AMA
AMERICAN MEDICAL ASSOCIATION

MEDICAL LIABILITY REFORM NOW! 2025

The facts you need to know to address the broken medical liability system

TABLE OF CONTENTS

The system is broken 1

Research on caps 10

State efforts to enact caps on noneconomic damages 12

Ballot initiatives 19

Federal efforts on liability reform 19

Judicial activity on caps 21

Innovative reforms 24

Conclusion 26

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The broken medical liability system remains one of the most vexing issues for physicians today. It places a wedge between physicians and their patients. It forces physicians to practice defensive medicine. It puts physicians at emotional, reputational and financial risk, and it drains resources out of an already financially strapped national health care system—resources that could be used for medical research or expanded access to care for patients. Now more than ever, the American Medical Association is committed to improving the medical liability system for both patients and physicians.

The AMA is pursuing legislative solutions at both the federal and state levels to address the problems with the current medical liability system and is actively collaborating with state medical associations and national medical specialty societies to advance these goals as well. "Medical Liability Reform – Now!" provides medical liability reform (MLR) advocates with the information they need to advocate for and defend MLR legislation. It includes background on the problems with the current system, proven solutions to improve the liability climate and a discussion of innovative reforms that could complement traditional MLR provisions. We hope this document sheds light on this particularly complicated issue and provides direction for those looking to fix it. This is a crucial period for MLR as federal policymakers and their state colleagues contemplate health system reform.

The system is broken

The physician perspective is personal

The medical liability issue is a very personal matter for physicians. A 2023 AMA research paper found that 31% of all physicians had been sued at some point in their careers. Given the longer exposure to liability risk, this percentage increases with age. Almost half of physicians age 55 and older had been sued. Physicians in some specialties are particularly at high risk. According to the AMA paper, over 75% of general surgeons and obstetricians/gynecologists (ob-gyns) age 55 and older faced a claim at some point in their careers, and almost half had been sued even before they turned 55.[1] Does this suggest that all those physicians are practicing bad medicine?

To the contrary, 2019 data from the Medical Professional Liability Association (MPL, formerly PIAA), a trade association of medical liability insurers, has shown that most liability claims are without merit. Sixty-five percent of claims that closed between 2016 and 2018 had been dropped, dismissed or withdrawn, and out of six percent of claims that were decided by a trial verdict, the vast majority of them (89%) had been won by the defendant in the case.[2]

A series of journal articles, which were based on analysis of closed claims from a national professional liability insurer, supported the conclusions drawn from the AMA and MPL data reported above. The first shows high rates of claim frequency, particularly among certain specialties.[3] For example, the authors projected that by age 65, 99% of physicians

1. Guardado J. Medical Liability Claim Frequency Among U.S. Physicians. Chicago, IL: American Medical Association; 2023. Policy Research Perspectives No. 2023-3. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/government/advocacy/policy-research-perspective-medical-liability-claim-frequency.pdf. Accessed April 15, 2023.
2. Medical Professional Liability Association. 2019. Data Sharing Project MPL Closed Claims 2016-2018 Snapshot.
3. Anupam BJ, Seabury S, Lakdawalla D, et al. Malpractice risk according to physician specialty. *N Engl J Med*. 2011;365:629-636.

in high-risk specialties would have already been subject to a claim. The analysis also showed that the large majority of claims (78%) did not result in an indemnity payment.

A second article offered further insight into how claims are resolved and also suggests that most liability claims are without merit.[4] Looking only at claims with a positive defense cost, it found that 55% resulted in litigation (the filing and conduct of a lawsuit). However, 54% of the litigated claims were dismissed by the court.

The third article provided a rare look at the time required to close a malpractice claim and how this varies across a number of claim characteristics.[5] The article focused only on claims with an indemnity payment or at least some defense costs. Claims without either tended to indicate a preemptive report, perhaps by the physician, and one where no allegation of malpractice was ever made. The authors found that the average time from claim filing to close was 20 months. Among claims with an indemnity payment, 27% took three or more years to close, and among claims without an indemnity payment, 12% took that long to close. Time to closure also varied across severity and physician specialty. Assuming a career length of 40 years, the authors estimated that an average physician spends nearly 11% of his or her career with an open, unresolved claim.

The high price of medical liability insurance is another reason that physicians are so sensitive to this issue. Physicians in certain states and specialties can face liability premiums of over $100,000, and even more than $200,000 per year as is the case for some obstetrician/gynecologists in Florida and Illinois.[6]

Access to care for patients is adversely affected

Because of the risk of being sued over the course of a physician's career, and because medical liability insurance is so costly, the fear of liability hangs like a cloud over physicians—and it never goes away. The liability environment influences how physicians practice and affects patients' access to care and treatment

A number of papers have clearly shown that the liability system affects not only how physicians practice, but where they practice as well. The research provides a convincing argument that physician supply is higher and patients' access to care is enhanced in areas where physicians are under less pressure from the liability system due to the enactment of traditional MLR provisions, such as caps on noneconomic damages. Summaries of several of these papers follow.[7]

Perry (2012) examined whether noneconomic damage caps are associated with physician supply.[8] He compared physician migration in states that had passed noneconomic damage caps to states that had not passed such reforms. He finds that those states that passed damage caps experience less out-migration of physicians than states that did not, which indicates they increase physician supply.

Matsa (2007) examined how physician supply responded to caps on noneconomic or total damages over the period from 1970 to 2000.[9] He found that the positive impact of caps was concentrated in rural counties, and among surgical and support specialists within those counties. Overall, he found that the number of physicians per capita in the most rural counties was about 4% larger in states with caps than in similar counties in states without caps. For surgical and support specialties in rural counties, states with caps had about 10% more physicians per capita than rural counties in states without caps. His work also suggested 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.

4. Anupam BJ, Chandra A, Lakdawalla D, et al. Outcomes of medical malpractice litigation against US physicians. *Arch Intern Med*. 2012;172(11):892-894.
5. Seabury SA, Chandra A, Lakdawalla D, et al. On average, physicians spend nearly 11% of their 40-year careers with an open, unresolved malpractice claim. *Health Aff*. 2013;32(1):111-119.
6. Guardado J. Prevalence of Medical Liability Premium Increases Unseen Since 2000s Continues for Fourth Year in a Row. Chicago, IL: American Medical Association; 2023. Policy Research Perspectives No. 2023-2. https://www.ama-assn.org/system/files/prp-mlm-premiums-2022.pdf. Accessed April 15, 2023.
7. Two AMA reports provide more extensive summaries of this research: (1) Kane CK, Emmons DW. The Impact of Liability Pressure and Caps on Damages on the Healthcare Market: An Update of Recent Literature. Chicago, IL: American Medical Association; 2007. Policy Research Perspectives No. 2007-1. (2) Kane CK, Emmons DW. The Impact of Caps on Damages. How are Markets for Medical Liability and Medical Services Affected? Chicago, IL: American Medical Association; 2005. Policy Research Perspectives No. 2005-2.
8. Perry, J.J, Clark, C. Medical Malpractice Liability and Physician Migration. *Bus Econ. 2012;47(3):202-213.*
9. Matsa, DA. Does Malpractice Liability Keep the Doctor Away? Evidence from Tort Reform Damage Caps. *J Legal Stud.* 2007;36(2):143–182.

Klick and Stratmann (2007) used a somewhat different approach than Matsa (2007) to examine the impact of caps on physician supply between 1980 and 2001.[10] Using physicians in low-risk specialties as a control group for physicians in high-risk specialties, Klick and Stratmann found that depending upon which specialties are defined as low- or high-risk, the number of physicians per capita in high-risk specialties was between 4% and 7% higher in states with caps on noneconomic damages than in states without caps.

Helland and Showalter (2006) examined the effect of caps on a different measure of physician supply, weekly hours of work, in 1983 and 1988.[11] They found that a 10% increase in expected liability costs was associated with a 2.9% decrease in weekly hours worked. The effects for physicians in solo practice and for physicians age 55 or older were even larger, with decreases of 6.6% and 12.2% respectively, for those two groups.

Kessler, Sage and Becker (2005) examined the effect of liability reforms on physician supply using annual data from 1985 through 2001.[12] They found that direct tort reforms increased physician supply by 2.4% relative to non-reform states.[13] They also looked at the impact on a number of high-risk specialties and found that the effect on emergency physicians was particularly large at 11.5%.

Encinosa and Hellinger (2005) looked specifically at the impact of noneconomic damage caps on physician supply using eight years of data from 1985 through 2000.[14] Their results suggested that caps increased the number of physicians per capita by 2.2% relative to counties in states without caps.

Helland and Seabury (2015) examined how physician supply responded to caps on noneconomic damages using state level estimates of the number of physicians per capita over the period from 1995 to 2010.[15] They found that noneconomic damage caps were associated with increases in supply of between 2% and 7% for physicians in high-risk specialties, depending on whether their classification of high-risk specialties was broad or narrow. Measuring risk directly by specialty-level estimates of claim frequency, they found that caps had a larger impact on specialties with higher frequency. The authors noted that caps were more likely to be adopted in states experiencing slower than average growth in physician supply. Thus, they used a strategy that accounted for that phenomenon in their estimation of the impact of caps.

Pesko et al., (2017) examined the impact of noneconomic damage caps that were enacted between 2003 and 2006 on the physician labor supply both for high-risk and low-risk specialties.[16] They found that noneconomic damage caps increased the supply of high-risk physicians <35 years of age by 0.93 physicians per 100,000 people in the year after the caps were enacted. Cumulatively, these caps were associated with an increase of 2.1 high-risk physicians <35 years of age per 100,000 people.

A 2016 report to the Medicare Payment Advisory Commission found a substantial body of evidence indicating that caps on noneconomic damages have a positive effect on physician supply. Another systematic review of 37 studies by Agarwal et al., (2019) found that caps on noneconomic damages were associated with an increase in physician supply.[17]

Accuracy and fairness

Research shows that the current system treats physicians and patients unfairly and that its outcomes are inaccurate. A 2006 review of closed claims showed that no injury had occurred in 3% of claims, and that in 37% of those that involved an injury there had been no error.[18] The same research showed that in terms of compensation for medical errors, the system "gets it wrong" about equally on

10. Klick, J, Stratmann T. Medical Malpractice Reform and Physicians in High Risk Specialties. *J Legal Stud*. 2007;36(2):121–139.
11. Helland E, Showalter MH. The Impact of Liability on the Physician Labor Market. *Journal of Law and Economics*. 2009; 52(4):635-663.
12. Kessler DP, Sage WM, Becker DJ. Impact of Malpractice Reforms on the Supply of Physician Services. *JAMA*. 2005;293(21):2618–2625.
13. Direct reforms include caps on economic, noneconomic, or total damages, abolition of punitive damages, no mandatory prejudgment interest, and collateral source rule reform.
14. Encinosa WE, Hellinger FJ. Have State Caps On Malpractice Awards Increased The Supply Of Physicians? *Health Aff*. 2005; W5-250-W5-258.
15. Helland E, Seabury SA. Tort Reform and Physician Labor Supply: A Review of the Evidence. *Int'l Rev. L. & Econ*. 2015;42(June):192–202.
16. Pesko MF, Cea M, Mendelsohn J, Bishop TF. *International Review of Law and Economics*. 2017;50:7-14. doi:10.1016/j.irle.2017.03.002
17. Agarwal R, Gupta A, Gupta S. The impact of tort reform on defensive medicine, quality of care, and physician supply: A systematic review. *Health Services Research*. 2019;54(4):851-859. doi:10.1111/1475-6773.13157
18. Studdert DM. Mello MM, Gawande AA. Claims, Errors, and Compensation Payments in Medical Malpractice Litigation. *N Engl J Med* 2006;354(19):2024–2033.

both sides. Twenty-seven percent of claims involving errors were uncompensated, while 28% of claims that did not involve an error were compensated. Earlier research that matched claim-level data with hospital records also suggested similar inaccuracies. It found that less than 15% of patients who suffered a negligent injury filed a claim and that negligence had occurred in only slightly more than 15% of filed claims.[19]

Claim costs

From a number of perspectives, the current liability system is extremely costly. MPL data show that the average indemnity payment on settled claims that closed between 2016 and 2018 was $372,309, and for tried claims decided in the plaintiff's favor, it was $635,829.[20] In addition to the costs generated by the amounts paid out to plaintiffs, claims are also costly to defend. The average defense cost for settled claims that closed between 2016 and 2018 was $77,117. For tried claims, it was $158,843 when there was a defendant victory and $236,519 for a plaintiff victory. For claims that were dropped, dismissed or withdrawn, the average defense cost was $30,439.[21] Although this is lower than for claims that are settled or tried, dropped claims accounted for a significant share (37.6%) of total defense costs in 2016–2018 given their prevalence—i.e., 65% of all closed claims.[22]

Those per-claim costs add up to very large amounts. According to data from the National Association of Insurance Commissioners, total (incurred) indemnity losses in 2022 were $6.3 billion—an increase of over $600 million from 2020, and defense costs were an additional $2.9 billion.[23] These claim costs have a direct effect on the cost of medical care.

