leaders. The MLM reports that these rates do not reflect credits, debits, dividends, or other factors that may reduce or increase the actual rates charged to physicians. The AMA alone is responsible for the accuracy of the above information taken from the MLM and believes the rates listed above are a reasonable benchmark to demonstrate professional liability insurance trends for select specialties in certain geographic areas. To view the full report or to verify its accuracy, the survey may be obtained by visiting [www.mlmonitor.com](http://www.mlmonitor.com) or by calling 312-944-7900. Notes: Connecticut 2003 - 2007 rates are for \$1 million/\$4 million limits, and New York 2004 - 2007 rates are for \$1.3 million/\$3.9 million limits. Pennsylvania premiums include PCF surcharges.

### Medical Liability Monitor Rate Survey Year-by-year Results

<b>Obstetrics/gynecology</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
California (Los Angeles)	52,874	52,874	54,563	60,259	63,272	63,272	63,272	63,272
Connecticut	63,292	77,533	94,978	123,470	148,164	170,389	170,389	170,389
Florida (Miami-Dade)	147,621	166,368	201,376	249,196	277,241	299,420	299,420	275,466
Illinois (Chicagoland)	78,880	88,928	102,640	139,696	147,540	143,040	138,484	138,484
New Jersey	68,000	68,000	70,720	102,643	128,304	146,267	171,199	171,199
New York (Nassau/Suffolk)	115,429	115,431	115,431	123,853	133,787	143,148	156,032	177,880
Pennsylvania (Philadelphia)	37,556	45,938	100,045	134,335	161,211	159,653	148,919	145,131
<b>General surgery</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
California (Los Angeles)	32,507	32,507	36,740	45,421	54,505	54,505	54,505	54,505
Connecticut	32,651	34,283	36,854	42,385	57,220	65,803	65,803	65,803
Florida (Miami-Dade)	110,068	124,046	174,268	226,542	277,241	299,420	299,420	275,466
Illinois (Chicagoland)	52,364	59,016	68,080	92,576	102,700	101,940	98,888	98,888
New Jersey	32,333	38,800	41,516	58,786	63,489	72,377	80,629	80,629
New York (Nassau/Suffolk)	62,733	65,870	65,870	74,211	80,163	85,772	93,491	106,583
Pennsylvania (Philadelphia)	33,684	35,793	82,157	108,038	128,524	129,654	120,012	116,609
<b>Internal medicine</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
California (Los Angeles)	10,097	10,097	11,164	12,493	14,237	14,237	14,237	14,237
Connecticut	7,736	9,863	13,820	21,420	28,917	34,700	34,700	34,700
Florida (Miami-Dade)	32,744	38,378	56,153	65,697	69,310	74,855	74,855	68,867
Illinois (Chicagoland)	19,604	22,060	26,404	35,756	38,424	38,424	37,688	37,688
New Jersey	11,359	12,495	13,620	20,893	23,818	26,107	27,613	27,613
New York (Nassau/Suffolk)	16,751	16,751	21,648	23,228	25,091	26,847	29,263	33,360
Pennsylvania (Philadelphia)	7,390	7,853	18,429	24,546	27,505	26,891	25,072	24,430

iii. A U.S. Department of Health and Human Services (HHS) report highlighted the rapid liability insurance rate escalation in states that had not established reasonable limits on unquantifiable and arbitrary non-economic damage awards. The government's report stated that 2001 premium increases in states without litigation reform ranged from 30 to 75 percent. In 2002, the situation deteriorated. **States without reasonable limits on non-economic damages experienced the largest increases by far, with increases of between 36 to 113 percent in 2002.** States with reasonable limits on non-economic damages did not experience the same rate spiking. (emphasis added)<sup>22</sup>

d. Defensive medicine: Altogether, medical liability adds billions of dollars to the cost of health care each year, which means higher health insurance premiums and higher medical costs for all Americans.

<sup>22</sup> OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, U.S. DEP'T OF HEALTH AND HUMAN SERVS., SPECIAL UPDATE ON MED. LIABILITY CRISIS (2002), available at <http://aspe.hhs.gov/daltcp/reports/mlupd1.htm> (last visited December 18, 2007).

i. A 2003 HHS report estimated the cost of defensive medicine to be between \$70 and \$126 billion per year.<sup>23</sup> Updating this to the most recent year of national health expenditure data available, 2005, the cost is \$99 to \$179 billion dollars per year. Direct tort reform, including but not limited to reasonable limits on non-economic damages (e.g., pain and suffering, mental anguish, physical impairment, etc.), would reduce national health care costs by that amount. Medicare spending alone would be reduced by \$17 to \$31 billion per year.

ii. Defensive medicine practices include tests and treatments that are performed to help avoid lawsuits. Defensive medicine takes many forms as physicians respond to the breakdown of access to care, including: referring patients to emergency departments, safety net hospitals and academic health centers; specialists declining to take call in the emergency department; and specialists declining elective referrals from emergency departments and safety net clinics, especially for uninsured patients.<sup>24</sup>

iii. At the height of the third crisis, a majority (59 percent) of physicians believed that the fear of liability discouraged open discussion and thinking about ways to reduce health care errors.<sup>25</sup>

iv. Over three-fourths (76 percent) of physicians believed that concern about medical liability litigation negatively affected their ability to provide quality care.<sup>26</sup>

f. Fear of medical liability suits causes some emergency room physicians to order more hospitalizations and medical tests than other ER doctors.<sup>27</sup>

### 3. Examples from the states

a. At the height of the recent crisis, the AMA identified the following states as crisis states: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Washington, West Virginia and Wyoming. For several reasons, the AMA is no longer categorizing states as crisis states, but the AMA remains committed to fixing the liability crisis at both the state and federal levels. Evidence of the crisis is shown in the following examples.

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<sup>23</sup> OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, U.S. DEP'T OF HEALTH AND HUMAN SERVS., ADDRESSING THE NEW HEALTH CARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE 11 (2003) [hereinafter ADDRESSING THE NEW HEALTH CARE CRISIS].

<sup>24</sup> ROBERT BERENSON ET AL., CTR. FOR STUDYING HEALTH SYS. CHANGE., *Medical Malpractice Liability Crisis Meets Markets: Stress in Unexpected Places* (2003), available at <http://www.hschange.org/CONTENT/605/?words=malpractice> (last visited December 18, 2007).

<sup>25</sup> HARRISINTERACTIVE INC., COMMON GOOD, COMMON GOOD FEAR OF LITIGATION STUDY: THE IMPACT ON MED. 65 (2002).

<sup>26</sup> *Id.* at 57. See also, Stuart Taylor & Evan Thomas, *Civil Wars*, NEWSWEEK, Dec. 15, 2003 (detailing America's increasingly litigious culture and its repercussions in the day to day work of physicians and other professionals).

<sup>27</sup> *Malpractice Fears Guide Behavior Of Some ER Physicians, Study Says*, HEALTH CARE DAILY, July 13, 2005.

i. Liability premiums in Connecticut, New Jersey and Pennsylvania have nearly tripled since 2000.<sup>28</sup>

ii. In New York, Gov. Eliot Spitzer has convened a task force on medical liability because of the dire medical liability climate in that state.

(a). New York physicians are facing double digit increases in their liability premiums. On July 2, 2007, the State Insurance Superintendent approved a 14 percent increase for the liability carriers writing policies in New York.<sup>29</sup>

(b). New York's Medical Malpractice Insurance Pool has a \$525 million deficit. This may lead to even larger premium increases or surcharges on physicians to offset the deficit.<sup>30</sup>

(c). Dr. Tamer Seckin is an obstetrician-gynecologist with 20 years of experience in this field of medicine. Dr. Seckin has decided to stop delivering high-risk babies because of liability cost concerns.<sup>31</sup>

(d). Dr. Scott Berlin also decided to stop delivering babies based on the medical liability premium increase. If he continued to deliver babies, his insurance premium would have climbed to close to \$200,000. His insurance will decrease by 75 percent based on this change in his practice.<sup>32</sup>

iii. In New Jersey, an appeals court upheld a \$70.8 million verdict against several physicians and a hospital. The award includes \$50 million in pain and suffering damages.<sup>33</sup>

iv. Philadelphia has lost 11 maternity wards since 1997. The *Philadelphia Inquirer* cited liability concerns as one of the main reasons for these closures.<sup>34</sup>

v. Tennessee physicians are the target of a legal system seeking to cash in on the lawsuit lottery. Between 1995 and 2005, 100 percent of cardiac surgeons, 92 percent of obstetrician-gynecologists, 92 percent of orthopedists and 70 percent of all doctors in Tennessee faced legal actions. (Tennessee Medical Association, Jan. 2005)

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<sup>28</sup> *Medical Liability Monitor* Rate Survey Issue (October 2007)

<sup>29</sup> New York State Insurance Department, *Rate Increase Staves Off Looming Insurance Industry Crisis as New Task Force Confronts Medical Malpractice Reform*. (2007) available at <http://www.ins.state.ny.us/press/2007/p0707021.htm> (last visited December 18, 2007).

<sup>30</sup> Ridgely Ochs, *NY Malpractice Fund "In Crisis*, *Newsday*, December 17, 2007.

<sup>31</sup> Julia Dahl, *Oh, Baby: N.Y. OB/GYN Crisis*, *New York Post*, September 26, 2007.

<sup>32</sup> Ridgely Ochs, *Long Island OB-GYNs Say Insurance Rates Too High*, July 16, 2007.

