



MEDICAL LIABILITY REFORM NOW! 2023

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

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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 in high-risk specialties would have already been subject

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.

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.

According to results from the American Congress of Obstetricians and Gynecologists (ACOG) 2015 Survey on Professional Liability,⁷ 49.7% of obstetricians/gynecologists had altered their practices since January 2012 due to the risk/fear of liability claims and litigation, and 39.8% had made changes to their practice due to insurance affordability or availability concerns. Of those reporting obstetric changes due to affordability or availability concerns:

- 13.6% decreased the number of obstetric high-risk patients they accepted
- 9.6% reported more cesarean births
- 8.4% eliminated vaginal births after cesarean (VBACs) from their practice
- 6.4% reported an overall decrease in the number of total deliveries

The 2013 Massachusetts Medical Society Physician Workforce Study revealed that 36% of Massachusetts physicians had altered or limited their scope of practice for fear of being sued.⁸ In a 2008 national survey of physicians, more than 60% agreed with the statement, "I order some tests or consultations simply to avoid the appearance of malpractice."⁹ A 2011 survey of physicians illustrates why the liability environment affects physicians' practice patterns—while 83% of physicians thought they could easily be sued for failing to order an indicated test, only 21% thought they could be sued for ordering a test that was not indicated.¹⁰

The 2010 Illinois "New Physician Workforce Study" provided insight into how new physicians—who are the future of medicine—were affected by the medical liability system. According to that survey, 49% of new Illinois physicians planned to relocate to a different state. Two-thirds of the new physicians

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. Carpentieri AM, et al. Overview of the 2015 ACOG Survey on Professional Liability. American Congress of Obstetricians and Gynecologists; 2015. acog.org/-/media/Departments/Professional-Liability/2015PLSurveyNationalSummary11315.pdf. Accessed Jan. 23, 2020.
8. Massachusetts Medical Society. Physician Workforce Study. 2013.
9. Carrier, ER, Reschovsky JD, Mello MM, et al. Physicians' fears of malpractice lawsuits are not assuaged by tort reforms. *Health Aff.* 2010;29(9):1585-1592.
10. Sirovich B, Woloshin S, Schwartz LM. Too Little? Too Much? Primary Care Physicians' Views on US Health Care. *Arch Int Med.* 2011;171(17):1582-1585.

who planned to leave Illinois cited the medical liability environment as an important or very important consideration in that decision.¹¹

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 a number of such papers follow.¹²

Perry (2012) examined whether noneconomic damage caps are associated with physician supply.¹³ He compared physician migration in states that had passed noneconomic damage caps to states that had not passed such reforms. He finds that 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 2000.¹⁴ 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.

Klick and Stratmann (2007) used a somewhat different approach than Matsa (2007) to examine the impact of caps on physician supply between 1980 and 2001.¹⁵ 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 1988.¹⁶ 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 2001.¹⁷ They found that direct tort reforms increased physician supply by 2.4% relative to non-reform states.¹⁸ 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 2000.¹⁹ 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

11. Illinois Hospital Association. 2010 *Illinois New Physician Workforce Study*. <https://www.northwestern.edu/newscenter/stories/2010/11/doctors-flee-illinois.html>. Accessed Feb. 22, 2022.

12. 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.

13. Perry, J.J, Clark, C. *Medical Malpractice Liability and Physician Migration*. *Bus Econ*. 2012;47(3):202-213.

14. Matsa, DA. *Does Malpractice Liability Keep the Doctor Away? Evidence from Tort Reform Damage Caps*. *J Legal Stud*. 2007;36(2):143-182.

15. Klick, J, Stratmann T. *Medical Malpractice Reform and Physicians in High Risk Specialties*. *J Legal Stud*. 2007;36(2):121-139.

16. Helland E, Showalter MH. *The Impact of Liability on the Physician Labor Market*. *Journal of Law and Economics*. 2009; 52(4):635-663.

17. Kessler DP, Sage WM, Becker DJ. *Impact of Malpractice Reforms on the Supply of Physician Services*. *JAMA*. 2005;293(21):2618-2625.

18. *Direct reforms include caps on economic, noneconomic, or total damages, abolition of punitive damages, no mandatory prejudgment interest, and collateral source rule reform.*

19. Encinosa WE, Hellinger FJ. *Have State Caps On Malpractice Awards Increased The Supply Of Physicians?* *Health Aff*. 2005; W5-250-W5-258.

2010.²⁰ 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.

A 2006 literature review by the Robert Wood Johnson Foundation reached a similar conclusion to the research summarized above. It concluded that, the best studies suggest that caps are associated with a small increase in physician supply.²¹

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.²² The same research showed that in terms of compensation for medical errors, the system “gets it wrong” about equally on 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.²³

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 \$635,829.²⁴ 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 \$30,439.²⁵ 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.²⁶

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 2020 were \$5.6 billion—an increase of over \$1 billion from 2018, and defense costs were an additional \$2.9 billion.²⁷ 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.²⁸ 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

20. 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.

21. Mello MM. Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms, The Robert Wood Johnson Foundation, Research Synthesis Report No. 10. 2006.

22. Studdert DM, Mello MM, Gawande AA. Claims, Errors, and Compensation Payments in Medical Malpractice Litigation. *N Engl J Med* 2006;354(19):2024–2033.

23. Weiler PC. *A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation*. Cambridge, MA: Harvard University Press; 1993.