Earlier we referenced a body of research based on analyses of closed claims from a national professional liability insurer.[24] Based also on these data, the same authors found that defense costs were more than twice as high for claims that resulted in indemnity payments than for claims where no indemnity payments were made. However, the authors concluded that there was still a meaningful cost tied to defending that latter group of claims, and considerable savings could be had if the costs of dispute resolution were lowered.[25]

The fear of liability affects health care spending

In addition to the direct effect that indemnity and defense costs have on medical spending, there is also a considerable indirect effect. Since the fear of lawsuits affects the way in which physicians practice, our medical liability system causes health care expenditures to be different than they otherwise would be. This is called "defensive medicine." However, it is very difficult to measure the extent and cost of defensive medicine, and more recent research shows that it is even more difficult than was previously thought.[26] This is because there are two types of defensive medicine—*positive* and *negative*. Positive defensive medicine is the tendency to provide more care to reduce liability risk. This is also known as assurance behavior and is what was conventionally thought of in previous studies. In contrast, negative defensive medicine, or avoidance behavior, refers to the tendency to avoid high-risk procedures for a given patient or avoid risky patients altogether to reduce risk.

19. Weiler PC. *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient* Compensation. Cambridge, MA: Harvard University Press; 1993.
20. Medical Professional Liability Association. 2019. Data Sharing Project MPL Closed Claims 2016-2018 Snapshot.
21. Medical Professional Liability Association. 2019. Data Sharing Project MPL Closed Claims 2016-2018 Snapshot.
22. Medical Professional Liability Association. 2019. Data Sharing Project MPL Closed Claims 2016-2018 Snapshot and AMA's calculations from data in that report.
23. National Association of Insurance Commissioners (NAIC). Report on Profitability by Line by State in 2022. 2024. https://content.naic.org/sites/default/files/publication-pbl-pb-profitability-line-state.pdf Accessed Mar5, 2025. The NAIC report does not report these figures; it only reports them as percentages of direct premiums earned. Thus, they were calculated by multiplying those percentages to direct premiums earned. Defense costs are called "loss adjustment expenses" in the NAIC report.
24. Anupam BJ, Seabury S, Lakdawalla D, et al. Malpractice Risk According to Physician Specialty. *N Engl J Med*. 2011;365:629–636. Anupam BJ, Chandra A, Lakdawalla D, et al. Outcomes of Medical Malpractice Litigation Against US Physicians. *Arch Intern Med*. 2012;172(11):892-894. Seabury SA, Chandra A, Lakdawalla D, et al. On average, physicians spend nearly 11% of their 40-year careers with an open, unresolved malpractice claim. *Health Aff*. 2013;32(1):111–119.
25. Seabury S, Chandra A, Lakdawalla D. Defense Costs of Medical Malpractice Claims. *N Engl J Med*. 2012:36;1354–1356.
26. Paik, M, Black B, Hyman, D. Damage Caps and Defensive Medicine Revisited. *J. Health Econ*. 2017; 51(January):84-97. Moghtaderi, A, Farmer, S, Black, B. Damage Caps and Defensive Medicine: Reexamination with Patient-Level Data. *J. Empir. Leg. Stud*. 2019; 16(1): 26-68. U.S. Congressional Budget Office. How Do Changes in Medical Malpractice Liability Laws Affect Health Care Spending and the Federal Budget? Working Paper 2019-03 (Washington, DC: U.S. Congressional Budget Office, April 2019).

Importantly, the two types of defensive medicine have opposing effects on health care spending, which makes it even more difficult to measure its extent and cost. Positive defensive medicine increases spending while negative defensive medicine *decreases* it. Therefore, laws aimed at reducing liability pressure and thus defensive medicine, such as caps, can also either increase or decrease spending. The net effect on total spending then depends on which effect dominates. For example, if these effects were to exactly offset each other, and studies were to thus find zero effects on total spending, this would not necessarily indicate that defensive medicine wasn't present; instead, researchers may have not been able to detect it. In short, it is presently very difficult to estimate the *total* cost of defensive medicine.

Much of the earlier research on the cost of defensive medicine focused on certain disease populations or procedures. In contrast, the more recent research examined more aggregate measures of spending on overall populations. Most research—earlier and more recent—is on the Medicare population because of a dearth of available expenditure data for the non-Medicare population.

The seminal paper that sought to quantify the extent of defensive medicine was Kessler and McClellan (1996). Kessler and McClellan (1996) examined hospital expenditures over the course of a year by Medicare beneficiaries with new diagnoses of acute myocardial infarction (AMI) or ischemic heart disease (IHD) in 1984, 1987 and 1990.[27] They compared those expenditures in states with direct, indirect or no tort reforms.[28] They found that within three to five years after the adoption of late 1980s direct reforms, hospital expenditures were reduced by 5% to 9% as compared to expenditures in states that did not adopt reforms.[29] Kessler and McClellan also tested for differences in mortality and complications, and found that these outcomes were similar regardless of whether a direct tort reform was in place. The finding that health did not worsen when those expenditures were reduced supports Kessler's and McClellan's conclusion that the expenditures had been incurred through the practice of defensive medicine.

In an extension of their 1996 work, Kessler and McClellan (2002) examined whether physicians' incentives to practice defensive medicine were affected by the increase in managed care enrollment from 1984 through 1994.[30] The authors found that for IHD patients, direct reforms had a larger negative impact on hospital expenditures in areas with low rather than high managed care penetration, leading to a decrease of 7.1% compared to 2.9%. Among AMI patients, the impact of tort reform was similar regardless of managed care penetration; it resulted in a 3.8% decrease in hospital spending.

Avraham and Schanzenbach (2015) used 1998 to 2009 data from the Nationwide Inpatient Sample (NIS) to examine the effect of noneconomic damage caps on the treatment intensity of heart attack patients aged 45 to 90.[31] They found that the likelihood of receiving an invasive procedure (angioplasty or bypass) declined by 1.25 to two percentage points following enactment of a cap—caps were associated with a decrease in treatment intensity. At the same time, they found no evidence that the decrease in treatment intensity led to an increase in mortality. Together, these results suggest that the extent of defensive medicine was reduced by caps on noneconomic damages.

Reisch et al., (2015) studied 252 breast pathologists and found that most participants reported using one or more assurance behaviors due to concerns about medical malpractices for both their personal (88%) and colleagues' (88%) practices.[32] These behaviors include ordering additional stains, recommending additional surgical sampling, obtaining second reviews, or choosing the more severe diagnosis for borderline cases.

27. Kessler DP, McClellan M. Do Doctors Practice Defensive Medicine? *Q J Econ*. 1996:111(2):353-390.
28. Direct reforms include caps on economic, noneconomic, or total damages, abolition of punitive damages, no mandatory prejudgment interest, and collateral source rule reform. Indirect reforms include limits on contingency fees, mandatory periodic payments, joint and several liability reform, statute of limitations reform, and existence of a patient compensation fund.
29. The 5% reduction was for AMI; 9% for IHD.
30. Kessler D, McClellan M. Malpractice Law And Health Care Reform: Optimal Liability Policy In And Era Of Managed Care. *J Public Econ*. 2002;84:175-197.
31. Avraham, R, Schanzenbach, M. The Impact of Tort Reform on Intensity of Treatment: Evidence from Heart Attack Patients. *J. Health Econ*. 2015;39(January):273–288.
32. Reisch LM, Carney PA, Oster NV, et al. Medical malpractice concerns and defensive medicine. *American Journal of Clinical Pathology*. 2015;144(6):916-922. doi:10.1309/ajcp80lyimooujif

Gruber and Fraker (2019) examined the impact of liability protection on defensive medicine by exploiting the Military Health System's liability structure.[33] Active-duty patients treated at military facilities cannot sue for negligent care, while protections are given to dependents treated at military facilities and to all patients who get care from civilian facilities. Exploiting this variation and exogenous shocks to care location choices from base-hospital closures, the research finds that liability immunity is associated with a 5% reduction in inpatient spending, with no significant adverse effects on patient outcomes.

In a 2006 background paper, the Congressional Budget Office (CBO) looked at the relationship between tort reform and hospital, physician and total Medicare expenditures on all beneficiaries over the 1980 through 2003 period.[34] The CBO concluded that hospital spending per beneficiary was 5% lower in states where noneconomic damages were capped, but attributed about half of that impact to the prospective payment system implemented in 1983.[35] While they found no impact of caps on physician spending, they estimated that total Medicare spending per beneficiary was 4% lower in states with caps.

The more recent research examined the effects of a latter wave of tort reforms that were implemented in the 2000s.[36] In contrast to much of the earlier literature, which typically focused on specific disease populations or procedures, Paik et al. (2017), Moghtaderi et al. (2019) and the CBO (2019) examined the effects of tort reforms on hospital, physician and *total* Medicare spending. Taken together, they provide mixed evidence.

Noneconomic damage caps either raised, lowered or did not affect spending, depending on which type of spending was examined, and the direction of the effect was also inconsistent across studies. This is not entirely surprising, given the opposing effects of positive and negative defensive medicine on spending discussed above. Those mixed findings led the CBO to conclude that noneconomic damage caps won't affect *total* Medicare spending. They also underscore the difficulty in estimating the extent and cost of defensive medicine.

Rather than comparing Medicare expenditures in states with and without tort reforms, some authors have examined whether Medicare expenditures are higher in states that have higher indemnity payments on liability claims.[37] Baicker, Fisher and Chandra (2007)[38] found that a 10% increase in average (per physician) indemnity payments between 1993 and 2001 was associated with a 1.5% to 1.8% increase in the utilization of half of the diagnostic and imaging procedures at which they looked.[39] For spending, they found that the same 10% increase in indemnity payments led to a 1% increase in Part B spending per beneficiary, but found no impact on total spending per beneficiary. The impact on imaging spending (2.2%) stood out as it was larger than that of any other testing or procedure category.