<sup>33</sup> *Pellicer v. St. Barnabas Hospital*, (A-1472-05) .N.J. Super. Ct. App. Div. (2007),

<sup>34</sup> Stacey Burling, *Demise of Maternity Wards Is Inducing The Baby Scramble*, *Philadelphia Inquirer*, May 6, 2007.

vi. The current crisis in Tennessee makes it difficult to attract physicians to the state, and patient access to physicians in high-risk specialties is suffering. A TMA survey found that 70 percent of Tennessee's physicians believe the state has a shortage of high-risk specialists.

vii. In Hawaii, rates for a leading insurer increased by 90 percent from 2002 to 2006. (Hawaii Medical Association (HMA) 2007) Premiums continued to increase despite the fact that over 86 percent of claims against Hawaii physicians were found to be without merit or closed without payment. (HMA 2007)

viii. In Illinois, there are still medical liability claims moving through litigation that do not fall under the state's 2005 cap on non-economic damages. These claims show the compelling need for the Illinois Supreme Court to reinstate Illinois' cap after it was stricken down in a Cook County Circuit Court. (see subsection II.D.1.b)

(a). In 2006, the average payment for economic damages in Cook County medical liability cases was \$345,775. The average payment for non-economic damages was \$2,213,864.<sup>35</sup>

(b). Illinois still has a shortage of specialists in the Southern half of the state. During the crisis, it was reported that neurosurgical trauma care was unavailable in southern Illinois. Since the cap passed in 2005, a few neurosurgeons have moved to that region, but the shortage remains. With the Illinois cap on non-economic damages being stricken down recently, the progress that has been made to address physician shortages is in serious jeopardy. (Illinois State Medical Society 2007)

(c). The Illinois Legislature enacted legislation in 2007 that expands the wrongful death cause of action in the state. So despite its efforts in 2005 to address the liability crisis, in 2007, the legislature is putting Illinois' liability climate back in jeopardy. House Bill 1798 was enacted, and it expands recovery for wrongful death cases to allow compensation for grief, sorrow, and mental suffering.<sup>36</sup>

## II. Solutions

A. Studies and expert opinions confirm that certain types of reform lower costs and improve access to care

A large and growing body of research shows that caps on non-economic damages lead to improved patient access to care, lower medical liability premiums, and lower health care costs. Periodically, the AMA has released summaries of this research, and the excerpts below are from

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<sup>35</sup> *Cook County Jury Verdict Reporter* (2006). Analysis by Illinois State Medical Society.

<sup>36</sup> 740 ILCS 180/2 (2007)

our two most recent reports.<sup>37,38</sup> Please refer to the reports for more detailed information on the research.

#### 1. Literature from 2006 and 2007

a. Born, Viscusi, and Baker (2006) find that insurers whose business is concentrated in states with caps have smaller losses than other insurers.<sup>39</sup> On average over the 1984 to 1993 period, a 10 percent increase in the share of business in states with non-economic caps leads to a four percent decrease in ultimate losses. The effect is more pronounced for firms with higher losses per premium dollar—these firms have the large claims that are likely to be affected by caps. Similar but slightly different-sized effects are found for caps on punitive damages. The authors also examine incurred losses and find an impact smaller than for ultimate losses. This suggests that caps have an impact larger than what insurers initially expect.

b. Kilgore, Morrisey, and Nelson (2006) investigate the association between a number of different types of tort reforms and medical liability premiums over the 1991 to 2004 period.<sup>40</sup> Their results show that on average, internal medicine premiums in states with caps on non-economic damages are 17.3 percent smaller than in states without caps. The impact of caps on general surgery and obstetrics/gynecology premiums is larger, 20.7 percent and 25.5 percent, respectively. Moreover, and consistent with what one might expect, the authors find that every \$100,000 increase in a cap raised premiums by 3.9 percent. Their results suggest that enacting a \$250,000 cap in states without caps, or with higher level caps, would result in premium savings of \$1.4 million. (8 percent of current premiums)

c. Matsa (2007) examines how physician supply responds to caps on non-economic or total damages over the period from 1970 to 2000.<sup>41</sup> He finds that the positive impact of caps is largely limited to rural counties, and to surgical and support specialists within those counties. Overall, he finds that the number of physicians per capita in the most rural counties is about four percent larger when a state has caps than in similar counties in states without caps. When Matsa looks at particular specialty groups within rural counties, he estimates that caps have an impact of 10 percent and 11 percent for surgical and support specialists, respectively, but no impact on the number of general/family practice physicians,

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<sup>37</sup> Kane, Carol K. and David W. Emmons. "The Impact of Liability Pressure and Caps on Damages on the Healthcare Market: An Update of Recent Literature" Physician Marketplace Report No. 2007-1. (Chicago, IL: American Medical Association, December 2007) <http://www.ama-assn.org/ama1/pub/upload/mm/363/prp2007-1.pdf>.

<sup>38</sup> Kane, Carol K. and David W. Emmons. "The Impact of Caps on Damages. How are Markets for Medical Liability and Medical Services Affected?" Physician Marketplace Report No. 2005-2. (Chicago, IL: American Medical Association, December 2005) <http://www.ama-assn.org/ama1/pub/upload/mm/363/prp200502caps.pdf>.

<sup>39</sup> Born, Patricia, W. Kip Viscusi, and Tom Baker. "The Effects of Tort Reform on Medical Malpractice Insurers' Ultimate Losses." NBER Working Paper 12086 (Cambridge, MA: National Bureau of Economic Research, March 2006) <http://www.nber.org/papers/w12086>.

<sup>40</sup> Kilgore, Meredith L, Michael A. Morrisey, and Leonard J. Nelson. "Tort Law and Medical Malpractice Insurance Premiums." *Inquiry* 43 (Fall 2006): 255-270.

<sup>41</sup> Matsa, David A. (forthcoming) "Does Malpractice Liability Keep the Doctor Away? Evidence from Tort Reform Damage Caps." *Journal of Legal Studies* 36 (June 2007).

or on medical specialists. His work also suggests that it takes at least six to 10 years for the full effect of caps on physician supply to be felt, and that this long term effect is approximately twice that of the short term effect.

d. Klick and Stratmann (2007) use a somewhat different approach than Matsa (2007) to examine the impact of caps on physician supply over the 1980 to 2001 period.<sup>42</sup> They recognize that a complicating factor in researchers' ability to estimate the impact of caps on physician supply is that forces which are correlated with physician supply may also be a determinant of caps. For example, a way to "net out" this confounding factor is to compare the changes in physician supply after caps between a "treatment" group (physicians likely to respond to caps) and a "control" group (physicians unlikely to respond in this fashion). Using low risk physicians as a control group for high risk physicians, Klick and Stratmann show that depending upon which specialties are defined as high or low risk, the number of high risk physicians per capita in states with caps on non-economic damages is between four percent and seven percent larger than in states without caps.

e. Helland and Showalter (2006) examine caps on a different measure of physician supply, weekly hours of work, in 1983 and 1988.<sup>43</sup> They find that a 10 percent increase in expected liability costs is associated with a 2.9 percent decrease in weekly hours worked. The effects for physicians in solo practice and for physicians age 55 or older are larger, with decreases of 6.6 percent and 12.2 percent respectively, for those two groups.

f. CBO (2006) focuses on the relationship between tort reform and hospital and physician expenditures of Medicare FFS beneficiaries and of the U.S. population at large.<sup>44</sup> For the Medicare population the analysis covers the 1980 through 2003 period; for the U.S. population it runs only through 2000. CBO finds that Part A (hospital) spending per beneficiary is five percent lower in states where non-economic damages were capped. CBO did not find evidence of such a relationship for Part B spending. The impact on Medicare total spending per beneficiary is four percent. They find some evidence of a relationship between caps and spending on hospital services in the general population, but it is only marginally significant and small in magnitude.

g. Baicker, Fisher, and Chandra (2007) focus on malpractice costs and a number of different categories of the healthcare expenditures of Medicare FFS beneficiaries, as well as their utilization of certain types of services.<sup>45</sup> They find that a 10 percent increase in average (per physician) indemnity payments between 1993 and 2001 is associated with about a one percent increase in per

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<sup>42</sup> Klick, Jonathan and Thomas Stratmann (forthcoming). "Medical Malpractice Reform and Physicians in High Risk Specialties." *Journal of Legal Studies* 36 (June 2007).

<sup>43</sup> Helland, Eric, and Mark H. Showalter. "The Impact of Liability on the Physician Labor Market." Rand Working Paper WR-384-ICJ. (Santa Monica, CA: Rand Institute for Civil Justice, April 2006) [http://www.rand.org/pubs/working\\_papers/2006/RAND\\_WR384.pdf](http://www.rand.org/pubs/working_papers/2006/RAND_WR384.pdf).

<sup>44</sup> United States Congress, Congressional Budget Office. *Preliminary Cost Estimate, H. R. 4250 Patient Protection Act of 1998*. (July 24, 1998) <http://www.cbo.gov/ftpdocs/7xx/doc701/hr4250.pdf>.

<sup>45</sup> Baicker, Katherine, Elliott S. Fisher, and Amitabh Chandra. "Malpractice Liability Costs and the Practice of Medicine in the Medicare Program." *Health Affairs* 26 (May/June 2007): 841-852.

beneficiary spending on Part B (physician) services. The impact on two subcomponents of Part B spending, evaluation and management and minor procedures, is similar, but the impact on imaging is larger, 2.2 percent. With regard to utilization, Baicker, Fisher, and Chandra find that a 10 percent increase in indemnity payments is associated with a 1.5 percent to 1.8 percent increase in the utilization of a number of diagnostic and imaging procedures, but no impact on surgical procedures. Their results suggest that the 60 percent increase in medical liability premiums between 2000 and 2003 is responsible for increased Part B Medicare spending of \$7.1 billion.

h. Roberts and Hoch (2007) explore the extent to which defensive practices vary with the degree of local litigation pressure.<sup>46</sup> They look at per-enrollee FFS Part B Medicare expenditures, and utilize a database maintained by the Mississippi Supreme Court that contains information on the number of malpractice filings in each county. Looking at the 1998 to 2002 period, Roberts and Hoch find that, on average, an additional lawsuit per 100,000 persons leads to another \$1.40 to \$2.49 in Part B Medicare spending per beneficiary. This implies that between 0.9 percent and 1.6 percent of spending is due to the litigation climate (including the direct impact of payouts to plaintiffs on health care costs). In the county with the most lawsuits, 277 per 100,000 persons, 15.9 percent of spending on physician services is due to litigation.