Roberts and Hoch (2007) used 1998 through 2002 Medicare expenditure data and county-level data on the number of medical liability lawsuits in Mississippi to examine the relationship between litigation and medical costs.[40] The authors found that an additional lawsuit per 100,000 persons led to higher Part B Medicare spending of $1.40 to $2.49 per beneficiary. This implied that in the average county in Mississippi, between 0.9% and 1.6% of Part B spending was due to the litigation

33. Frakes M, Gruber J. Defensive medicine: Evidence from military immunity. *American Economic Journal: Economic Policy*. 2019;11(3):197-231. doi:10.1257/pol.20180167.
34. U.S. Congressional Budget Office. Medical Malpractice Tort Limits And Health Care Spending, Background Paper (Washington, DC: U.S. Congressional Budget Office, April 2006).
35. CBO's work suggests that states that were under greater pressure from the PPS system to reduce expenditures were more likely than other states to enact caps. The 5% estimated impact of caps picks up some of this relationship.
36. Paik, M, Black B, Hyman, D. Damage Caps and Defensive Medicine Revisited. *J. Health Econ*. 2017; 51(January):84-97. Moghtaderi, A, Farmer, S, Black, B. Damage Caps and Defensive Medicine: Reexamination with Patient-Level Data. *J. Empir. Leg. Stud*. 2019; 16(1): 26-68. U.S. Congressional Budget Office. How Do Changes in Medical Malpractice Liability Laws Affect Health Care Spending and the Federal Budget? Working Paper 2019-03 (Washington, DC: U.S. Congressional Budget Office, April 2019).
37. When the authors looked at premiums as a measure of liability pressure rather than indemnity payments, their results were similar.
38. Baicker K, Fisher ES, Chandra A. Malpractice Liability Costs and the Practice of Medicine in the Medicare Program. *Health Aff*. 2007;26:841–852.
39. They found an impact on carotid duplex, echocardiography, electrocardiogram, (EKG), and computed tomography (CT)/magnetic resonance imaging (MRI) scanning. They found no impact on prostate-specific antigen (PSA) testing, cardiac catheterization, chest x-rays and mammograms.
40. Roberts B, Hock I. Malpractice Litigation and Medical Costs in Mississippi. *Health Econ*. 2007;16(8):841–859.

climate (including the direct impact of payouts to plaintiffs on health care costs).[41] In the county with the most lawsuits, 277 per 100,000 persons, 15.9% of spending on physician services was due to litigation.

Taken as a whole, the earlier Medicare-based research suggests that defensive medicine affects Medicare spending, but that this effect may be concentrated in some disease populations or procedures. In contrast, the more recent research, which looks at the effects of a latter wave of reforms on more aggregate measures of spending, finds mixed and inconclusive evidence on the spending effects of noneconomic damage caps, perhaps due to the opposing effects of positive and defensive medicine.

Other empirical papers suggest the practice of defensive medicine using data on the non-Medicare population. Avraham, Dafny and Schanzenbach (2010) used a proprietary multi-employer database to examine the relationship between tort reform and the health insurance premiums of employer-sponsored health plans over the 1998 through 2006 period.[42] The authors found that if implemented together, joint and several liability reform, caps on punitive damages, caps on noneconomic damages and collateral source rule reform would reduce the health insurance premiums of self-insured plans by 2.1%, driven largely by the latter two reforms.

Thomas, Ziller and Thayer (2010) used medical liability premiums as a measure of liability pressure.[43] They estimated how episode-of-care costs for Cigna Healthcare claims responded to changes in that measure over the 2004 to 2006 period, or to variation in the measure across areas. The authors' work showed that a 10% decrease in medical liability premiums would lead to a statistically significant decrease in costs in 2% of the *different types* of episodes in their data, which was equivalent to 35.8% of the *total number* of episodes over that period (the affected episodes were high-volume ones). They also concluded that a 10% decrease in premiums would result in a decrease in total costs of less than 1%.

Xu, Spurr, Nan and Fendrick (2013) examined the effect of the medical liability environment on the rate of referrals received by specialist physicians.[44] It analyzed a sample of ambulatory visits to specialist doctors in an office-based setting during the 2003–2007 period. The study assessed whether the rate of referrals was associated with a state's liability environment, including whether it had a cap on noneconomic damages. It found that noneconomic damage caps of $250,000 were significantly associated with a lower likelihood of a specialist receiving a referral. This finding is consistent with a reduced practice of defensive medicine resulting from the existence of a cap.

The CBO working paper (2019) referenced above also examined the effects of the more recent wave of tort reforms on Medicaid spending in total, as well as for different subsets of beneficiaries. It found some evidence that noneconomic damage caps may reduce Medicaid spending for some beneficiaries—namely, nonelderly, able-bodied adults; however, none of their estimates were statistically significant. The largest and most consistently negative effects were for this population, and the estimates suggest that fully phased-in noneconomic damage caps would lower per-beneficiary Medicaid spending by about 10%.[45]

This evidence is consistent with the practice of defensive medicine.[46]

A recurring problem

The problems with the medical liability system are not new. 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. This exodus of capacity resulted in an availability crisis and created an affordability issue for those physicians

41. The lower of the two estimates is from a regression that includes county fixed effects. The percentage impacts are calculated at the mean number of suits per 100,000 (16.05), with average Medicare physician spending per beneficiary of $2431 ($1.40 * 16.05 /$2431 = 0.009, for example).
42. Dafny RA, Schanzenbach MM. The Impact of Tort Reform on Employer-Sponsored Health Insurance Premiums. Journal of Law, Economics, and Organization. 2012; 28(4):657-686.
43. Thomas WJ, Ziller EC, Thayer DA. Low Costs of Defensive Medicine, Small Savings From Tort Reform. *Health Aff*. 2010;29:1578–1584.
44. Xu, X, Spurr, SJ, Nan, B, Fendrick, AM. The Effect of Medical Malpractice Liability on Rate of Referrals Received by Specialist Physicians. *Health Econ Policy Law. 2013;8(4):453-75*.
45. U.S. Congressional Budget Office. How Do Changes in Medical Malpractice Liability Laws Affect Health Care Spending and the Federal Budget? Working Paper 2019-03 (Washington, DC: U.S. Congressional Budget Office, April 2019).
46. Frakes, M, Gruber, M. Defensive Medicine: Evidence from Military Immunity. *American Economic Journal: Economic Policy*.2019;11(3):197-231.

and hospitals lucky enough to find insurance. 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.

In California, between 1968 and 1974, the number of medical liability claims doubled, and the number of losses in excess of $300,000 increased dramatically, 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).[47]

During the 1980s, the second liability crisis—characterized by a lack of affordability—shook the industry, as claim frequency and severity increased again and premiums rose rapidly. 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 risk and hold down their premiums. Some physicians closed practices in states where premiums and the risk of being sued were especially high.

The third liability crisis began in the early 2000s. Liability premiums skyrocketed, and access to care was threatened in many states.

Access to care during the last liability crisis

At the height of the third liability crisis in the mid-2000s, 45% of hospitals reported that the professional liability crisis resulted in the loss of physicians or reduced coverage in emergency departments.[48] According to a 2006 ACOG survey, the lack of affordable liability insurance forced 70% of obstetricians/gynecologists to make changes to their practice in the preceding three-year period. Of those who made changes, liability concerns forced 7% to stop practicing obstetrics. Finally, ACOG reported that close to 90% of obstetricians/gynecologists have had at least one liability claim filed against them over the course of their career with the average being 2.6% claims per obstetrician/gynecologist.[49]

Residents and students also expressed grave concerns about the liability situation and their ability to practice medicine in high-risk specialties at the height of the third liability crisis. In a 2003 survey, 62% of medical residents reported that liability issues were their top concern, surpassing any other concern. This represented an enormous increase from 2001 when, according to 2003 survey data, only 15% of residents said liability was a concern.[50]

Medical students were also affected by the third liability crisis. In fact, half of the respondents to an AMA survey indicated the medical liability environment was a factor in their specialty choice.[51] Thirty-nine percent said the medical liability environment was a factor in their choice of state in which to complete residency training.[52] Sixty-one percent of students reported they were extremely concerned that the current medical liability environment was decreasing physicians' ability to provide quality medical care.[53]

At the height of the third crisis, a majority (59%) of physicians believed that the fear of liability discouraged open discussion and thinking about ways to reduce health care errors.[54] More than three-fourths (76%) of physicians believed that concern about medical liability litigation negatively affected their ability to provide quality care.[55] Fear

47. Anderson RE. Commentaries Defending the Practice of Medicine. Arch Int Med. 2004;164(11):1173-8.
48. Am. Hosp. Ass'n., Prof'l Liability Ins. Survey (2003).
49. Wilson N, Strunk AL. Overview of the 2006 ACOG Survey on Professional Liability. *ACOG Clinical Review*. 2007;12(2):1–16.
50. Meritt, Hawkins & Assoc., Summary Report: 2003 Survey of Final Year Med. Residents 5 (2003).
51. AMA Division of Market Research & Analysis. AMA Survey: Med. Students' Opinions of the Current Medical Liability Environment. 2003.
52. Id.
53. Id.
54. Harris Interactive Inc. Common Good, Common Good Fear of Litigation Study: The Impact on Med. 65. 2002.
55. Id. See also, Taylor S, Thomas E. 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).

of medical liability suits caused some emergency room physicians to order more hospitalizations and medical tests than other emergency room doctors.[56]

Premiums during the last liability crisis

The Medical Liability Monitor (MLM) reports medical liability premiums for major medical liability insurance carriers for obstetrics/gynecology, general surgery and internal medicine in each state (or sub-state area) where they provide liability coverage. The premium data on page 11 below, which are from the Annual Rate Survey (October) editions of the MLM, illustrate the explosive premium growth faced by physicians during the third medical liability crisis from 2000–2004. The table also shows premiums for California—a state that passed strong tort reforms in 1975—to illustrate the relative stability in premiums in that state compared to others.

Premiums in several states more than doubled during the 2000–2004 period. As the table shows, some Florida obstetricians/gynecologists and general surgeons faced premiums that were over $275,000 in 2004. According to the Florida Association of Realtors and the University of Florida Real Estate Research Center, that was more than the median sale price for a house in that area at that time ($273,900).[57]

Premiums after the last crisis

After the crisis, a growing number of premiums started to decrease.[58] Since then, however, fewer premiums have fallen over time, and decreases have become much less common than premium increases. The major trend had generally been one of increasing stability, though stability has been slowing down since 2019.

Also in 2019, for the first time since the last crisis, the share of premiums that increased year-to-year went up significantly. The proportion of premiums that went up in 2018 almost doubled in 2019. Then in 2020, an even higher share increased, when 31.1% of premiums went up from the previous year. Once again, and despite a small dip in 2021, over 36% of premiums increased in 2022.[59] This trend continued to gain momentum, and by 2024, almost half (49.8%) of reported premiums rose from the previous year. This was the highest proportion observed since 2005.

Some actuaries believe that we have not yet entered a hard market. However, there are signs that such conditions may become a reality in the near future. The average change in premiums across the nation was 2.5% in 2024—up from 1.0% in 2020. There were 16 states where at least some of the premiums reported increased by 10% or more—up from 12 such states in 2021. Premium increases were more widespread as they were observed in 45 states and the District of Columbia in 2024. Although there may not be a hard market yet in the U.S. as a whole, there appears to be a hard market in a considerable number of states, such as Illinois, where 90.7%, 81.5% and 88.2% of its premiums increased respectively in each of the last three years.[60] In sum, average premiums have been going up in recent years. To put it in perspective, however, at this stage the current hard market is not as severe and is spreading at a slower pace than the last liability crisis.

It is not atypical for there to be hard and soft markets—i.e., for premiums to go up and down, as this is part of the insurance cycle. How severe and widespread the current hard market may become is still uncertain; hence, the next editions of the MLM data are awaited with great anticipation.

56. Malpractice Fears Guide Behavior of Some ER Physicians, Study Says. Health Care Daily. July 13, 2005.
57. https://www.bizjournals.com/southflorida/stories/2005/05/09/story6.html. Accessed Feb. 22, 2022.
58. Guardado. J. Prevalence of Medical Liability Premium Increases Unseen Since 2000s Continues for Fourth Year in a Row. Chicago IL: American Medical Association; 2023. Policy Research Perspectives No. 2023-2. https://www.ama-assn.org/system/files/prp-mlm-premiums-2022.pdf. Accessed April 15, 2023. This subsection is based entirely on this particular report.
59. Hardiman, A. Upward Trajectory of Medical Liability Premiums Persists for Sixth Year in a Row. Chicago, IL: American Medical Association; 2025. Policy Research Perspectives No. 2025-1. https://www.ama-assn.org/system/files/prp-mlm-premiums-2025.pdf. Accessed March 3, 2025.
60. Hardiman, A. Upward Trajectory of Medical Liability Premiums Persists for Sixth Year in a Row. Chicago, IL: American Medical Association; 2025. Policy Research Perspectives No. 2025-1. https://www.ama-assn.org/system/files/prp-mlm-premiums-2025.pdf. Accessed March 3, 2025.