## 2. Literature through 2005

a. Viscusi and Born (2005) examined the impact of tort reforms enacted in the mid to late 1980s on medical liability premium revenues and incurred losses.<sup>47</sup> They found that insurers in states that enacted caps on non-economic damages had losses 17 percent lower than those of insurers in other states. Earned premiums were six percent lower. In addition, they found that losses and premiums of insurers in states where punitive damages were not allowed were 16 percent and eight percent lower, respectively, than losses and premiums of insurers in states that allowed punitive damages. Caps on punitive damages had, predictably, smaller impacts than the prohibition of punitive damages, only seven percent on losses and no impact on premiums.

b. Thorpe's work (2004) was similar to that of Viscusi and Born (2005).<sup>48</sup> Thorpe found that premium revenue was between 13 percent and 17 percent lower in states that capped non-economic or total damages than in states that did not. Unlike Viscusi and Born (2005), he did not find that premium revenue was affected by limitations on punitive damages.

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<sup>46</sup> Roberts, Brandon and Irving Hock. "Malpractice Litigation and Medical Costs in Mississippi." *Health Economics* 16 (August 2007): 841-859.

<sup>47</sup> W. Kip Viscusi and Patricia H. Born, *Damage Caps, Insurability, and The Performance of Medical Malpractice Insurance*, THE J. OF RISK AND INS., Mar. 2005, at 23-43.

<sup>48</sup> Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends And The Impact Of State Tort Reforms*, HEALTH AFFAIRS, Jan. 21, 2004, at W4-20-W4-30, <http://content.healthaffairs.org/contents-by-date.0.shtml> (last accessed on July 7, 2005).

c. Zuckerman, Bovbjerg, and Sloan (1990) estimated the impact of a variety of tort reforms on premiums and claim severity.<sup>49</sup> The base-rate premium data and average (per-claim) indemnity data were for 1975 through 1986 and from separate surveys of insurers. The authors found that capping physician liability (but not caps on non-economic damages) reduced premiums for general surgeons by 13 percent in the year following enactment of that reform and by 34 percent over the long term. The impact on premiums paid by general practitioners and obstetricians and gynecologists was similar. Looking at physicians across all specialties, they found that caps on non-economic damages (but not caps on physician liability) decreased the average indemnity per paid claim (claim severity). The authors were not able to resolve the different impacts that caps on physician liability and caps on non-economic damages had on premiums and losses.

d. Sloan, Mergenhagen, and Bovbjerg (1989) looked at the impact of tort reform using closed claim data for 1975 through 1978 and for 1984.<sup>50</sup> The authors found that caps on non-economic damages reduced insurer payouts by 31 percent and reduced payouts-plus-expenses by 23 percent. The impacts of caps on total damages were somewhat larger, 38 percent and 39 percent, respectively.

e. Kessler and McClellan (1996) compared hospital expenditures on Medicare beneficiaries with heart disease in states with direct, indirect, and no tort reforms.<sup>51</sup> Direct reforms include but are not limited to caps on non-economic damages. They concluded that states adopting direct reforms in the late 1980s exhibited reductions in hospital expenditures of five percent to nine percent within three to five years without substantial adverse effects on mortality or complications. Because outcomes were not affected, they attributed the cost difference to defensive medicine. If their results are applied to all medical spending, this would have amounted to an \$83.9 to \$151.1 billion reduction in national health spending in 2003.

f. Kessler and McClellan (1997) examined “malpractice pressure,” measured by liability premiums and claim frequency, and how that pressure was affected by tort reform.<sup>52</sup> Both the premium and frequency data were from 1985 through 1993 surveys of physicians conducted by the AMA. They found that direct reforms reduced premiums by 8.4 percent within the first three years after a reform, and reduced the likelihood that a physician would be sued by 2.1 percent. A number of literature reviews have also concluded that caps on non-economic damages work to reduce claim severity and premiums.

g. Using a variety of data sources, Hamm, Wazzan, and Frech (2005) concluded that MICRA has led to a reduction in medical liability costs both through a

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<sup>49</sup> Stephen Zuckerman, Randall R. Bovbjerg, and Frank Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, INQUIRY, Summer 1990, at 167-182.

<sup>50</sup> Frank A. Sloan, Paul M. Mergenhagen, and Randall R. Bovbjerg, *Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: a Microanalysis*, J. OF HEALTH POLITICS, POLICY AND LAW, 663, 663-669 (1989).

<sup>51</sup> Daniel Kessler and Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 445 Q. J. OF ECON. 353, 353-390 (1996).

<sup>52</sup> Daniel P. Kessler and Mark B. McClellan, *The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care*, LAW AND CONTEMPORARY PROBS., Winter 1997, at 81-106.

reduction in the filing of legally weak claims and a reduction in the severity of paid claims.<sup>53</sup> After comparing claim frequency in California to that in other states, they also concluded that MICRA did not reduce access to the courts.

h. The Congressional Budget Office (1998) concluded that caps on non-economic damages were one of two reforms that, “have been found extremely effective in reducing the amount of claims paid and medical liability premiums.”<sup>54</sup> The other reform was collateral source offset provisions.

i. The Office of Technology Assessment (1993) concluded that, “caps on damage awards were the only type of state tort reform that consistently showed significant results in reducing the malpractice cost indicators.”<sup>55</sup>

j. Kessler, Sage, and Becker (2005) examined physician supply using annual data for the period from 1985 through 2001.<sup>56</sup> They found that direct tort reforms increased physician supply by 2.4 percent relative to non-reform states. They also looked at the impact on a number of high-risk specialties and found that the impact on emergency physicians was particularly large at 11.5 percent.

k. Encinosa and Hellinger’s paper (2005) was similar.<sup>57</sup> It, however, looked specifically at the impact of caps on non-economic damages on physician supply, and included only eight years of data from 1985 through 2000. Their results suggest that caps increased the number of physicians per capita by 2.2 percent relative to states without caps.

l. A 2006 literature review by the Robert Wood Johnson Foundation confirmed the results of the research cited above. It concluded that, “Good evidence shows that caps on damages reduce average award size by 20 to 30 percent,” and that the, “best studies suggest that caps are associated with a small increase in physician supply.”<sup>58</sup> An additional conclusion was that “The most recent controlled studies show that caps moderately constrain the growth of premiums.”<sup>59</sup>

## B. State efforts to enact caps on non-economic damages

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<sup>53</sup> WILLIAM G. HAMM, C. PAUL WAZZAN AND H.E. FRECH, III, MICRA AND ACCESS TO HEALTHCARE (2005).

<sup>54</sup> CONG. BUDGET OFFICE, PRELIMINARY COST ESTIMATE, H.R. 4250, PATIENT PROTECTION ACT OF 1998 (1998), available at <http://www.cbo.gov/ftpdocs/7xx/doc701/hr4250.pdf> (last accessed on Oct. 18, 2005).

<sup>55</sup> OFFICE OF THE TECH. ASSESSMENT, IMPACT OF LEGAL REFORMS ON MEDICAL MALPRACTICE COSTS, OTA-BP-H-119 (1993), available at <http://www.wws.princeton.edu/cgi-bin/byteserv.prl/~ota/disk1/1993/9329/9329.pdf> (last accessed on Oct. 18, 2005). The OTA was a nonpartisan analytical agency that provided assistance to the U.S. Congress for 23 years through 1995.

<sup>56</sup> Daniel P. Kessler, William M. Sage, and David J. Becker, *Impact of Malpractice Reforms on the Supply of Physician Services*, 293 JAMA 2618-2625 (2005).

<sup>57</sup> William E. Encinosa and Fred J. Hellinger, *Have State Caps On Malpractice Awards Increased The Supply Of Physicians?*, HEALTH AFFAIRS, May 31, 2005, at W5-250-W5-W258, available at <http://content.healthaffairs.org/contents-by-date.0.shtml> (last accessed on July 7, 2005).

<sup>58</sup> Michelle M. Mello, *Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms*, The Robert Wood Johnson Foundation, Research Synthesis Report No. 10., May 2006, at 13.

<sup>59</sup> *Id.* at 14.

1. As of Jan. 7, 2008, 24 states have enacted a cap on non-economic damages, while six states have a cap on total damages. Colorado places a cap on total damages and on non-economic damages.

2. States with a cap on non-economic damages – Alaska, California, Colorado, Florida, Georgia, Hawaii, Idaho, Kansas, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, West Virginia, and Wisconsin.

3. States with a cap on total damages – Colorado, Indiana, Louisiana, Nebraska, New Mexico, and Virginia.

More information on state cap statutes and other state medical liability reform laws can be found at the following link:

[http://www.ama-assn.org/ama1/x-ama/upload/mm/378/stlaw\\_cht1\\_406.pdf](http://www.ama-assn.org/ama1/x-ama/upload/mm/378/stlaw_cht1_406.pdf)

4. A cap's effectiveness depends on the specific provisions of the legislation with which it was enacted. For example, some states have a "hard" cap on non-economic damages while others have a "soft" cap on non-economic damages. A hard cap, like the \$250,000 cap found in California's MICRA, is not subject to exceptions, does not adjust over time, and applies irrespective of the number of defendants or plaintiffs. By contrast, a "soft" cap may be subject to numerous exceptions; annual increases with inflation, other economic indicators, or based on a set schedule; or individual application to every defendant or plaintiff, thereby allowing several caps for a single claim.

5. Recognizing the limitations of a soft cap, several states, such as Alaska, Mississippi and Missouri, have enacted legislation to strengthen their cap. Likewise, Nevada voters adopted a ballot initiative in 2004 to replace a cap riddled with exceptions with a hard \$350,000 cap on non-economic damages.

6. A cap on non-economic damages that is set too high will also have a limited effect. For example, prior to modifying legislation in 2003, West Virginia had a \$1 million cap on non-economic damages. At this high level the cap was ineffective.