Research on caps

Caps on noneconomic damages have proven to be successful at maintaining a stable liability climate in states that enact them. A large body of research shows that caps on noneconomic damages lead to improved access to care for patients, constrained medical liability premium growth, lower claim frequency, reduced average claim payments and lower health care costs. The AMA is committed to advocating for traditional reforms—such as caps on noneconomic damages—as the cornerstone to fixing the broken liability system. The AMA is also calling for testing of innovative reforms to see if any of them can be proven successful as well.

The following articles, most of them conducted independently and subject to peer review in academic journals, show the beneficial effects that caps have on premiums, costs and the federal deficit. Their effect on patient access to care was addressed in an earlier section of this document.[61]

Kessler and McClellan (1997) looked at the relationship between tort reform and liability pressure, where pressure was measured by premiums paid by physicians and claim frequency.[62] Both the premium and the frequency data were from 1985 through 1993 surveys of physicians conducted by the AMA. The authors found that direct reforms reduced premiums by 8.4% within the first three years after a reform and reduced the likelihood that a physician would be sued by 2.1% points (or 24%).

Thorpe (2004) examined the impact of various types of caps that were enacted in the mid- to late 1980s.[63] He found that medical liability premium revenue was 17% lower in states that capped noneconomic or total damages than in states that did not.

Viscusi and Born (2005) examined the impact of caps and other tort reforms that were enacted in the mid- to late 1980s.[64] They found that insurers in states that enacted caps on noneconomic damages had losses 17% lower than those of insurers in other states. Earned premiums were 6% lower. In addition, they found that losses and premiums of insurers in states where punitive damages were not allowed were 16% and 8% 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 7% on losses and no impact on premiums.

Born, Viscusi and Baker (2009) examined the effects of reforms on ultimate[65] losses and whether those effects were larger for insurers that experience greater losses. They found that insurers whose business was concentrated in states with caps had smaller losses than other insurers.[66] For example, on average over the 1984 to 1999 period, a 10% increase in the share of business in states with noneconomic caps led to a 2.5% decrease in losses developed to the fifth year. The effects were more pronounced for firms with higher losses per premium dollar—those firms had large claims that were likely to be affected by caps. The authors also examined incurred[67] losses and found smaller impacts than for losses developed to the fifth year, as well as for losses developed to the tenth year in the analysis that assessed the effect by size of loss. This suggests that the caps had a larger impact on ultimate losses than on losses that the insurers initially expected.

Kilgore, Morrisey and Nelson (2006) investigated the association between a number of different types of tort reforms and medical liability premiums over the 1991 to 2004 period.[68] Their results showed that, on average, internal medicine premiums in coverage regions in states with caps on noneconomic damages were 17.3% lower than in regions in states without caps. The impact of caps on general surgery and obstetrics/gynecology premiums was larger, 20.7% and 25.5%, respectively. Moreover, and consistent with what one might expect, the

61. Also see footnote 12 for two AMA reports that provide more lengthy and detailed summaries of these and related research papers.
62. Kessler DP, McClellan MB. The Effects of Malpractice Pressure and- Liability Reforms on Physicians' Perceptions of Medical Care. *Law and Contemp Problems*. 1997;60(1):81–106.
63. Thorpe KE. The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms. *Health Aff*. 2004:W4-20-W4-30.
64. Viscusi WK, Born PH. Damage Caps, Insurability, and the Performance of Medical Malpractice Insurance. *J Risk and Ins*. 2005;72(1):23–43.
65. The ultimate loss on a claim is the known amount that is actually paid out after a claim has closed.
66. Born PW, Viscusi K, Baker T. The Effects of Tort Reform on Medical Malpractice Insurers' Ultimate Losses. *The Journal of Risk and Insurance*. 2009;76(1):197-219.
67. The incurred loss on a claim is the *estimated* amount that will be paid out on a claim once it has closed.
68. Kilgore ML, Morrisey MA, Nelson LJ. Tort Law and Medical Malpractice Insurance Premiums. *Inquiry*. 2006;43:255–270.

authors found that every $100,000 increase in a cap raised premiums by 3.9%. 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 billion annually.

Paik, Black and Hyman (2013) studied the effect of damage caps passed in the 1990s and 2000s on claim rates and payouts.[69] Importantly, they allow for a phase-in of caps—i.e., time for them to have an effect. They find that damage caps are associated with lower claim rates and payouts per claim, with a large combined impact on payout per physician. They also find that the reduction in claim rates is concentrated in claims with larger payouts and that the effects of stricter caps are larger.

Seabury, Helland and Jena (2014) examined the impact of noneconomic damage caps and other types of tort reform on average indemnity payments made on medical liability claims closed between 1985 and 2010.[70] They found that noneconomic damage caps reduced average indemnity payments by $42,980, a reduction of about 15% relative to the average payment over their sample period. The largest impacts in dollar terms were in pediatrics and obstetrics/gynecology, where average payments were reduced by more than $100,000. Seabury, Helland and Jena also tested whether caps set at lower levels had a larger impact on average payments than caps set at higher levels. They found that $250,000 caps reduced average payments by almost $60,000, or by 20%. They did not find a statistically significant impact of $500,000 caps. When looking at specialty specific effects, they found impacts of $250,000 caps on average payments in all specialty categories except ophthalmology. Again, the largest dollar impacts were in obstetrics/gynecology ($124,005) and pediatrics ($146,481). Caps set at $500,000, on the other hand, only had a statistically significant impact in three specialties: general surgery, internal medicine and obstetrics/gynecology.

Yu and Baker (2022) examined the effect of the 2011 North Carolina's adoption of a noneconomic damages cap by comparing county-level liability premiums for three specialties between North Carolina and states without caps both before and after the reform. They found a lagged but significant reduction in premiums for each specialty studied in North Carolina.[71]

In addition to the original research summarized above, a number of literature reviews and extrapolations based on original research have also concluded that caps on noneconomic damages reduce claim severity and premiums. 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."[72] The non-partisan CBO (1998) noted that caps on noneconomic damages were one of two reforms that "have been found extremely effective in reducing the amount of claims paid and medical liability premiums."[73] The other reform was collateral source offset provisions.

Using a variety of data sources, Hamm, Frech, and Wazzan (2014) examined the impact of California's MICRA. They concluded that:

- A cap lowers medical liability insurance premiums by reducing insurers' loss costs.
- A cap on noneconomic damages reduces health care costs, making health care more affordable.
- The MICRA cap has not reduced access to the courts for individuals with meritorious claims.
- Notwithstanding the MICRA cap, the rate of increase in medical liability damages awards in California far exceeds the rate of inflation.
- An increase in the cap on noneconomic damages would significantly increase the cost of health care in California.[74]

69. Paik M, Black B, Hyman D. The Receding Tide of Medical Malpractice Litigation: Part 2—Effect of Damage Caps. *J Empir Leg Stud. 2013;10(4):639-669.*
70. Seabury SA, Helland E, Jena AB. Medical Malpractice Reform: Noneconomic Damages Caps Reduced Payments 15%, With Varied Effects By Specialty. *Health Aff*. 2014;33(11): 2048-2056.
71. Yu H, Baker O. Do noneconomic damage caps reduce medical malpractice insurance premiums? evidence from North Carolina. *Risk Management and Insurance Review.* 2022;25(2):201-218. doi:10.1111/rmir.12216
72. Office of the Tech. Assessment. Impact of Legal Reforms on Medical Malpractice Costs. OTA-BP-H-119. 1993. The OTA was a nonpartisan analytical agency that provided assistance to the U.S. Congress for 23 years through 1995.
73. U.S. Congressional Budget Office. Preliminary Budget Office, Preliminary Cost Estimate on H.R. 4250, Patient Protection Act of 1998. https://www.cbo.gov/publication/10981. Accessed Feb. 22, 2022.
74. Hamm WG, Frech HE, Wazzan CP, MICRA and Access to Healthcare. 2014. http://micra.org/wp-content/uploads/2016/02/FINAL2014MICRAReport01.21.14.pdf. Accessed Jan. 23, 2019.

The CBO (2019) estimated that enacting federal legislation that caps noneconomic damages at $250,000 would reduce total national health care spending by about 0.5%.[75] The CBO also estimated that those damage caps, as well as caps on attorneys' fees, would lower the federal deficit by $27.9 billion over the 10-year period from 2020 through 2029.[76]

Finally, a 2016 report to the Medicare Payment Advisory Commission found a substantial body of evidence indicating that caps on noneconomic damages moderately constrained the growth of premiums over time, producing a difference of from 6% to 13% on average in a given year.[77]

State efforts to enact caps on noneconomic damages

Background

As of January 2025, about half of the states have in place some variation of a cap on noneconomic damages while six states place a cap on total damages. (Colorado places a cap on both noneconomic damages and total damages and is listed in both categories.) However, the caps in these states vary greatly by amount, exceptions and causes of action covered.

States with a cap on noneconomic damages for personal injury, wrongful death and/or both related to medical liability claims include: Alaska, California, Colorado, Hawaii, Idaho, Iowa, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, North Carolina, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia and Wisconsin. States with a cap on total damages include: Colorado, Indiana, Louisiana, Nebraska, New Mexico and Virginia.

A cap's effectiveness depends on the specific provisions of the legislation. For example, some states have a hard cap on noneconomic damages while others have a soft cap on noneconomic damages. A hard cap 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 (1) numerous exceptions for various injuries or legal findings, (2) annual increases (e.g., indexed for inflation), (3) increases based on a set schedule, or (4) individual application to every defendant or plaintiff, thereby allowing several caps for a single claim.

Discussion on state caps on noneconomic damages

Alaska

Since 2005 Alaska has had a $250,000 cap on noneconomic damages awarded in a personal injury cause of action, and a $400,000 cap on noneconomic damages awarded in a cause of action involving wrongful death or a severe permanent physical impairment that is more than 70% disabling.[78] A single cap applies regardless of the number of health care providers against whom the claim is asserted or the number of causes of action filed.

California

In 1975 California enacted the Medical Injury Compensation Reform Act (MICRA), which contained a number of reforms, including a $250,000 hard cap on noneconomic damages. MICRA has been held up as "the gold standard" of MLR and a model for repeated attempts at federal reform legislation. A study by the RAND Corp. 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 noneconomic damages caused plaintiff attorney fees to be reduced 60% while net recoveries to patients and their families were only reduced 15%.[79]

In 2022 California enacted AB-35, MICRA Modernization legislation, which passed through the California Legislature with nearly unanimous

75. U.S. Congressional Budget Office. How Do Changes in Medical Malpractice Liability Laws Affect Health Care Spending and the Federal Budget? Working Paper 2019-03
76. U.S. Congressional Budget Office. How Do Changes in Medical Malpractice Liability Laws Affect Health Care Spending and the Federal Budget? Working Paper 2019-03
77. Mello MM, Kachalia Allen, Medical Malpractice: Evidence on Reform Alternatives and Claims Involving Elderly Patients. *A Report to the Medicare Payment Advisory Commission. 2016.*
78. Alaska Stat. § 09.55.549.
79. Pace NM, Golinelli D, Zakaras L. Capping Noneconomic Awards in Medical Malpractice Trials xxiv. RAND Corp: 2004.

support.[80] Previously, MICRA limited recovery of noneconomic damages to $250,000, regardless of the number of defendants. AB-35 increased the $250,000 cap to $350,000 for non-death cases and $500,000 for wrongful death cases on the effective date Jan. 1, 2023, followed by incremental increases over 10 years to $750,000 for non-death cases and $1,000,000 for wrongful death cases, after which a 2.0% annual inflationary adjustment will apply. As of Jan. 1, 2025, the $250,000 cap has been adjusted to $430,000 and the $500,000 wrongful death cap is now $600,000. AB-35 also created three separate categories for a total of three possible caps in each case. A health care provider or health care institution can only be held liable for damages under one category regardless of how the categories are applied or combined. The new categories include: (1) one cap for health care providers (regardless of the number of providers or causes of action); (2) one cap for health care institutions (regardless of the number of institutions or causes of action); and (3) one cap for unaffiliated health care institutions or providers at that institution that commit a separate and independent negligent act.

In addition to changes to the cap on noneconomic damages, AB-35 made adjustments to periodic payments and limited attorney contingency fees. At the request of either party, periodic payments can be used for future economic damages starting at $250,000. AB-35 created a two-tiered system (from a four-tiered system) with the option to petition courts for a higher contingency fee for cases that go to trial: (1) 25% contingency fee limit for claims resolved *prior* to a civil complaint being filed or arbitration demand being made; (2) 33% contingency fee limit for claims resolved *after* a civil complaint is filed or arbitration demand is made.

Finally, AB-35 established new discovery and evidentiary protections for all pre-litigation expressions of sympathy, regret or benevolence, including statements of fault, by a health care provider to an injured patient or their family in relation to the pain, suffering, or death of a person or an adverse patient safety event or unexpected medical outcome.

By successfully supporting the enactment of AB-35, the California Medical Association was able to avoid a multimillion-dollar ballot fight.

Colorado

In June 2024 Colorado enacted HB24-1472 that increased caps in medical liability and wrongful death cases. Beginning Jan. 1, 2025, the law incrementally increases the medical liability wrongful death damages limitation to $1.575 million over the course of five years. Thereafter, the cap is adjusted biennially for inflation. Prior to HB24-1472, Colorado law limited the amount recoverable for noneconomic damages in medical liability actions to $300,000. Beginning Jan. 1, 2025, HB24-1472 incrementally increases the noneconomic damages limitation to $875,000 over the course of five years. Thereafter, the cap is adjusted biennially for inflation. Because of HB24-1472's enactment, the Colorado Medical Society did not have to spend millions of dollars in a ballot contest.

Florida

In 2003 Florida enacted a law that provided a separate cap on noneconomic damages for practitioners and non-practitioners. For practitioners, the cap was $500,000 per claimant regardless of the number of defendants. For non-practitioners, the cap was $750,000 per claimant regardless of the number of defendants. The cap could 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 found a manifest injustice would occur if the cap was not increased because the noneconomic harm sustained by the patient was particularly severe, and the defendant's negligence caused a catastrophic injury to the patient. In a series of decisions, the Florida Supreme Court struck down Florida's cap on noneconomic damages in medical malpractice personal injury suits and wrongful death cases.

Georgia

In 2005 Georgia enacted a hard $350,000 cap on noneconomic damages awarded in a medical liability action, including wrongful death, against all health care providers and a separate $350,000 cap on noneconomic damages awarded against a single medical facility that would increase to $700,000 if more than one facility was involved. No more than

80. https://leginfo.legislature.ca.gov/faces/billStatusClient.xhtml?bill_id=202120220AB35

$1.05 million could be awarded in a medical liability cause of action. The caps applied to each claimant, but the term "claimant" was 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. In a controversial ruling, the Georgia Supreme Court ruled in 2010 that the law was unconstitutional.[81]

Hawaii

Hawaii has a $375,000 cap on noneconomic damages, with exceptions for certain types of damage, i.e., mental anguish.[82]

Idaho

In 2003 Idaho put in place a $250,000 cap on noneconomic damages (Idaho previously had a $400,000 cap on noneconomic damages that adjusted annually for inflation since 1988) that applies per claimant in all personal injury and wrongful death actions, effective in 2004. The cap has been adjusted annually since July 1, 2004, based on the average state wage increase. In 2024, the cap was $490,512.[83]

Illinois

On Aug. 25, 2005, Gov. Rod Blagojevich signed into law an MLR bill that included a $500,000 cap on noneconomic damages for awards in a medical liability cause of action (including wrongful death) against a physician, and a separate $1 million cap on noneconomic damages for awards in a medical liability cause of action (including wrongful death) against a hospital and its personnel or hospital affiliates. These caps were struck down in 2010.

Indiana

Indiana had a $1.25 million total damage cap for any act of malpractice that occurred after June 30, 1999, and before July 1, 2017. A $1.65 million total cap applied with respect to any act of malpractice that occurred after June 30, 2017, and before July 1, 2019. A $1.8 million total cap now exists for any act of malpractice that occurs after June 30, 2019.

Health care providers are not liable for more than: (1) $250,000 for an act of malpractice that occurred after June 30, 1999, and before July 1, 2017; (2) $400,000 for an act of malpractice that occurred after June 30, 2017, and before July 1, 2019; and (3) $500,000 for an act of malpractice that occurred after June 30, 2019.

Any amount awarded in excess of the total liability of a health care provider is paid through the Patient Compensation Fund.[84]

Iowa

In 2017 Iowa put in place a $250,000 cap on noneconomic damages, although no cap applied in cases involving permanent impairment, substantial disfigurement or wrongful death.[85] In February 2023, Gov. Kim Reynolds signed HF 161 into law, which amended the 2017 law. Starting in January 2028, and each year after that, the $250,000 cap will be increased by 2.1%. While the $250,000 cap still does not apply if a jury determines that there is a substantial or permanent loss or impairment of a bodily function or substantial disfigurement, in such cases noneconomic damages are limited to $1 million, or $2 million if the civil action includes a hospital. Starting in January 2028, this cap also increases by 2.1% and each Jan. 1 thereafter.

Kansas

On April 17, 2014, Gov. Sam Brownback signed S.B. 311, which gradually increased the state's $250,000 cap to $350,000 over an eight-year span.[86] In 2021 the Kansas Supreme Court ruled that this cap was unconstitutional.[87]

Louisiana

Louisiana has a $500,000 cap on total damages, excluding damages recoverable for future medical care. A health care provider covered by the Patient's Compensation Fund shall not be liable for more than $100,000. The Patient's Compensation Fund will cover the excess amount awarded up to the cap.[88]

Maine

In 2023 Maine expanded the previous $750,000 cap on noneconomic damages in wrongful death actions to $100,00,000.[89]

81. Atlanta Oculoplastic Surgery v. Nestlehutt, et al. 691 S.E.2d 218 (Ga. 2010)
82. Hawaii Statutes § 663-8.7.
83. Idaho Code Ann. § 6-1603.
84. Indiana Code § 34-18-14-3.
85. Iowa Code § 147.136A; Iowa Code § 147.139; and Iowa Code § 135P.1.
86. Kan. Stat. Ann. 60-19a02.
87. *Hilburn v. Enerpipe*, 442 P.3d 509 (Kan. 2019)
88. Louisiana Revised Statutes § 40:1231.2
89. Maine Revised Statutes Title 18-C, § 2-807.

Maryland

In 2005 Maryland enacted a law putting in place separate noneconomic damages caps for personal injury and wrongful death suits involving two or more claimants or beneficiaries. Noneconomic damages awarded against a physician for personal injury were capped at $650,000 until Jan. 1, 2009, after which the cap increases $15,000 each year.[90] The cap applies in aggregate to all claims and all defendants arising from the same medical injury. The $650,000 cap also applies in wrongful death actions if the claim involves only one claimant or beneficiary. As of January 2025, this $650,000 cap has been adjusted to $905,000. For wrongful death claims involving two or more claimants or beneficiaries, the total cap on noneconomic damages is 125% of the current cap's year. As of October 2024, this cap was $1,425,000.

Massachusetts

Massachusetts has a $500,000 cap on noneconomic damages, with exceptions for proof of substantial disfigurement or permanent loss or impairment of a bodily function, or other special circumstances which warrant a finding that imposition of such limitation would deprive the plaintiff of just compensation for the injuries sustained.[91]

Michigan

Michigan has two caps for noneconomic damages. Michigan has a "soft" cap of $586,300 in 2025. A different cap applies where the plaintiff is hemiplegic, paraplegic, or quadriplegic due to an injury to the brain or spinal cord, or where the plaintiff has permanently impaired cognitive capacity, or the plaintiff has had a permanent loss of or damage to a reproductive organ. In such cases, in 2025 the cap is $1,047,000.[92]

Mississippi

Since June 2004 Mississippi has had a $500,000 cap on noneconomic damages for medical liability causes of action filed against a health care provider.[93]

Missouri

In 2015 Missouri put in place a statutory $400,000 cap on noneconomic damages and a higher cap of $700,000 for catastrophic personal injury or death.[94] Both are subject to an annual index of 1.7% for inflation, and the cap applies irrespective of the number of defendants. In 2025 the caps are $473,445 and $828,529, respectively. In July 2021, the Missouri Supreme Court upheld the constitutionality of the noneconomic caps in the 2015 law.[95] A prior Missouri cap law was struck down in 2012.[96]

Montana

Prior to 2025, Montana had a $250,000 can on noneconomic damages. In 2025, Montana changed the cap to $300,000 in 2025, $350,000 on Jan. 1, 2026, $400,000 on Jan. 1, 2027, $450,000 in Jan. 1, 2028, and $500,000 in Jan. 1, 2029. Starting Jan. 1, 2030, and every Jan. 1, thereafter, the cap must be increased by 2% of the prior year's limit.[97]

Nebraska

Nebraska has a cap on total damages, both economic and noneconomic damages. For malpractice that allegedly occurred after Dec. 31, 2014, the cap is $2.25M.

Health care providers who qualify under the Hospital-Medical Liability Act (i.e., carry minimum levels of liability insurance and pay a surcharge into excess coverage fund) shall not be liable for more than $800,000 in total damages. Any excess damages shall be paid from the excess coverage fund.[98]

Nevada

In June 2023 the Nevada governor approved AB 404. Prior to AB 404's enactment, noneconomic damages were capped at $350,000, regardless of the number of plaintiffs, defendants or theories upon which liability could be based. Per AB 404, the cap increases $80,000 on Jan. 1 of each year beginning on Jan. 1, 2024, and ending on Jan. 1, 2028, when the cap reaches $750,000. Starting Jan. 1, 2029, the cap will increase every year by 2.1%.[99] As of Jan. 1, 2025, the cap is $510,000.

In 2002 Nevada established 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

90. Md. Code Ann., Cts. & Jud. Proc. § 3-2A-09.
91. Massachusetts General Laws Chapter 231, section 60H.
92. Michigan Compiled Laws § 600.1483.
93. Miss. Code Ann. § 11-1-60.
94. Mo. Rev. Stat. § 538.210.
95. *Ordinola v. Univ. Physician Associates*, 625 S.W.3d 445, 453 (Mo. banc 2021)
96. *Watts v. Lester E. Cox Med. Ctr.*, 376 S.W.3d 633 (Mo. 2012)
97. Montana Code Annotated section 25-9-411, amended by HB 195.1 (2025). 25-9-411.
98. Nebraska Revised Statute 44-2825
99. NRS 41A.035

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.[100]

In cases where the physician 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, there is a rebuttable presumption that the medical condition is the result of the original traumatic injury, and the $50,000 limit applies.

New Mexico

In 2021 New Mexico enacted HB 75 and HB 11, and then in 2023 it added SB 523. These new laws amended the New Mexico Medical Malpractice Act.[101] For physicians that are not employed by a hospital or independent outpatient health care facility, the cap is $750,000 plus medical costs, except for punitive damages and past and future medical care, and the cap is Consumer Price Index (CPI) adjusted annually. To receive the benefits of this cap, the physician must have medical liability insurance coverage of at least $250,000 and pay a surcharge into the New Mexico patient compensation fund. If a physician meets these requirements, then amounts over $250,000 up to the cap are paid by the patient compensation fund.