7. State legislation enacting caps on non-economic damages (See the next section, "C. Election 2004 ballot measures," for supplemental information on Florida, Nevada and Wyoming)

a. Alaska

i. Signed into law by Gov. Frank Murkowski on June 7, 2005, S.B. 67 strengthened Alaska's existing cap on non-economic damages by establishing a \$250,000 cap on non-economic damages awarded in a personal injury cause of action, and a \$400,000 cap on non-economic damages awarded in a cause of action involving wrongful death or a severe permanent physical impairment that is more than seventy percent disabling.<sup>60</sup> A single cap applies regardless of the number of health care

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<sup>60</sup> Alaska Stat. § 09.55.549 (2007)

providers against whom the claim is asserted or the number of causes of action filed.

b. Florida

i. After four special sessions, Florida's legislature enacted S.B. 2-D, which was signed into law by Gov. Jeb Bush on Aug. 14, 2003. In its final form, the bill did not provide the level of reforms advocated by Gov. Bush's task force or by the Florida Medical Association (FMA). In particular, the language on non-economic damages and exceptions to the cap added during late stages of negotiations prohibited FMA from supporting the legislation in its final form.<sup>61</sup>

ii. S.B. 2-D provided a separate cap on non-economic damages for practitioners and non-practitioners. For practitioners, the cap is \$500,000 per claimant regardless of the number of defendants. For non-practitioners, the cap is \$750,000 per claimant regardless of the number of defendants. The cap can increase to \$1 million for practitioners and \$1.5 million for non-practitioners if the negligence resulted in death or a permanent vegetative state, or if the court finds a manifest injustice would occur if the cap were not increased because the non-economic harm sustained by the patient was particularly severe and the defendant's negligence caused a catastrophic injury to the patient. While physicians' insurance rate growth in Florida averaged eight percent in 2005, and five percent in 2004, after double-digit increases in the four preceding years, only a small portion of the leveling-off was attributable to the caps after adjustment for other factors (e.g., an overestimation of the number of Florida physicians with \$1 million dollar coverage policies, a moderation of losses and the effect of prior years' rate increases).<sup>62</sup>

iii. In April, 2006, Gov. Bush also signed legislation that repealed the doctrine of joint and several liability, an act that should bring greater equity to the civil justice system by restoring overall predictability. Joint and several liability permits a disproportionate level of liability to be assessed to a party regardless of their level of fault in a matter, such that a defendant can be held liable for the entire amount of damages even if only marginally responsible for an injury.<sup>63</sup>

c. Georgia

a. On Feb. 16, 2005, Gov. Sonny Purdue signed into law S.B. 3.<sup>64</sup> As enacted, S.B. 3 created a Texas-style cap on non-economic damages. The new law established a hard \$350,000 cap on non-economic damages awarded in a medical liability action, including wrongful death, against all health care providers and a separate \$350,000 cap on non-economic damages awarded against a single medical facility that can increase to \$700,000 if more than one facility is involved. No more than \$1.05

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<sup>61</sup> FLA. STAT. ch. 766.118 (2004).

<sup>62</sup> Brian Bandell, *Doctors finally get single digit insurance hikes*, BIZJOURNALS, June 13, 2005.

<sup>63</sup> *Gov. Bush Signs Important Fla. Tort Reform Legislation*, INSURANCE JOURNAL, Apr. 27, 2006.

million can be awarded in a medical liability cause of action. The caps apply to each claimant, but the term “claimant” is defined in the law as including all persons claiming to have sustained damages as a result of the bodily injury or death of a single person.

d. Idaho

i. On March 26, 2003, Gov. Dirk Kempthorne signed into law H.B. 92 which included a \$250,000 cap on non-economic damages (Idaho previously had a \$400,000 cap on non-economic damages which adjusted annually for inflation since 1988). The new cap also adjusts annually for inflation based on the average annual wage beginning July 1, 2004. The cap does not apply to causes of action arising out of willful or reckless misconduct, or felonious actions.<sup>65</sup>

e. Illinois

i. On Aug. 25, 2005, Gov. Rod Blagojevich signed into law a medical liability reform bill that included a \$500,000 cap on non-economic damages<sup>66</sup> for awards in a medical liability cause of action, including wrongful death, against a physician, the physician’s business or corporate entity, and the physician’s employees or other health care professionals. The new law also established a separate \$1 million cap on non-economic damages for awards in a medical liability cause of action, including wrongful death, against a hospital and its personnel or hospital affiliates. Both caps apply to all plaintiffs in any civil action arising out of the care. The caps apply to injuries that occur after the effective date of the act. The cap was recently struck down in a Cook County Circuit Court (see subsection II.D.1.b).

ii. To date the results have been positive. They are in peril though unless the Illinois Supreme Court reinstates the state’s cap on non-economic damages. Since the enactment of the cap in 2005:

- (a). ISMIE Mutual Insurance Company has reduced 2006-07 average collected premiums by 5.2 percent. It has lifted its new business moratorium for up to 400 new insureds. It has also implemented a policy holder dividend program.
- (b). AP Capital (AP Assurance) has rolled back 2007 rates by 14 percent.
- (c). ProNational (ProAssurance) rolled back 2007 rates by six percent.
- (d). Medical Protective (MedPro) announced its intent to seek a larger Illinois market share and rolled back 2007 rates by an average 32 percent.

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<sup>64</sup> O.C.G.A. § 51-13-1 (2007)

<sup>65</sup> ID. REV. STAT. § 6-1603 (2004).

<sup>66</sup> 735 ILCS 5/2-1706.5 (2008)

(e). Professional Solutions Insurance Company (PSIC) rolled back 2006-07 rates by almost 30 percent.<sup>67</sup>

f. Maryland

i. Enacted in January 2005, Maryland's H.B. 2 (2004) established a separate cap on non-economic damages for personal injury and wrongful death suits involving two or more claimants or beneficiaries. Non-economic damages awarded against a physician for personal injury, are capped at \$650,000 until Jan. 1, 2009, after which the cap will increase \$15,000 each year.<sup>68</sup> The cap applies in aggregate to all claims and all defendants arising from the same medical injury. (Cap also applies in wrongful death actions if the claim involves only one claimant or beneficiary). For wrongful death claims involving two or more claimants or beneficiaries, the total cap on non-economic damages is \$812,500 (i.e., 125 percent of the current \$650,000 non-economic damages cap in PI claims).

g. Mississippi

i. On June 3, 2004, the Mississippi Legislature enacted H.B. 13, a civil justice reform bill that further strengthened Mississippi's medical liability reform laws. Most importantly, the bill created a hard \$500,000 cap on non-economic damages for medical liability causes of action filed against a health care provider. This provision deleted exceptions to the original 2002 law, as well as scheduled increases to the cap.<sup>69</sup>

ii. These reforms have had results. The Medical Assurance Company of Mississippi (MACM), the state's largest medical malpractice insurer, announced a 5 percent decrease in premiums for 2006. The Mississippi insurer's board also voted to refund at least 20 percent of each policyholder's annual premium in 2006.<sup>70</sup> In 2007, MACM reduced premiums by 10 percent and planned to decrease premiums by 15.5 percent in 2008. (Mississippi State Medical Association 2007)

h. Missouri

i. On March 29, 2005, Gov. Matt Blunt signed into law H.B. 393, which among other medical liability reforms, included language strengthening Missouri's cap on non-economic damages. With passage of H.B. 393, Missouri now has a hard \$350,000 cap on non-economic damages.<sup>71</sup> H.B. 393 deleted language in Missouri's law that adjusted the cap annually and deleted the word "occurrence" from the law, thereby

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<sup>67</sup> Illinois State Medical Society, *Reality Medicine*, available at [http://www.realitymedicine.com/resources/rm\\_2007.pdf](http://www.realitymedicine.com/resources/rm_2007.pdf) (last viewed on December 18, 2007)

<sup>68</sup> Md. COURTS AND JUDICIAL PROCEEDINGS Code Ann. § 3-2A-09 (2007)

<sup>69</sup> Miss. Code Ann. § 11-1-60 (2007)

<sup>70</sup> Meg Fletcher, *State tort reform measures, loss control programs bring stabilization to medical malpractice market*, BUS. INS., Nov. 14, 2005, at 20.

<sup>71</sup> § 538.210 R.S.Mo. (2007)

clarifying that multiple caps cannot apply to a single defendant (effectively overturning the *Scott* decision in which the Missouri Supreme Court interpreted the term “per occurrence” to apply to each individual act of negligence even if multiple caps could apply to a single defendant). H.B. 393 also specifies that a single \$350,000 cap will apply irrespective of the number of defendants.

i. Nevada

i. As the result of passage of the Keep Our Doctors in Nevada initiative in 2004, Nevada has a \$350,000 cap on non-economic damages in medical liability cases.<sup>72</sup>

ii. Cap on trauma care. In August 2002, Nevada enacted A.B. 1 which in part establishes a \$50,000 cap on civil damages for claims arising from care necessitated by a traumatic event demanding immediate attention that is rendered in good faith to a patient who enters the hospital through the emergency room or trauma center. This limit does not apply to any act or omission in rendering care or assistance that occurs after the patient is stabilized (unless surgery is required within a reasonable time after the patient is stabilized), that is unrelated to the original traumatic injury, or that arose out of gross negligence or reckless, willful or wanton conduct.<sup>73</sup>

iii. In cases where the physician or dentist provides follow-up care to a patient treated in the above circumstances and the patient files a medical liability claim based on a medical condition that arose during follow-up care, the medical condition is rebuttably presumed to be the result of the original traumatic injury and the \$50,000 limit applies.

iv. The Nevada reforms have stabilized Nevada’s liability climate. One example is the Independent Nevada Doctors Insurance Exchange which lowered its premiums for internists and surgeons by over 20 percent in 2007.<sup>74</sup>

j. Ohio

i. On Jan. 10, 2003, Gov. Robert Taft signed into law S.B. 281, a medical liability reform bill to address the growing crisis in Ohio. Among other provisions, the bill established a sliding cap on non-economic damages. The cap is the greater of \$250,000 or three times the plaintiff’s economic loss up to a maximum of \$350,000 for each plaintiff or \$500,000 per occurrence. The maximum cap is \$500,000 per plaintiff or \$1,000,000 per occurrence for a claim based on either (a) a permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system, or (b) a permanent physical functional injury that

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<sup>72</sup> NEV. REV. STAT. § 41A.031 (2004).