For "independent outpatient health care facilities"—which includes ambulatory surgical centers, urgent care facility or free-standing emergency rooms that are not controlled by a hospital, except for punitive damages and past and future medical care and related benefits—the cap is $750,000 for an injury or death that occurred in 2022 and 2023. If an injury or wrongful death occurred in 2024, a cap of $1,000,000 applies (excluding medical costs). For an injury or wrongful death occurring in 2025 and future years the $1,000,000 is CPI adjusted. For the cap to be applicable, the independent outpatient health care facility must have medical liability insurance of at least $500,000 and pay the required surcharge into the patient compensation fund. The patient compensation fund will then pay any difference between the $500,000 and the cap.The following are the caps for hospitals and hospital-controlled outpatient health care facilities: (1) if the injury or death occurred in 2022, the cap is $4,000,000; (2) if the injury or death occurred in 2023, the cap is $4,500,000; (3) if the injury or death occurred in 2024, the cap is $5,000,000); (4) if the injury or death occurred in 2025, the cap is $5,500,000; (5) if the injury or death occurred in 2026, the cap is $6,000,000, which, starting in 2027, is adjusted annually. Hospitals and hospital-controlled outpatient health care facilities will also be covered by the patient compensation fund through 2026.

North Carolina

In 2011 North Carolina enacted a $500,000 cap on noneconomic damages for medical liability actions (including actions for personal injury or death). The cap applies to all defendants and noneconomic damage awards cannot exceed $500,000 against individual defendants for all claims brought by all parties arising out of the same professional services. The cap is indexed for inflation on Jan. 1 of every third year, beginning with Jan. 1, 2014, and as of 2023 the cap has been adjusted to $656,730. However, there is no limit on the amount of noneconomic damages if the trier of fact finds both of the following:

- The plaintiff suffered disfigurement, loss of use of part of the body, permanent injury or death.
- The defendant's acts or failures, which are the proximate cause of the plaintiff's injuries, were committed in reckless disregard of the rights of others, grossly negligent, fraudulent, intentional or with malice.[102]

North Dakota

North Dakota has a $500,000 cap on noneconomic damages.[103]

Ohio

In 2003 Ohio put in place a sliding cap on noneconomic 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 (1) a permanent and

100. NRS 41.503
101. N.M Statutes §§ 41-5-3 et al.
102. N.C. Gen. Stat. § 90-21.19
103. North Dakota Century Code § 32-42-02.

substantial physical deformity, loss of use of a limb, or loss of a bodily organ system, or (2) a permanent physical functional injury that permanently prevents the injured person from being able to care for oneself independently and perform life-sustaining activities.[104]

Oklahoma

In 2011 Oklahoma passed a $350,000 cap for noneconomic damages, subject to exceptions. The law did not apply to actions brought under the Governmental Tort Claims Act or to actions for wrongful death.[105] In 2019, however, the Oklahoma Supreme Court held that Oklahoma's cap on noneconomic damages was unconstitutional.[106]

Oregon

Oregon had a $500,000 cap on noneconomic damages until the Oregon Supreme Court struck it down in 2020.[107]

South Carolina

In 2005 South Carolina enacted a $350,000 cap on noneconomic damages for a judgment against a single health care provider or institution. An award for noneconomic damages against two or more health care providers or institutions cannot exceed $1.05 million with a single provider or institution 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 CPI.[108] In 2024 the $350,000 cap was adjusted to $564,168 and the $1.05 cap to $1,692,503.

South Dakota

South Dakota has a $500,000 cap on noneconomic damages.[109]

Tennessee

Tennessee has a $750,000 limit on compensation for noneconomic damages for all injuries and occurrences in a civil action, including health care liability actions. The limit on noneconomic damages applies regardless if the action is based on a single act or omission or on a series of acts or omissions.

The limit on compensation for noneconomic damages may increase to $1 million in cases of catastrophic loss or injury, which may include:

- Spinal cord injuries resulting in paraplegia or quadriplegia
- Amputation of two hands or two feet or one of each
- Third-degree burns covering 40% of the body or the face
- Wrongful death of a parent with a minor child(ren)

The limit shall not apply to personal injury or wrongful death cases when one of the following conditions is met:

- The defendant had a specific intent to inflict serious physical injury
- The defendant intentionally falsified, destroyed or concealed records containing material evidence for the purpose of evading liability in the claim
- The defendant was under the influence of alcohol, drugs or other intoxicant or stimulant resulting in substantial impairment and causing the injury or death.[110]

Texas

In 2003 Texas enacted sweeping medical liability reforms. Texas has a hard cap of $250,000 on noneconomic 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. A hard cap of $250,000 exists on noneconomic 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 may not exceed $500,000 in noneconomic damages, with each institution not liable for more than $250,000 in noneconomic damages.[111] 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.

104. Ohio Rev. Code Ann. § 2323.43.
105. Oklahoma House Bill 2128 (2011)
106. *Beason v. I. E. Miller Servs., Inc.*, 441 P.3d 1107 (Okla. 2019)
107. Busch v. McInnis Waste Systems, 468 P.3d 419 (Or. 2020).
108. South Carolina 15-32-200 et seq.
109. South Dakota Codified Laws § 21-3-11.
110. Tenn. Code Ann. § 29-39-102.
111. Tex. Civ. Prac. & Rem. Code Ann. § 74.301.

The cap on noneconomic 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 medical liability claim, and the cap applies regardless of the number of defendants or causes of action asserted.

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 noneconomic 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 noneconomic 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 noneconomic 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 noneconomic 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."

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 limits on noneconomic damages in medical and health liability cases as described above. The final vote was 51.1% in favor of Proposition 12 and 48.9% against.[112]

112. Tex. Const. Art. III, § 66.

Utah

Since 2010 Utah has had a[113] $450,000 hard cap on noneconomic damages. The Utah Supreme Court has ruled that caps on noneconomic damages in medical liability wrongful death cases are unconstitutional.[114]

Virginia

Virginia has a $2.65 million cap on total damages. The cap increases by $50,000 per year, until the increases stop at $3 million for claims after July 1, 2031.[115]

West Virginia

Since 2003 West Virginia has had a $250,000 cap on noneconomic 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 is adjusted annually for inflation up to $375,000 per occurrence or $750,000 for injuries that fall within the exception.[116]

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 emergency medical services (EMS) agency or employee of a licensed EMS agency, or (2) any act or omission of a health care provider in rendering continued care or assistance in the event 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

113. Utah Code Ann. § 78B-3-410.
114. *Smith v. United States*, 2015 UT 68, ¶ 18, 356 P.3d 1249.
115. Virginia Code § 8.01-581.15.
116. W. Va. Code § 55-7B-8.

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.

Wisconsin

Since 2006 Wisconsin has limited noneconomic damages in medical liability cases to $750,000[117] for each occurrence. The law covers all health care providers acting within the scope of their employment and providing health care services. The law does not place a limit on the recovery of economic losses, such as lost wages and medical costs.

The 2006 law came in response to a Supreme Court of Wisconsin decision in 2005 that struck down the state's previous cap on noneconomic damages.[118]

Ballot initiatives

Ballot initiatives are returning as a strategy to weaken or abolish tort reform protections. In 2022 the California Medical Association and coalition partners were confronted with the prospects of a ballot initiative that, if approved by voters, would have gutted MICRA in several key respects, including the elimination of caps on noneconomic damages in broad circumstances. The California Medical Association and its coalition were able to successfully negotiate a bill, AB 35, that modernized MICRA while at the same time maintaining MICRA's important guardrails.

In 2024 the Colorado Medical Society confronted a potential ballot initiative that would have eliminated all liability caps in the state and eviscerated statutory protections for confidentiality in peer review programs. The Colorado Medical Society and coalition partners were able to get enacted a law retaining caps on noneconomic damages and peer review confidentiality, thereby avoiding an expensive and potentially detrimental fight at the ballot box.

Federal efforts on liability reform

While stakeholders continue 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 state courts or stripped of their most effective provisions under state constitutions that limit reform. The following outlines the most recent federal efforts to achieve national liability reform.

Action in Congress

Over the last decade, Congress has tackled various aspects of medical liability reform:

- **ACCESS Act (2022)**: Reintroduced to improve patient access to healthcare by reducing the burden of the liability system. The ACCESS Act includes reforms from California and Texas, such as caps on noneconomic damages and expert witness qualifications.
- **Good Samaritan Health Professionals Act (2021)**: Aims to protect health care professionals volunteering during federally declared disasters from liability and ensure they are not turned away due to confusion and uncertainty about the application of state Good Samaritan laws. The act was a part of the House version of the reauthorization of the

117. Wis. Stat, § 893.55.
118. *Ferdon ex rel. Petrucelli v. Wis. Patients Comp. Fund*, 701 N.W.2d 440 (Wis. 2005).

Pandemic and All-Hazards Preparedness Act but was not included in the Senate version.

- **Coronavirus Provider Protection Act (2021)**: Introduced as H.R. 3021, it provides liability protection to providers for all care affected by the pandemic, including care that was altered due to government guidance, and not just for care for COVID-19 patients or suspected patients.
- **SAFE TO WORK Act (2020)**: Introduced to provide targeted and limited liability relief for healthcare professionals during the pandemic by creating a federal right of action for coronavirus-related medical liability suits, preempting state laws on the issue unless state law provides greater liability protection.
- **CARES Act (2020)**: Extends liability protection to volunteer health care providers treating COVID-19
- **Protecting Access to Care Act (PACA) (2017)**: Introduced in 2017 in the House of Representatives, PACA includes key elements of comprehensive reform. While it has not been introduced in the Senate, the AMA continues to strongly support a comprehensive federal liability reform package to ensure accessible and affordable care for patients
- **Sports Medicine Licensure Clarity Act (2017)**: Thirty-nine cosponsors introduced the act, which was included in the FAA Reauthorization Act of 2018 and signed into law. The AMA supported the bill, which extends the malpractice insurance coverage of a state-licensed medical professional to another state when the professional provides medical services to an athlete, athletic team or team staff member pursuant to a written agreement.
- **HEALTH Act (2016)**: In addition to seeking traditional solutions, the AMA advocates funding for state-based pilot programs to develop promising alternative reforms. The Help Efficient, Accessible, Low Cost, Timely Healthcare (HEALTH) Act contained the most comprehensive liability reform package at the federal level.
- **Family Health Care Accessibility Act (2016)**: Included in the 21st Century Cures Act and signed into law. This legislation provides Federal Tort Claims Act (FTCA) medical malpractice liability coverage to all qualified health care professionals who volunteer at community health centers by deeming them employees of the Public Health Service.
- **Sports Medicine Licensure Clarity Act (2016)**: Passed to ensure that athletic trainers are covered by their liability insurance when they provide care services to their team while traveling.
- **Medicare Access and CHIP Reauthorization Act (MACRA) (2015)**: Passed with bipartisan support, MACRA repeals the Medicare sustainable growth rate (SGR) formula, which was strongly supported by the AMA. MACRA incorporates the Standard of Care Protection Act, which prohibits federal quality program standards and performance metrics from establishing a "standard of care" in medical liability actions.
- **Appropriation of grants on alternative reforms**: As part of its health system reform efforts, the AMA urged the Obama administration and Congress to fund demonstration projects on innovative reforms. In 2009, $25 million in funding was provided to establish medical liability and patient safety demonstration grants and planning grants. The Agency for Healthcare Research and Quality (AHRQ) implemented the programs.
    - AHRQ awarded $23.2 million in grant funding for seven demonstration grants and 13 planning grants. Early disclosure and compensation models were implemented in Illinois, Massachusetts, New York and Washington, while Oregon reviewed the safe harbor concept under a grant from AHRQ.
    - Based on expert input and lessons learned, AHRQ developed the Communication and Optimal Resolution (CANDOR) process, which is a patient-centered approach emphasizing early disclosure of adverse events and proactive resolution methods for patient harm incidents.