<sup>73</sup> *Id.* at § 41.503.

<sup>74</sup> *Medical Liability Monitor* Rate Survey Edition (October 2007)

permanently prevents the injured person from being able to care for oneself independently and perform life sustaining activities.<sup>75</sup>

ii. Rate filings indicate single-digit decreases in 2006 and 2007 for the top five medical liability carriers in Ohio. The state's largest medical liability insurer, Medical Assurance, reported that premiums remained flat for 2006 and decreased 19.7 percent in 2007. (increase for 2001-2004 was 101 percent). Medical Protective reported a five percent decrease in rates for 2006 and another four percent decrease in 2007. Some areas such as Columbus and Cincinnati saw decreases averaging 11 percent. Since 2000, the number of companies selling medical liability insurance in Ohio dropped from 14 to five by 2002. Because of the improved tort reform environment, two new carriers have entered Ohio's medical liability insurance market place offering competitive professional liability products. (Ohio State Medical Association 2007)

k. Oklahoma

i. On May 28, 2004, Gov. Brad Henry signed into law a civil justice reform bill (H.B. 2661). The bill maintained the existing cap on non-economic damages for obstetrics and emergency room care, which was enacted in 2003 (see ii, below), and established a \$300,000 cap on non-economic damages<sup>76</sup> for all other medical liability causes of action. The cap applies only if the defendant has made an offer of judgment and the amount of the verdict awarded to the plaintiff is at least 1.5 times the amount of the final offer of judgment. The cap applies to each medical injury regardless of the number of actions brought and adjusts annually based on any increases in the Consumer Price Index. The cap does not apply if the jury finds by a preponderance of the evidence that the defendant's conduct was willful or wanton or by clear and convincing evidence that the defendant committed negligence. Before these questions can be presented to the jury, the judge must first determine there is enough evidence to establish these findings. The cap does not apply in cases involving wrongful death as this is prohibited by the Oklahoma Constitution.<sup>77</sup>

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<sup>75</sup> OHIO REV. CODE § 2323.43 (2004).

<sup>76</sup> 63 Okl. St. § 1-1708.1F (2007)

<sup>77</sup> Okl. Const. Art. XXIII, § 7 (2007)

ii. Previously, on June 4, 2003, Oklahoma Gov. Brad Henry signed into law S.B. 629. Among other provisions, S.B. 629 includes a \$300,000 cap on non-economic damages for cases involving pregnancy, labor and delivery, or care provided immediately post-partum. The cap also applies in cases involving emergency-room care or medical services provided as a follow up to such care. The bill allows a judge to lift the cap if the judge makes a finding that there is clear and convincing evidence of negligence. The cap applies regardless of the number of parties against whom the medical negligence action is brought. The \$300,000 damage limit does not apply in wrongful death cases. The cap provision is scheduled to sunset in five years.<sup>78</sup>

#### I. South Carolina

i. Signed into law by Gov. Mark Sanford on April 4, 2005, S.B. 83 establishes a \$350,000 cap on non-economic damages<sup>79</sup> in a medical liability action against a single health care provider or single health care institution. If the award is against more than one health care provider or more than one institution, the total award for non-economic damages cannot exceed \$1.05 million, with each defendant not liable for more than \$350,000. The cap applies separately to each claimant and adjusts annually based on an increase or decrease in the Consumer Price Index.

#### m. Texas

i. On June 11, 2003, Gov. Rick Perry signed H.B. 4 into law. H.B. 4 contained sweeping tort reforms, many of which exclusively address medical liability litigation against physicians. Of these reforms, perhaps the most important is the hard cap of \$250,000 on non-economic damages per claimant in any judgment against a physician or health care provider, regardless of any applicable theories of vicarious liability, the number of defendants involved, or the number of causes of action asserted as part of the claimant's case against the physician. H.B. 4 also placed a hard cap of \$250,000 on non-economic damages per claimant in any judgment against a health care institution in a medical liability cause of action. A judgment against two health care institutions can not exceed \$500,000 in non-economic damages, with each institution not liable for more than \$250,000 in non-economic damages.<sup>80</sup> All persons claiming to have sustained damages as a result of the bodily injury or death of a single person are considered a single claimant.

ii. The law states that the cap on non-economic damages applies per "claimant," which is defined as, "a person, including a decedent's estate, seeking or who has sought recovery of damages in a health care liability claim. All persons claiming to have sustained damages as a result of the bodily injury or death of a single person are considered a single

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<sup>78</sup> OK CODE §63-1-1708.1F (2004).

<sup>79</sup> S.C. Code Ann. § 15-32-220 (2006)

<sup>80</sup> TEX. CIV. PRAC. & REM. § 74.301(2004).

claimant." The law also states the cap applies regardless of the number of defendants or causes of action asserted.

iii. The caps provision states as follows: "(a) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider other than a health care institution, the limit of civil liability for non-economic damages of the physician or health care provider other than a health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$250,000 for each claimant, regardless of the number of defendant physicians or health care providers other than a health care institution against whom the claim is asserted or the number of separate causes of action on which the claim is based, (b) in an action on a health care liability claim where final judgment is rendered against a single health care institution, the limit of civil liability for non-economic damages inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$250,000 for each claimant, (c) in an action on a health care liability claim where final judgment is rendered against more than one health care institution, the limit of civil liability for non-economic damages for each health care institution is, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$250,000 for each claimant and the limit of civil liability for non-economic damages for all health care institutions, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$500,000 for each claimant."

iv. On Sept. 13, 2003, the people of Texas approved Proposition 12, a ballot initiative to amend the state constitution to specifically allow the legislature to enact laws that place limits on non-economic damages in medical and health liability cases.<sup>81</sup> The final vote was 51.12 percent in favor of Proposition 12 and 48.88 percent against.<sup>82</sup>

v. Since passage of Proposition 12 and H.B. 4, rate cuts by the six largest physician insurance carriers in Texas have reduced premiums by \$327.94 million. Roughly half of Texas' physicians are paying lower liability premiums than they were in 2001.<sup>83</sup>

- (a). Texas Medical Liability Trust – 31.3 percent decrease in premiums
- (b). APIE – 17.4 percent decrease in premiums
- (c). Medical Protective – 25.7 percent decrease in premiums

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<sup>81</sup> A tribute to the effectiveness of Proposition 12 came soon after its passing when personal injury trial attorney and member of the Oklahoma legislature Stratton Taylor sent a letter to his ATLA colleagues in Texas to offer the services of his firm to any Texas attorney wishing to forum-shop and file suit in Oklahoma—where there are still no caps. Editorial, *Oklahoma!*, THE WALL ST. J., Dec. 19, 2003.

<sup>82</sup> Tex. Const. Art. III, § 66

<sup>83</sup> Texas Medical Association, available at <http://www.texmed.org/Template.aspx?id=5238> (last viewed on December 18, 2007)

- (d). Joint Underwriting Association – 10 percent decrease in premiums
- (e). The Doctors Company – 25.3 percent decrease in premiums
- (f). Advocate MD – 29.5 percent decrease in premiums

vi. Since Proposition 12 passed, four new rate-regulated carriers have entered the Texas market. Twenty-six risk retention groups, captive, surplus lines, and other unregulated insurers have entered the market. Thirteen percent of the commercial liability market is controlled by new entrants coming to the state after the 2003 reforms.<sup>84</sup>

vii. There has been a 50 percent reduction in the number of lawsuits filed in most Texas counties, and 3,000 more physicians have come to the state.<sup>85</sup>

viii. Texas licensed 3,324 new physicians in 2007 which is 808 more than the previous year. Texas has seen an increase in the number of desperately needed specialists included among the new physicians.<sup>86</sup>

ix. Medical liability reforms have worked so well in Texas, that the *ABA Journal* wrote a cover story on them in 2006. In the article, several lawyers indicated that their business is down considerably since the 2003 reforms. The article states, “Firms are breaking up or dropping whole practice groups. Some lawyers have simply retired or left the profession.”<sup>87</sup>

#### n. West Virginia

i. On March 11, 2003, West Virginia Gov. Bob Wise signed into law H.B. 2122. As enacted, the bill contained a number of reforms including a \$250,000 cap on non-economic damages applied per occurrence regardless of the number of defendants or plaintiffs. The cap increases to \$500,000 per occurrence for cases involving a permanent and substantial physical deformity, loss of use of a limb or loss of a bodily organ system, or permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself or herself and perform life sustaining activities. The cap will be adjusted annually for inflation up to \$375,000 per occurrence or \$750,000 for injuries that fall within the exception.<sup>88</sup>

ii. The bill also included a \$500,000 cap on civil damages for any injury to or death of a patient as a result of health care services rendered in good faith and necessitated by an emergency condition for which the patient enters a health care facility designated as a trauma center. This limit also applies in the following circumstances: (1) to health care services rendered by a licensed EMS agency or employee of a licensed EMS agency, or (2) any act or omission of a health care provider in

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<sup>84</sup> *Id.*

<sup>85</sup> *Id.*

<sup>86</sup> *Id.*

rendering continued care or assistance in the event that surgery is required as a result of the patient's emergency condition.

This limit does not apply if the care is rendered in willful and wanton or reckless disregard of a risk of harm to the patient or in clear violation of established written protocols for triage and emergency health care procedures developed by the office of emergency medical services. Likewise, the limit does not apply to any act or omission in rendering care that occurs after the patient has been stabilized and is considered a non-emergency patient, or care that is unrelated to the original emergency condition.

If the physician who provided care to the patient when the patient was presented with an emergency condition provides follow-up care to the same patient and a medical condition arises during the course of this follow-up care that is directly related to the original emergency condition, there is a rebuttable presumption that the medical condition was the result of the original emergency condition, and, therefore, the cap applies. There is also a rebuttable presumption that a medical condition that arises in the course of follow-up care provided by a health care provider in the trauma center is directly related to the original emergency condition, where the follow-up care is provided within a reasonable time after the patient's admission to the trauma center.<sup>89</sup>

iii. Results have been positive for West Virginia physicians since the reforms were enacted. For example, the West Virginia Physicians' Mutual Insurance Company reduced rates in 2007 by 13 percent for internists, 24 percent for surgeons and 25 percent for OB/GYNs.<sup>90</sup>

o. Wisconsin

i. On March 22, 2006, Gov. Jim Doyle signed Assembly Bill 1073. A.B. 1073 limits non-economic damages in medical liability cases to \$750,000<sup>91</sup> for each occurrence. The bill covers all health care providers acting within the scope of their employment and providing health care services. The bill does not place a limit on the recovery of economic losses, such as lost wages and medical costs.

A.B. 1073 came in response to a Supreme Court of Wisconsin decision in 2005 that struck down the state's previous cap on non-economic damages.<sup>92</sup> The current cap has not faced judicial scrutiny yet.

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<sup>87</sup> Terry Carter, *Tort Reform Texas Style*, ABA Journal, October 2006.

<sup>88</sup> W. VA. CODE § 55-7B-8 (2004).

<sup>89</sup> *Id.* at § 55-7B-9C.

<sup>90</sup> *Medical Liability Monitor Rate Survey Edition* (October 2007)

<sup>91</sup> Wis. Stat. § 893.55 (2007)

<sup>92</sup> *Ferdon v. Wis. Patients Comp. Fund*, 2005 WI 125 (Wis. 2005).

### C. Successful ballot initiatives

In addition to Texas, three other states, Florida, Nevada and Wyoming, had successful ballot initiatives related to medical liability reform that went before voters in the 2004 November elections. The following is a summary of these initiatives and what voters decided.

#### 1. Florida

Voters approved constitutional Amendment 3, stating that an injured claimant who enters into a contingency fee agreement with an attorney for a medical liability claim is entitled to no less than 70 percent of the first \$250,000 and 90 percent of any damage award over \$250,000. Voters also approved two amendments sponsored by trial attorneys. One of these amendments, Amendment 7, gives the public access to any records made or received by a health care provider or facility related to an adverse medical incident. The other amendment, Amendment 8, denies licensure to a physician who has been “found to have committed” three or more incidents of medical liability. The language “found to have committed” means a finding of a physician’s medical liability by either: (1) a final judgment of a court; (2) a final administrative agency decision; or (3) a decision resulting from binding arbitration. “Found to have committed” does not, therefore, include settlements of medical liability claims. Nor does it include a report to a medical liability insurance carrier that a claim has, or will be, filed.

#### 2. Nevada

Voters approved the “Keep our Doctors in Nevada” initiative (Question 3) which amended Nevada’s medical liability reform statute to include MICRA-style reforms.<sup>93</sup> The approved initiative amended Nevada’s existing medical liability reform statute by: (1) deleting the current exceptions to Nevada’s \$350,000 cap on non-economic damages in medical liability cases; (2) strengthening the existing joint and several liability reform law by applying it to both economic and non-economic damages; (3) requiring periodic payment of future damages over \$50,000 at the request of either party; (4) placing limits on attorney contingency fees; and (5) strengthening Nevada’s existing statute of limitations.

Voters also defeated two ballot initiatives (Questions 4 and 5) sponsored by trial lawyers. Question 4 called for auto, homeowners, and medical liability insurers to roll back their rates to the amount charged on Dec. 1, 2005, and reduce them an additional 20 percent. Question 5 focused on frivolous lawsuits. If approved, both measures would have invalidated any medical liability reforms enacted by the legislature or voters, including Question 3.

#### 3. Wyoming

In Wyoming, voters approved one constitutional amendment<sup>94</sup> and defeated another. The approved amendment, Amendment C, allows the legislature to pass laws creating medical screening panels or other alternative dispute resolution systems in medical liability cases. The defeated amendment, Amendment D, would have allowed the legislature to enact a cap on non-economic damages in medical liability cases. Wyoming is currently one of

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<sup>93</sup> Nev. Rev. Stat. Ann. § 41A.035

<sup>94</sup> Wyo. Const. Art. 10, § 4 (2007)

four states where the state constitution explicitly prohibits the legislature from enacting limits on damages.<sup>95</sup>

Both amendments were passed by the legislature during a special session in July 2004. For a constitutional amendment to pass in Wyoming, it requires a simple majority of votes cast in the general election. But voters who do not cast a vote either way for an amendment are counted as “no” votes. This means an amendment sometimes will fail even if it receives over half the votes cast on that ballot question.

#### D. Judicial activity

1. The courts in the following states upheld legislation for caps on non-economic damages: Alaska, California, Colorado, Idaho, Kansas, Maryland, Michigan, Minnesota, Missouri, Nebraska, Utah, Virginia, West Virginia and Wisconsin.<sup>96</sup> Courts in Indiana, Louisiana and New Mexico upheld caps that encompass both economic and non-economic damages.<sup>97</sup> Louisiana's cap, akin to New Mexico's, does not include medical expenses, which are paid as incurred.<sup>98</sup>

Courts in the following states struck down caps on non-economic damages: Alabama, Illinois, Kansas, New Hampshire, North Dakota, Ohio, Oregon, South Dakota, Washington and Wisconsin.<sup>99</sup> In Florida and Texas, caps were upheld, but with some restrictions.<sup>100</sup> More details on recent cases follow.

a. Wisconsin. In a 4-3 opinion issued July 14, 2005, the Wisconsin Supreme Court struck down Wisconsin's cap on non-economic damages, which had been in place since 1995. Specifically, the court held that Wisconsin's \$350,000 cap (adjusted for inflation) on non-economic medical malpractice damages set forth in Wis. Stat. §§ 655.017 and 893.55 (4)(d) violated the Equal Protection Clause

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<sup>95</sup> *Id.*

<sup>96</sup> See *Smith v. Botsford*, 419 F. 3d 513 (6<sup>th</sup> Cir. 2005); *Evans v. State*, 56 P.3d 1046 (Alaska 2002); *Hoffman v. U.S.*, 767 F.2d 1431 (9<sup>th</sup> Cir. 1985); *Fein v. Permanente*, 695 P.2d 665 (Ca. 1985); *Scholz v. Metro. Pathologists P.C.*, 851 P.2d 901 (Colo. 1993); *Kirkland v. Blaine County Med. Ctr.*, 4 P.3d 1115 (Idaho 2002); *LeBron v. Gottlieb Memorial Hospital, et. al.* (Cook County 06 L 12109); *Samsel v. Wheeler Transp. Serv., Inc.* 246 Kan. 336 (Kan. 1990); *Murphy v. Edmunds*, 601 A.2d 102 (Md. 1992); *Zdrojewski v. Murphy*, 657 N.W.2d 721 (Mich. Ct. App. 2002); *Adams v. Children's Mercy Hosp.*, 848 S.W.2d 535 (Mo. Ct. App. 1993); *Linder v. Smith*, 629 P.2d 1187 (Mont. 1981); *Prendergast v. Nelson*, 256 N.W.2d 657 (Neb. 1977); *Gourley ex. rel. Gourley v. Neb. Methodist Health Sys.*, 633 N.W.2d 43 (Neb. 2003); *Judd v. Drezga*, 103 P.3d 135 (Ut. 2004); *Etheridge, et. al. v. Med. Ctr. Hosp.*, 367 S.E.2d 525 (Va. 1989); *Robinson v. Charleston Area Med. Ctr.*, 186 W.Va. 720 (W. Va. 1991); *Verba v. Ghaphery*, 552 S.E.2d (W. Va. 2001); *Guzman v. St. Francis Hosp.*, 623 N.W.2d 776 (Wis. Ct. App. 2000), *Maurin v. Hall*, 682 NW2d 866 (Wis. 2004), *but see Ferdon v. Wis. Patients Comp. Fund*, 2005 WI 125 (Wis. 2005).

<sup>97</sup> *Johnson v. St. Vincent Hosp.*, 404 N.E.2d 585 (Ind. 1980); *Butler v. Flint Goodrich Hosp.*, 607 So.2d 517 (La. 1992), *Fed. Express Corp. v. U.S.*, 228 F. Supp. 2d 1267 (N.M. 2002).

<sup>98</sup> LA. REV. STAT. § 40:1299.42(B)(1) (2003).

<sup>99</sup> See *Moore v. Mobile Infirmary Ass'n*, 592 So.2d 156 (Ala. 1991); *Best v. Taylor Mach. Works*, 689 N.E.2d 1057 (Ill. 1997); *Kan. Malpractice Victims Coalition v. Bell*, 757 P.2d 251 (Kan. 1988) (new law enacted in 1988); *Carson v. Mauer*, 424 A.2d 825 (N.H. 1980); *Arneson v. Olson*, 270 N.W.2d (N.D. 1978); *State ex rel. Ohio Academy of Trial Lawyers v. Sheward*, 715 N.E. 2d 1062 (Oh. 1999); *Lakin v. Senco Products, Inc.*, 987 P.2d 463 (Or. 1999); *Sofie v. Fibreboard Corp.*, 771 P.2d 711 (Wash. 1989); *Ferdon v. Wis. Patients Comp. Fund*, 2005 WI 125 (Wis. 2005).