Judicial activity on caps

The courts in the following states have upheld caps on noneconomic damages statutes: Alaska, California, Colorado, Idaho, Indiana, Maryland, Michigan, Minnesota, Missouri, North Dakota, Ohio, Texas, Utah, West Virginia and Wisconsin.[119] Courts in Indiana, Louisiana, Nebraska, New Mexico and Virginia upheld caps that encompass both economic and noneconomic damages.[120]

Courts in the following states struck down caps on damages: Alabama, Florida, Georgia, Illinois, Kansas, Oklahoma, Oregon and Washington.[121]

Notable rulings

California

On Sept. 1, 2011, California's Fifth District Court of Appeal upheld MICRA's $250,000 cap on noneconomic damages (*Stinnett v. Tam*). The court rejected claims by the appellant that MICRA was unconstitutional based on equal protection grounds. It also denied the appellant's claim that MICRA violated her right to a jury trial. Appellant argued unsuccessfully that improvements in California's medical liability climate negated the need for MICRA's cap on noneconomic damages.[122]

On Sept. 23, 2013, the Second Appellate District similarly rejected constitutional claims of violation of the right to a jury trial, equal protection and separation of powers.[123] The court said that the plaintiff's argument that the MICRA cap should be indexed for inflation "should be directed to the legislature."

On Aug. 22, 2014, the Fourth Appellate District, in an unpublished decision, upheld MICRA against a claim that it violated the right of trial by jury, equal protection of the laws, and separation of powers.[124]

On June 9, 2015, the First Appellate District upheld MICRA against a claim that it violated the right of due process, trial by jury and equal protection of the law. In connection with the equal protection argument, the court rejected the assertion that circumstances had changed since enactment of MICRA. It observed, "generally, modification or repeal of a statute made obsolete by changed conditions is a legislative, not a judicial, prerogative."[125]

Florida

On March 13, 2014, the Florida Supreme Court, by a split decision, found that in a wrongful death action the cap on noneconomic damages was without a rational basis. According to the court, the cap imposed "unfair and illogical burdens on injured parties when an act of medical negligence gives rise to multiple claimants." Accordingly, the court held that the cap violated the Equal Protection Clause of the Florida Constitution.[126]

In a follow-up decision on June 8, 2017, the Florida Supreme Court ruled that caps on personal injury noneconomic damages in medical negligence actions imposed by Fla. Stat. 766.118 violated the equal protection clause of the Florida Constitution.[127] The court went on to hold that caps on personal injury noneconomic damages do not pass what

119. *See Smith v. Botsford*, 419 F. 3d 513 (6th Cir. 2005); *Evans v. State*, 56 P.3d 1046 (Alaska 2002); *Hoffman v. U.S.*, 767 F.2d 1431 (9th Cir. 1985); *Fein v. Permanente*, 695 P.2d 665 (Cal. 1985); *Stinnett v. Tam*, 130 Cal.Rptr.3d 732 (Cal. Ct. App. 2011); *Hughes v. Pham*, No. E052469, LEXIS (Cal. App. Aug. 22, 2014); *Chan v. Curran*, 237 Cal. App. 4th 601 (2015); *Scholz v. Metro. Pathologists* P.C., 851 P.2d 901 (Colo. 1993); *Kirkland v. Blaine County Med. Ctr.*, 4 P.3d 1115 (Idaho 2002); *Plank v. Comm. Hosp. of Indiana*, et al., 981 N.E.2d 49 (Ind. 2013); *Murphy v. Edmunds*, 601 A.2d 102 (Md. 1992); *DRD Pool Serv. v. Freed*, 5 A.3d 45 (Md. 2010); *Rodriguez v. Cooper*, 182 A.3d 853 (Md. 2018); *Zdrojewski v. Murphy*, 657 N.W.2d 721 (Mich. Ct. App. 2002); *Schweich, et. al. v. Ziegler*, 463 N.W.2d 722 (Minn.1990); *Ordinola v. Univ. Physician Associates*, 625 S.W.3d 445, 453 (Mo. banc 2021); *Arbino v. Johnson & Johnson*, 880 N.E.2d 420 (Ohio 2007); *Wayt v. DHSC, L.L.C.*, 122 N.E.3d 92 (Oh. 2018); *Watson v. Hortman, et. al.*, 844 F.Supp.2d 795 (E.D. Texas 2012); *Judd v. Drezga*, 103 P.3d 135 (Utah 2004); *Robinson v. Charleston Area Med. Ctr.*, 414 S.E.2d 877 (W. Va. 1991); *MacDonald v. City Hospital*, 715 S.E.2d 405 (W. Va. 2011); *Verba v. Ghaphery*, 552 S.E.2d 406 (W. Va. 2001); and *Mayo v. Wisconsin Injured Patients and Families Compensation Fund*, 914 N.W. 2d 678 (Wis. 2018).

120. *Johnson v. St. Vincent Hosp.*, 404 N.E.2d 585 (Ind. 1980); *In re Stephens*, 867 N.E.2d 148 (Ind. 2007); *Arrington v. Galen-Med*, 947 So.2d 724 (La. 2007); *Oliver v. Magnolia Clinic, et. al.*, 85 So.3d 39 (La. 2012); *Prendergast v. Nelson*, 256 N.W.2d 657 (Neb. 1977); *Gourley ex. rel. Gourley v. Neb. Methodist Health Sys.*, 663 N.W.2d 43 (Neb. 2003); *Fed. Express Corp. v. U.S.*, 228 F. Supp. 2d 1267 (N.M. 2002); *Siebert v. Okun*, 485 P.3d 1265 (2021); and *Etheridge, et. al. v. Med. Ctr. Hosp.*, 376 S.E.2d 525 (Va. 1989).

121. *See Moore v. Mobile Infirmary Ass'n*, 592 So.2d 156 (Ala. 1991); *N. Broward Hosp Dist. v. Kalitan*, 219 So. 3d 49 (Fla. 2017); *Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt*, 286 Ga. 731 (2010); *Lebron v. Gottlieb Mem. Hosp.*, 930 N.E.2d 895 (Ill. 2010); *Hilburn v. Enerpipe*, 442 P.3d 509 (Kan. 2019); *Watts v. Lester E. Cox Med. Ctr.*, 376 SW 3d 633 (Mo. 2012); *Carson v. Mauer,* 424 A.2d 825 (N.H. 1980) (overruled on other grounds); *Arneson v. Olson,* 270 N.W.2d 125 (N.D. 1978); *Woods v. Unity Health Center, Inc.*, 196 P.3d 529 (Okla. 2008); *Beason v. I. E. Miller Servs., Inc.*, 441 P.3d 1107 (Okla. 2019); *Busch v. McInnis Waste Sys., Inc.*, 366 Or. 628 (2020); *Sofie v. Fibreboard Corp.*, 771 P.2d 711 (Wash. 1989).

122. *Stinnett v. Tam*, 130 Cal.Rptr.3d 732 (Cal. Ct. App. 2011).

123. *Rashidi v. Moser*, 219 Cal.App.4th 1170 (Cal. Ct. App. 2013).

124. *Hughes v. Pham*, No. E052469, LEXIS (Cal. App. Aug. 22, 2014).

125. *Chan v. Curran*, 237 Cal.App. 4th 601 (Cal. Ct. App. 2015).

126. *Estate of McCall v. United States*, 134 So.3d 894 (Fla. 2014).

127. *North Broward Hosp. Dist. v. Kalitan*, 219 So.3d 49 (Fla. 2017).

is known as the "rational relationship test," where a challenged law must be rationally related to a legitimate government interest. In its opinion, the court relied heavily on its 2014 decision striking down noneconomic damage caps in wrongful death medical negligence cases.

Georgia

On March 22, 2010, the Georgia Supreme Court struck down the state's cap on noneconomic damages.[128] The Supreme Court ruled that the cap violated the right to a trial by jury provision of the Georgia Constitution. The Georgia statute being challenged included a $350,000 cap on noneconomic damages against all health care providers in a claim, a separate $350,000 cap on noneconomic damages against a single medical facility that could increase to $700,000 if more than one facility was involved, and a $1.05 million total limit on noneconomic damages in a medical liability claim.

Illinois

On Feb. 4, 2010, the Illinois Supreme Court upheld a lower court ruling that held that Illinois' cap on noneconomic damages for medical liability claims ($500,000 for physicians/$1 million for hospitals) was unconstitutional.[129] The Supreme Court ruled by a 4–2 majority that the legislatively created cap violated the state's separation of powers requirement by establishing a legislative remittitur.[130] The MLR legislation was enacted in 2005 and included other liability provisions, such as an apology inadmissibility provision and expert witness requirements. All were nullified by the ruling based on the statute's inseverability provision.

Indiana

In January 2013 the Indiana Supreme Court rejected a challenge to the state's $1,250,000 cap on damages in medical liability cases.[131] The plaintiff complained that the trial court had denied him an opportunity to prove that the cap no longer served the purposes for which it was originally enacted and was thus unconstitutional. The court held that such evidence might be allowed in a proper case, but here the plaintiff had forfeited his right to challenge the cap because he had not raised the issue properly in the trial court.

128. *Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt*, 691 S.E.2d 218 (Ga. 2010).
129. *Lebron v. Gottlieb Mem. Hosp.*, 930 N.E.2d 895 (Ill. 2010).
130. Remittitur is the process by which excessive jury verdicts are reduced by a court.
131. *Plank v. Comm. Hosp. of Indiana, et al.*, 981 N.E.2d 49 (Ind. 2013).

Louisiana

In 2007 the Louisiana Supreme Court reinstated the state's cap on total damages in medical liability cases.[132] The $500,000 cap (excluding future medical care) was struck down by the 3rd Circuit Court of Appeals in 2006.[133] 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. In 2012 the Louisiana Supreme Court reaffirmed the state's $500,000 limit on total medical liability damages, once again declaring the cap constitutional and applicable to all health care providers.[134]

Maryland

In 2010 Maryland's highest court ruled that the cap on noneconomic damages in general tort claims is constitutional.[135] It based this decision on the legal doctrine of *stare decisis*, meaning that the court based its decision on prior legal decisions.[136]

Michigan

On Aug. 18, 2005, the U.S. Court of Appeals for the 6th Circuit upheld Michigan's cap on noneconomic damages.[137] Specifically, the court held the cap does not violate the Seventh Amendment or Equal Protection Clause of the U.S. Constitution.[138]

Missouri

In August 2012 the Supreme Court of Missouri threw out the state's $350,000 noneconomic damages cap on medical lawsuits, which was established in 2005.[139] Prior to 2005, Missouri had a less restrictive cap on noneconomic damages of $579,000 (adjusted for inflation). The court's 2012 decision overturned the 1992 state Supreme Court decision that was the basis for the previous cap.[140]

In response to this 2012 Missouri Supreme Court case, in 2015 Missouri enacted a new medical liability reform law that addressed concerns raised in that decision. For "non-catastrophic" injuries, the cap

132. *Arrington v. Galen-Med*, 947 So. 2d 724 (La. 2007).
133. *Arrington v. ER Physicians Group*, 940 So.2d 777 (La. Ct. App. 2006).
134. *Oliver v. Magnolia Clinic*, et. al., 85 So.3d 39 (La. 2012).
135. *DRD Pool Serv. v. Freed*, 5 A.3d 45 (Md. 2010).
136. *Oaks v. Connors*, 660 A.2d 423 (Md. 1995); *Murphy v. Edmonds*, 601 A.2d 102 (Md. 1992).
137. MCLS § 600.1483 (2008).
138. *Smith v. Botsford General Hosp*. 419 F.3d 513 (6th Cir. 2005).
139. *Watts v. Lester E. Cox Med. Ctr.*, 376 S.W.3d 633 (Mo. 2012).
140. *Adams By and Through Adams v. Children's Mercy Hosp.*, 832 S.W.2d 898 (Mo. banc 1992).

was initially established at $400,000, while the cap for "catastrophic" injuries was set at $700,000, and the caps are adjusted annually by 1.7%. In 2023, the caps were set at $457,749 and $801,861, respectively. In July 2021 the Missouri Supreme Court upheld the constitutionality of the noneconomic caps in the 2015 law.[141]

New Mexico

In March 2021 the New Mexico Supreme Court upheld the constitutionality of the existing cap of $600,000 on noneconomic damages.[142]

Oklahoma

In 2008 the Oklahoma Supreme Court struck down several medical liability statutes and caps on noneconomic damages on the grounds that the statutes and caps violated the Oklahoma Constitution.[143] In 2011 Oklahoma enacted a law putting in place a cap of $350,000 for noneconomic damages. In 2019 the Oklahoma Supreme Court ruled that this cap was unconstitutional.[144]

Oregon

In 2020 the Oregon Supreme Court invalidated the state's cap on noneconomic damages, finding that while the court "had no doubt that [the cap] was intended to reduce insurance costs and improve insurance availability," it nevertheless violated the state constitution's remedy clause.[145]

Tennessee

In June 2021 the Tennessee Supreme Court upheld the constitutionality of Tennessee's cap of $750,000 on noneconomic damages.[146]

Texas

In March 2012, in a one-page ruling, a federal judge upheld Texas' $250,000 cap on noneconomic damages.[147] This cap was established in 2003 through the Medical Malpractice and Tort Reform Act of 2003, a law that was later approved via constitutional amendment, Proposition 12. The Medical Malpractice and Tort Reform Act has survived more recent challenges as well.[148]

Utah

In an opinion issued Nov. 5, 2004, the Utah Supreme Court upheld Utah's cap on noneconomic damages[149] 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.[150] The court also held that the cap does not violate separation of powers or right to a jury trial as protected by the Utah Constitution.