<sup>100</sup> See *Univ. of Miami v. Echarte*, 618 So.2d 189 (Fla. 1993); *Lucas v. U.S.*, 757 S.W.2d 687 (Tex. 1988); *Rose v. Doctors Hosp.*, 801 S.W.2d 841 (Tex. 1990).

of Wisconsin's Constitution. In numerous prior cases, the Wisconsin Supreme Court had addressed the constitutionality of various provisions in Wis. Stat. § 655, including the cap on non-economic damages, upholding the provision as constitutional each time.<sup>101</sup>

b. Illinois. On Nov. 13, 2007, Cook County Circuit Court Judge Diane Larsen ruled that the cap on non-economic damages for medical liability claims violated the Illinois Constitution on separation of powers grounds.<sup>102</sup> Judge Larson found that the 2005 cap on non-economic damages (\$500,000 per physician and \$1,000,000 per hospital<sup>103</sup>) was an unconstitutional legislative remittitur. This means that the courts alone have the authority to determine if a damage award is excessive—not the legislature. Based on a procedural issue, the ruling on the cap negates the rest of the law as well.

c. Louisiana. The Louisiana Supreme Court recently reinstated the state's cap on total damages in medical liability cases.<sup>104</sup> The \$500,000 cap<sup>105</sup> (excluding future medical care) was struck down by the 3<sup>rd</sup> Circuit Court of Appeals in 2006.<sup>106</sup> The court of appeals determined that the current cap did not provide an adequate remedy and was unconstitutional because of this finding. The Louisiana Supreme Court set aside and vacated the judgment based on pleading and appellate errors. The court then sent the *Arrington* case back to the appellate level for consideration of the remaining issues in those cases. This is a very positive development in Louisiana, but the fight will continue as the two cases continue in the lower courts.

d. Michigan. On Aug. 18, 2005, the U.S. Court of Appeals for the 6<sup>th</sup> Circuit upheld Michigan's cap on non-economic damages.<sup>107</sup> Specifically the court held the cap does not violate the Seventh Amendment or Equal Protection Clause of the U.S. Constitution.<sup>108</sup>

e. Utah. In an opinion issued Nov. 5, 2004, the Utah Supreme Court upheld Utah's cap on non-economic damages<sup>109</sup> as constitutional. Specifically the court held that the cap does not violate the open courts, uniform operation of laws or due process provisions of the Utah Constitution. The court also held the cap does not violate the separation of powers or right to a jury trial as protected by the Utah Constitution.<sup>110</sup>

## 2. Favorable state case law establishes rationale for supporting legislative reforms - failed legal challenges brought against caps on non-economic damages<sup>111</sup>

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<sup>101</sup> *Ferdon v. Wis. Patients Comp. Fund*, 2005 WI 125 (Wis. 2005).

<sup>102</sup> *LeBron v. Gottlieb Memorial Hospital, et. al.* (Cook County 06 L 12109).

<sup>103</sup> 735 ILCS 5/2-1706.5 (2008)

<sup>104</sup> *Arrington v. Galen-Med*, 947 So. 2d 724 (La. 2007).

<sup>105</sup> La. R.S. 40:1299.42 (2007)

<sup>106</sup> *Arrington v. ER Physicians Group*, 940 So. 2d 777 (La. Ct App. 2006).

<sup>107</sup> MCLS § 600.1483 (2008)

<sup>108</sup> *Smith v. Botsford General Hosp.* 419 F.3d 513 (6<sup>th</sup> Cir. 2005).

<sup>109</sup> Utah Code Ann. § 78-14-7.1

<sup>110</sup> *Judd v. Drezga*, 103 P.3d 135 (Utah 2004).

<sup>111</sup> See cases cited *supra*, note 90.

a. Equal protection clause

i. Under the “deferential rational relationship” test, a number of courts have upheld damages caps as a permissive and rational means of achieving the legitimate state goal of reducing insurance premiums paid by physicians.

ii. Other societal goals supporting the implementation of caps that have been upheld by the court include; (i) ensuring the availability of physicians in the state, (ii) continuing the existence of state compensation funds, (iii) continuing the existence of insurance for physicians in the state, and (iv) assuring medical related payments to all claimants.

iii. Courts have held it constitutional for damage caps to differentiate between medical liability tort claimants who have suffered injuries valued at a level below the damages cap, and those who have suffered damages valued above the damages cap amount based upon the legitimate purpose of the legislature.

b. Due process clause

Court analysis of due process challenges also has proceeded under the rational relationship test, where damages caps have been found to be neither arbitrary nor irrational legislative goals.

c. Right to trial by jury

i. After a plaintiff is awarded damages up to the amount of the statutory cap, the determination of damages is removed from consideration by the jury and given to the court. This is not a denial of the right to trial by jury, since the jury already has completed its fact-finding mission, determining that the plaintiff is owed compensation. Deciding how much a patient will recover is a question of law for the court. The court implements the policy decision of the legislature.

ii. Reviewing courts also have held that it is within the legislature’s power to modify common law and statutory rights and remedies, as was done with the caps.

d. Open court challenge

The courts have struck down the argument that a damage cap impermissibly allows the legislature to intrude on the judicial process. Instead of being an impermissible barrier to the courts, the cap is merely a limitation on recoveries.

e. Intrusion on the rulemaking power of the judicial branch

The courts did not find that caps allow the legislature to overstep its constitutional powers. Instead, the courts found that the legislature has full purview over questions of policy, as opposed to procedural questions. Damage

caps are questions of policy, properly within the legislature's scope of power.

#### E. California's solution: MICRA

1. California enacted the Medical Injury Compensation Reform Act of 1975 (MICRA) which largely eliminates the lottery aspect of medical liability litigation in that state.<sup>112</sup>
2. Now, in California, claims are settled in one-third less time than in states without caps on non-economic damages.<sup>113</sup> This not only decreases the cost of litigation, it also means injured patients receive payment much faster in California.
3. California's experience with MICRA shows that tort reform works. MICRA has been held up as "the gold standard" of tort reform, and a model for repeated attempts at Federal reform legislation.
4. A study by the RAND Corporation showed that MICRA was successful at decreasing insurer payouts and redistributing money from trial lawyers to injured patients. MICRA's contingency fee reform and limit on non-economic damages caused plaintiff attorney fees to be reduced 60 percent, while net recoveries to patients and their families were only reduced 15 percent.<sup>114</sup>
5. According to Phil Hinderberger of Norcal Mutual, before MICRA was passed, "California physicians paid almost 25 percent of all medical liability premiums paid in the [U.S.] at a time when they represented only about 10 percent of all practicing physicians in the [U.S.]. Today, California physicians pay about [10] percent of all medical liability premiums paid in the [U.S.] which represents a fair share."<sup>115</sup>
6. According to the National Association of Insurance Commissioners, while total premiums in the rest of the U.S. rose 1,045 percent between 1976 and 2005, the increase in California premiums was less than one third of that amount (322 percent).<sup>116</sup>
7. According to HHS, "the percentage of claims resolved through settlement and arbitration has increased in California, saving money for injured patients."<sup>117</sup> "Premiums for specialists in Los Angeles are substantially less than for specialists in metropolitan areas in states without reforms such as Florida, Illinois and Nevada."<sup>118</sup> For example, an obstetrician-gynecologist in Los Angeles can expect to pay \$63,272 per year for liability

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<sup>112</sup> CAL. CIV. CODE § 3333.2 (2004).

<sup>113</sup> *Harming Patient Access to Care: The Impact of Excessive Litigation: Hearing Before the Subcomm. on Health of the Comm. on Energy and Commerce*, 107<sup>th</sup> Cong. 88 (2002) [hereinafter Anderson statement] (statement of Richard E. Anderson, Chairman of the Doctors' Co. for the Physician Ins. Ass'n of Am.).

<sup>114</sup> NICHOLAS M. PACE, ET AL., RAND CORP., CAPPING NON-ECONOMIC AWARDS IN MEDICAL MALPRACTICE TRIALS xxiv (2004).

<sup>115</sup> Posting of Phil Hinderberger, [phil-hinderberger@norcalmutual.org](mailto:phil-hinderberger@norcalmutual.org), to [asmac-1@unity.ama-assn.org](mailto:asmac-1@unity.ama-assn.org) (Jan. 20, 2003) (copy on file with author).

<sup>116</sup> NAT'L ASS'N OF INS. COMM'RS, PROFITABILITY BY LINE BY STATE IN 2005 (National Association of Insurance Commissioners Insurance Products & Services Division), at 123-24 (2007). Statistics presented in *MLR – Now!* have been derived from this and previous versions of the report dating back to 1975.

<sup>117</sup> INSURANCE CYCLE, *supra* note 24, at 4.

<sup>118</sup> *Id.*

insurance, whereas the same obstetrician-gynecologist would pay nearly \$275,466 in South Florida.<sup>119</sup>

## F. Federal legislation

1. Although some states are attempting to address the medical liability crisis at the state level, a federal solution is also needed. Many state liability reform laws have been nullified by activist state courts or stripped of their most effective provisions under state constitutions that limit reform.

2. The existing crisis is not confined within state lines. Many patients are losing access to their physicians, forcing them to travel to neighboring states for their critical health care services.

3. All patients pay the escalating costs generated by our nation's dysfunctional medical liability system. These costs are especially high for the federal government, since one-third of the total health care spending in our country is paid by the Medicare and Medicaid Programs.

### 4. Activities in the U.S. House of Representatives

#### a. 110<sup>th</sup> Congress

i. On May 24, 2007, H.R. 2497, the “Fair and Reliable Medical Justice Act of 2007,” was introduced. The AMA supported the intent of H.R. 2497, which would encourage state-based alternatives to the medical litigation system. H.R. 2497 includes provisions that would:

- (a). Restore fairness and reliability to the medical justice system and promote patient safety by fostering alternatives to current medical tort litigation;
- (b). Promote patient safety through early disclosure of health care errors;
- (c). Support states in developing alternatives; and
- (d). Amend the Public Health Service Act and authorize the Secretary of Health and Human Services to award 10 five-year grants to states to create demonstration projects to evaluate alternatives to the current medical liability system.

ii. On June 6, 2007, H.R. 2580, the “Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2007,” was introduced. The AMA supported H.R. 2580, which is modeled after the successful MICRA statute. H.R. 2580 includes provisions that would:

- (a). Set a statute of limitations of three years after the date of manifestation of injury or one year after the claimant discovers the injury, with certain exceptions;

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<sup>119</sup> Med. Liability Monitor, 30 (2005).