West Virginia

On June 22, 2011, the West Virginia Supreme Court of Appeals upheld the state's cap on noneconomic damages.[151] It rejected claims by the appellant that the cap on noneconomic damages violated the right to a jury trial, separation of powers, equal protection, special legislation and/or the "certain remedy" provisions of the West Virginia Constitution.

Wisconsin

On June 27, 2018, the Wisconsin Supreme Court, in a split decision, upheld the cap on noneconomic damages against a claim that it was either invalid on its face or as applied, based on equal protection and due process grounds. The court held that the damages cap, Wis Stat. 839.55, should be analyzed under a rational basis test, which the law passed.[152]

Judicial support for caps on noneconomic damages

Favorable state case law establishes a rationale for supporting legislative reforms.[153]

Equal protection clause

Under the "deferential rational relationship" test, a number of courts have upheld damage caps as a permissive and rational means of achieving the legitimate state goal of reducing insurance premiums paid by physicians. Other societal goals supporting the implementation of caps that have been upheld by courts include:

- Ensuring the availability of physicians in the state
- Continuing the existence of state compensation funds

141. *Ordinola v. Univ. Physician Associates*, 625 S.W.3d 445, 453 (Mo. banc 2021).
142. *Siebert v. Okun*, 485 P.3d 1265 (2021).
143. *Woods v. Unity Health Center, Inc.*, 196 P.3d 529 (Okla. 2008).
144. *Beason v. I. E. Miller Servs., Inc.*, 441 P.3d 1107 (Okla. 2019).
145. *Busch v. McInnis Waste Sys., Inc.*, 366 Or. 628 (2020).
146. *Yebuah v. Ctr. for Urological Treatment, PLC*, 624 S.W.3d 481, 491 (Tenn. 2021).
147. *Watson v. Hortman, et. al.*, 844 F.Supp.2d 795 (E.D. Texas 2012).
148. See https://www.texmed.org/TexasMedicineDetail.aspx?id=53720.
149. Utah Code Ann. § 78-14-7.1
150. *Judd v. Drezga*, 103 P.3d 135 (Utah 2004).
151. *MacDonald v. City Hospital,* 715 S.E.2d 405 (W. Va. 2011).
152. *Mayo v. Wisconsin Injured Patients and Families Compensation Fund*, 914 N.W.2d 678 (Wis. 2018).
153. *See cases cited supra*, note 123.

- Continuing the existence of insurance for physicians in the state
- Assuring medical related payments to all claimants

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

Due process clause

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

Right to trial by jury

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.

Reviewing courts also have held that it is within the legislature's power to modify common law and statutory rights and remedies.

Open court challenge

Some courts have rejected 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, a cap is merely a limitation on recoveries.

Intrusion on the rulemaking power of the judicial branch

Some courts did not find that caps allow the legislature to overstep its constitutional powers. Instead, courts have 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 power.

Other issues

Court decisions on other issues relating to medical liability reform can be found at the website for the Litigation Center of the American Medical Association and the State Medical Societies.[154]

154. https://www.ama-assn.org/health-care-advocacy/judicial-advocacy/litigation-center

Innovative reforms

While the AMA remains fully committed to the enactment of proven MLR laws, such as MICRA, the AMA is also calling for the implementation and evaluation of innovative reforms to see if those reforms can improve the nation's medical liability climate. The AMA has called for federal funding for pilot projects to test such concepts as health courts, liability safe harbors for the practice of evidence-based medicine, early disclosure and compensation models, expert witness guidelines and affidavits of merit, to name some of the more promising options. These reforms could either complement traditional MLR provisions, such as caps, or they may be able to improve the liability climate in a state that is not able to enact traditional MLR provisions for political or judicial reasons. Implementation and evaluation of these innovative reforms are needed to determine their effectiveness.

Health courts

Health courts are an idea that gained attention during the most recent liability crisis. Policymakers seeking an innovative solution to fix the medical liability system were intrigued with the concept, and the AMA supports the testing and evaluation of health court pilot projects as an innovative way to address the medical liability problem. Health court proponents suggest that such courts can:

- Lead to a fairer and more expedited resolution of medical liability claims
- Lead to verdicts being based more on whether or not there was a deviation from the standard of care rather than emotional appeals to juries
- Provide compensation to those harmed by medical negligence in a fairer and more streamlined fashion
- Dismiss meritless claims in a timely manner

However, there is no unanimous support for health courts from the medical community. Those skeptical of health courts have expressed concern about their ability to decrease costs and concern about the judicial appointment process.

The AMA adopted a detailed list of health court recommendations in 2007 to serve as legislative guidelines for state medical associations interested in establishing a health court. Included on the list

are six main health court principles:

- Health courts should be structured to create a fair and expeditious system for the resolution of medical liability claims—with a goal of resolving all claims within one year from the filing date.
- Health court judges should have specialized training in the delivery of medical care that qualifies them for serving on a health court.
- Negligence should be the minimum threshold for compensation to award damages.
- Health court judgments should not limit the recovery of economic damages, but noneconomic damages should be based on a schedule.
- Qualified experts should be consulted to assist a health court in reaching a judgment.
- Health court pilot projects should have a sunset mechanism in place to ensure that participating physicians, hospitals and insurers do not experience a drastic financial impact based on the new judicial format.[155]

Liability safe harbors for the practice of evidence-based medicine

In 2009 the AMA adopted principles related to liability safe harbors for physicians when they practice in accord with evidence-based medicine (EBM) guidelines. This is a concept that has garnered increased attention in the health system reform debate.

While EBM guidelines hold potential for improving patient care and lowering health care costs, they may also expand physician liability if policymakers do not establish protections for physicians who comply with EBM guidelines. The AMA principles are meant to offer guidance to federal, state or local policymakers as they seek to implement and evaluate pilot projects on this concept.

In the early 1990s, a handful of states attempted to implement programs that offered EBM guideline protections to physicians. The program in Maine was the most thorough and lasted for close to a decade. The Maine program was sunset eventually due to a lack of use by physicians, but several of the provisions included in the Maine program are relevant to current efforts and could be used by lawmakers as a starting point.

The following AMA principles and legislative recommendations include several aspects of the Maine statutory and regulatory framework. The principles are broad enough to provide state or local entities with necessary flexibility as they implement such a program, but they also highlight the key provisions that are needed to ensure that the program offers sufficient liability protections to physicians to make it successful.

- Participation in a pilot program relating to evidence-based guidelines would be voluntary for patients and physicians.
- Physicians who elect to participate in the program would follow evidence-based guidelines that could include a decision support process/application based on the guidelines.
- Participating physicians who follow evidence-based guidelines should receive liability protections for diagnosis and treatment in compliance with the guidelines.
- Such liability protections could include, but are not limited to:
    - Civil immunity related to the claims
    - An affirmative defense to the claims
    - A higher burden of proof for plaintiffs
- There would be no presumption of negligence if a participating physician does not adhere to the guidelines.
- Admissibility of a guideline by a plaintiff(s) should be prohibited unless the physician introduces that guideline first.
- The evidence-based guidelines should be developed and promulgated by national medical specialty societies or other public or private groups that provide physicians with substantial representation on oversight committees and with central decision-making roles in the development of the guidelines.
- Implementation of the evidence-based guidelines in the pilot program should be done in accord with AMA Policy H-410.980 (Principles for the Implementation of Clinical Practice Guidelines at the Local/State/Regional Level).

Expert witness requirements

The AMA has adopted a model bill that was drafted to help states strengthen their expert witness requirements. The AMA's goals in drafting the

155. Health Court Principles H-435.951.

model bill were to ensure that expert witnesses are qualified to provide the testimony that they are offering and to provide state medical boards with the authority to review and sanction improper testimony. Nearly every state requires expert testimony to prove a medical liability claim, but the requirements to qualify as an expert vary. Under the AMA model bill, a person may qualify as an expert witness on the issue of the appropriate medical standard of care if the witness:

- Is licensed in the state, or some other state, as a doctor of medicine or osteopathy
- Is trained and experienced in the same discipline or school of practice as the defendant or has specialty expertise in the disease process or procedure performed in the case
- Is certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association, or by a board with equivalent standards
- Within five years of the date of alleged occurrence or omission giving rise to the claim, was in active medical practice in the same discipline or school of practice as the defendant or has devoted a substantial portion of their time teaching at an accredited medical school or in university-based research in relation to the medical care and type of treatment at issue

The model bill also calls for the temporary deeming of out-of-state experts with an in-state license for the purpose of providing expert testimony. This will give the in-state medical board the right to review and possibly discipline an out-of-state expert for improper testimony. In 2011 Florida enacted a law that requires the department of health to issue a certificate to an out-of-state physician seeking to provide testimony in a medical liability case. The statute subjects the out-of-state physician to the jurisdiction of the department of health or board of medicine.[156]

Affidavit of merit

An affidavit of merit, sometimes called a certificate of merit, is a procedural tool that some states employ to limit the adjudication of meritless lawsuits. In some states, a plaintiff must file an affidavit along with the complaint to establish that the claim has merit.

In other states, plaintiffs must file such an affidavit following a defendant's answer to the complaint. It is usually signed by a health care professional who qualifies under state law as an expert witness. As with other pre-trial mechanisms, affidavits of merit help eliminate meritless lawsuits that burden the court system and can save defendants the costs of litigation. About half of the states have some form of certificate or affidavit of merit requirement in place.

The AMA has drafted model legislation for states to use if they wish to consider an affidavit of merit provision. The AMA model bill calls on the plaintiff or the plaintiff's attorney to file an affidavit with the court stating that they have obtained the written opinion of a legally qualified health care provider that states that the defendant health care provider failed to use such care as a reasonably prudent and careful health care provider would have under similar circumstances and that such failure to use such reasonable care directly caused or directly contributed to the cause of the damages claimed in the petition. The model bill uses the suggested expert witness requirements from the AMA's model bill on this topic as well.

Conclusion

As this document has articulated, medical liability remains a continuing concern for physicians. It affects both how and where they practice. The ramifications of the broken liability system are wide-ranging, from patients who now have limited access to health care to the financial implications on the health care system as a whole. A growing number of policymakers from both sides of the aisle agree that this issue needs to be addressed. The AMA remains committed to advocating for proven reforms—such as caps on noneconomic damages—to fix the problem. The AMA is also advocating for innovative reforms as a way to complement traditional reforms. This AMA effort is occurring at both the federal and state levels.

Please visit ama-assn.org/practice-management/sustainability/state-medical-liability-reform

156. Fla. Stat. § 458.3175