- (b). Limit non-economic damages to \$250,000. Make each party liable only for the amount of damages directly proportional to such party's percentage of responsibility;
- (c). Allow the court to restrict the payment of attorney contingency fees. Limit the fees to a decreasing percentage based on the increasing value of the amount awarded;
- (d). Prescribe qualifications for expert witnesses;
- (e). Allow the introduction of collateral source benefits and the amount paid to secure such benefits as evidence. Prohibit a provider of such benefits from recovering any amount from an award in a health care lawsuit involving injury or wrongful death;
- (f). Authorize the award of punitive damages only where: (1) it is proven by clear and convincing evidence that a person acted with malicious intent to injure the claimant or deliberately failed to avoid unnecessary injury the claimant was substantially certain to suffer; and (2) compensatory damages are awarded. Limit punitive damages to the greater of two times the amount of economic damages or \$250,000;
- (g). Limit the liability of manufacturers, distributors, suppliers, and providers of medical products that comply with Food and Drug Administration (FDA) standards; and
- (h). Provide for periodic payments of future damage awards.

iii. On Sept. 10, 2007, H.R. 3509, the "Medical Justice Act of 2007," was introduced. H.R. 3509 is almost identical to the Texas tort reform bill (H.B. 4), which passed in 2003. H.R. 3509 encompasses a broad legislative medical liability reform initiative that would impose the following:

- (a). Cap on non-economic damages against health care practitioners and health care institutions;
- (b). Cap, in wrongful death cases, on total damages against any single health care practitioner;
- (c). Limitation on insurer liability when an insurer rejects certain settlement offers;
- (d). Mandatory jury instructions on cap on damages and determination of negligence;
- (e). Production of expert reports;
- (f). Production of expert opinions by actively practicing physicians;
- (g). Payment of future damages on periodic or accrual basis;
- (h). Unanimous jury verdicts for punitive or exemplary damages;
- (i). Proportionate liability;
- (j). Award litigation costs resulting from a defense-initiated settlement process;
- (k). Statute of limitations; and
- (l). Limitation on liability for good samaritans providing emergency health care.

## 5. Activities in the U.S. Senate

### a. 110<sup>th</sup> Congress

i. On Jan. 10, 2007, S. 243, the “Medical Care Access Protection Act of 2007,” was introduced. The AMA supported the bill’s proven reform provisions. S. 243 includes proven reform provisions that would:

- (a). Set a statute of limitations of three years after the date of manifestation of injury or one year after the claimant discovers the injury, with certain exceptions;
- (b). Require sanctions for the filing of frivolous lawsuits;
- (c). Limit non-economic damages to \$250,000 from the provider or health care institution, but no more than \$500,000 from multiple health care institutions. Make each party liable only for the amount of damages directly proportional to such party's percentage of responsibility;
- (d). Allow restriction of the payment of attorney contingency fees. Limit the fees to a decreasing percentage based on the increasing value of the amount awarded;
- (e). Prescribe qualifications for expert witnesses;
- (f). Allow awards of punitive damages only where: (1) it is proven by clear and convincing evidence that a person acted with malicious intent to injure the claimant or deliberately failed to avoid unnecessary injury the claimant was substantially certain to suffer; and (2) compensatory damages are awarded. Limit punitive damages to the greater of two times the amount of economic damages or \$250,000;
- (g). Prohibit a health care provider from being named as a party in a product liability or class action lawsuit for prescribing or dispensing a Food and Drug Administration (FDA)-approved prescription drug, biological product, or medical device for an approved indication; and
- (h). Provide for periodic payments of future damage awards.

ii. On Jan. 10, 2007, S. 244, the “Healthy Mothers and Healthy Babies Access to Care Act of 2007,” was introduced. This legislation included liability reform provisions identical to S. 243. These provisions specifically apply to liability claims related to obstetrical or gynecological services. The AMA supported the bill’s proven reform provisions.

iii. On May 24, 2007, S. 1481, “Fair and Reliable Medical Justice Act of 2007,” was introduced in the Senate. S. 1481 is the companion bill to H.R. 2497. S. 1481 proposed to do the following:

- (a). Restore fairness and reliability to the medical justice system and promote patient safety by fostering alternatives to current medical tort litigation;
- (b). Promote patient safety through early disclosure of health care errors;
- (c). Support states in developing alternatives; and
- (d). Amend the Public Health Service Act and authorize the Secretary of Health and Human Services to award 10 five-year grants to states to create demonstration projects to evaluate alternatives to the current medical liability system.

iv. On Dec. 12, 2007, the Senate considered the “Healthy Mothers and Healthy Babies Rural Access to Care” amendment to H.R. 2419, the “Farm, Nutrition, and Bioenergy Act of 2007.” The amendment included a \$250,000 cap on non-economic damages targeted exclusively to health care providers and institutions that offer obstetrical and gynecological care in rural areas. The amendment failed by a vote of 41 to 53.

#### 6. Public support for federal legislation

- a. The American public continues to support medical liability reform.
- b. Seventy-six percent of those surveyed in a 2006 Harris Interactive poll favor a law that would guarantee an injured patient full payment for lost wages and medical expenses and place reasonable limits on awards for “pain and suffering” in medical liability cases. Three-quarters of the Americans surveyed said they wanted their elected representatives in Washington to support comprehensive medical liability reform.<sup>120</sup>
- c. A Gallup poll confirms this public opinion. The poll results, released February 4, 2003, show that 72 percent of Americans support limiting the amount patients can be awarded for “pain and suffering.”

### III. Patient safety efforts

- A. Quality of care declines when patients are denied access to physicians.
- B. A culture of safety requires a legal environment that encourages professionals and organizations to work together to identify problems in providing care, evaluate the causes, and use that information to improve care for all patients.
- C. A recent *New England Journal of Medicine* report declares that, “... in spite of the mission of malpractice law to improve the quality of care through deterrence—indeed, perhaps because of it—the fear of litigation obstructs progress in ensuring patient safety.”<sup>121</sup>
- D. The current litigation system does **not** encourage a culture of safety because it:

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<sup>121</sup> David Studdert, Michelle Mello & Troyen Brennan, *Medical Malpractice*, 350 NEW ENG. J. MED., 283, 287 (2004).

1. Encourages defensive medicine.
2. Creates a lottery mentality throughout the nation's court system.
3. Enriches certain trial lawyers at the expense of patients and physicians.

E. The Harvard Medical Practice Study used New York State hospital and medical professional liability claims data to estimate the incidence of adverse events among hospitalized patients and to characterize the relationship between adverse events and medical liability claims. The study found that, "... a substantial majority of malpractice claims filed are not based on actual provider carelessness."<sup>122</sup> In fact, the authors found that negligence had occurred in only one-sixth of the filed claims.<sup>123</sup> Finally, they concluded that "in its initial filing stage the tort system is even more error-prone than the medical care system."<sup>124</sup>

One of the authors of the Harvard study, Troyen A. Brennan and two colleagues, conducted a follow-up in 1996.<sup>125</sup> They found that the only significant predictor of payment to medical liability plaintiffs in the form of a jury verdict or a settlement was the severity of a patient's disability, and *not* the presence of an adverse event due to negligence.<sup>126</sup>

The Institute of Medicine report "To Err is Human" (the "IOM Report") used information from the Harvard study to speculate that up to 98,000 deaths per year are due to preventable medical errors. While there are many reasons to take issue with the way that particular estimate was derived,<sup>127</sup> the principal finding of the report was that the vast majority of patient injuries are due to defects in the systems of medical care delivery, and not due to negligence on the part of providers. True advocates of patient safety—such as the AMA and the IOM Report—are fighting to replace the fault-based, adversarial medical liability system (which gives all parties strong incentives to conceal errors and system defects) with a system that encourages all parties to promote patient safety by reporting errors and system defects. However, trial lawyers stand in firm opposition to changing our broken liability system, because today's injured patients are tomorrow's multimillion dollar clients.

F. AMA policy is to be part of the solution, not the problem. The AMA believes that one preventable error is one error too many. In fact, the AMA helped launch the National Patient Safety Foundation in 1996, well before publication of the IOM report, and has contributed \$7.3 million to the foundation's efforts. The foundation's approach is to create a culture of cooperative learning and mutual improvement, as opposed to a culture of shame and blame.

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<sup>122</sup> PAUL C. WIELER ET AL., *A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION & PATIENT COMPENSATION* 140 (Harvard University Press 1993).

<sup>123</sup> *Id.* at 139.

<sup>124</sup> *Id.* at 140.

<sup>125</sup> Troyen A. Brennan, Colin M. Sox & Helen R. Burstin, *supra* note 140.

<sup>126</sup> *Id.* at 1965.

<sup>127</sup> For example, McDonald et al. find that the underlying studies of the IOM report were "observational," not intended "to describe causal relationships." The authors state "The Harvard study includes no information about the baseline risk of death in these patients or information about deaths in any comparison group. Therefore, it cannot be determined whether adverse events are correlated with, let alone whether they cause, death." The authors comment that "reliance on studies without controls to make headline claims about huge numbers of preventable deaths was one error it did not catch." See Clement J. McDonald et al., *Deaths Due to Medical Errors Are Exaggerated in Institute of Medicine Report*, 284 JAMA 93, 93 (2000).

G. On July 29, 2005, President Bush signed the “Patient Safety and Quality Improvement Act” (P.L. 109-41). The AMA was instrumental in the bill’s passage and enactment into law. It creates a confidential, voluntary reporting system in which physicians and other health care providers can report information on errors to entities known as Patient Safety Organizations (PSOs). The PSOs collect and analyze unique “patient safety data” that is confidential and legally protected.

**Note: The most current version of this document can be accessed electronically by visiting the AMA Web site: <http://www.ama-assn.org/go/mlrnow> Additional background and data can be found on the AMA Web site at <http://www.ama-assn.org/go/liabilityreform>**