24. Medical Professional Liability Association. 2019. Data Sharing Project MPL Closed Claims 2016-2018 Snapshot.

25. Medical Professional Liability Association. 2019. Data Sharing Project MPL Closed Claims 2016-2018 Snapshot.

26. Medical Professional Liability Association. 2019. Data Sharing Project MPL Closed Claims 2016-2018 Snapshot and AMA’s calculations from data in that report.

27. National Association of Insurance Commissioners (NAIC). Report on Profitability by Line by State in 2020. 2021. <https://content.naic.org/sites/default/files/publication-pbl-pb-profitability-line-state.pdf> Accessed Jan 26, 2022. 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.

28. 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.

considerable savings could be had if the costs of dispute resolution were lowered.²⁹

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.³⁰ 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.

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 1990.³¹ They compared those expenditures in states with direct, indirect or no tort reforms.³² 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.³³ 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 1994.³⁴ 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.

29. Seabury S, Chandra A, Lakdawalla D. Defense Costs of Medical Malpractice Claims. *N Engl J Med*. 2012;36:1354–1356.

30. 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).

31. Kessler DP, McClellan M. Do Doctors Practice Defensive Medicine? *Q J Econ*. 1996;111(2):353-390.

32. 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.

33. The 5% reduction was for AMI; 9% for IHD.

34. 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.

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 90.³⁵ 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.

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.³⁶ 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 1983.³⁷ 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.³⁸ 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 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.³⁹ Baicker, Fisher and Chandra (2007)⁴⁰ 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.⁴¹ 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.⁴² 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 climate (including the direct impact

35. 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.

36. U.S. Congressional Budget Office. Medical Malpractice Tort Limits And Health Care Spending, Background Paper (Washington, DC: U.S. Congressional Budget Office, April 2006).

37. 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.

38. 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).

39. When the authors looked at premiums as a measure of liability pressure rather than indemnity payments, their results were similar.

40. Baicker K, Fisher ES, Chandra A. Malpractice Liability Costs and the Practice of Medicine in the Medicare Program. *Health Aff.* 2007;26:841–852.

41. 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.

42. Roberts B, Hock I. Malpractice Litigation and Medical Costs in Mississippi. *Health Econ.* 2007;16(8):841–859.

of payouts to plaintiffs on health care costs).⁴³ 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.⁴⁴ 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.⁴⁵ 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.⁴⁶ 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%.⁴⁷

Finally, Frakes and Gruber (2019) exploit liability rules in the Military Health System to estimate the extent of defensive medicine. Since active-duty patients receiving treatment at military facilities cannot sue for harm arising from adverse events, Frakes and Gruber (2019) compare the treatment intensity and patient outcomes of this legal immunity group to those of patients who are able to sue—dependents treated at military facilities as well as all patients, active duty or not—receiving care from civilian facilities. They find suggestive evidence that legal immunity reduces inpatient spending by 5% with no measurable negative effect on patient outcomes.

43. 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).

44. 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.

45. Thomas WJ, Ziller EC, Thayer DA. Low Costs of Defensive Medicine, Small Savings From Tort Reform. *Health Aff*. 2010;29:1578–1584.

46. 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.

47. 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).

This evidence is consistent with the practice of defensive medicine.⁴⁸

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 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).⁴⁹

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.⁵⁰ 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.⁵¹

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.⁵²

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.⁵³ Thirty-nine percent said the medical liability environment was a factor in their choice of state in which to complete residency training.⁵⁴ 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.⁵⁵

48. Frakes, M, Gruber, M. Defensive Medicine: Evidence from Military Immunity. *American Economic Journal: Economic Policy*.2019;11(3):197-231.

49. Anderson RE. Commentaries Defending the Practice of Medicine. *Arch Int Med*. 2004;164(11):1173-8.

50. Am. Hosp. Ass'n., Prof'l Liability Ins. Survey (2003).

51. Wilson N, Strunk AL. Overview of the 2006 ACOG Survey on Professional Liability. *ACOG Clinical Review*. 2007;12(2):1–16.

52. Meritt, Hawkins & Assoc., Summary Report: 2003 Survey of Final Year Med. Residents 5 (2003).

53. AMA Division of Market Research & Analysis. AMA Survey: Med. Students' Opinions of the Current Medical Liability Environment. 2003.

54. Id.

55. Id.

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.⁵⁶ More than three-fourths (76%) of physicians believed that concern about medical liability litigation negatively affected their ability to provide quality care.⁵⁷ Fear of medical liability suits caused some emergency room physicians to order more hospitalizations and medical tests than other emergency room doctors.⁵⁸

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).⁵⁹

Premiums after the last crisis

After the crisis, a growing number of premiums started to decrease.⁶⁰ 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 2022.⁶¹ This was the highest proportion observed since 2005.

According to some actuaries, we were already in the early stages of a hard market—a period of increasing premiums—in 2020. They expected that insurers would sustain or even push for higher premiums in 2021.⁶² The 2021 and 2022 MLM data indicate that this is coming to fruition.⁶³ The average change in premiums across the nation was 2.5% in 2022—up from 1.0% in 2020. Among premium increases, the average increase was 8.1% in 2022, which was higher than the 6.3% observed in 2020. There were 15 states where at least some of the premiums reported increased by 10% or more—up from 12 such states in 2021. Smaller increases in premiums were more widespread as they were observed in 38 states in 2022. 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 64.3%, 80.6% and 90.7% of its premiums increased respectively in each of the last three years. 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.

56. Harris Interactive Inc. Common Good, Common Good Fear of Litigation Study: The Impact on Med. 65. 2002.

57. 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).

58. Malpractice Fears Guide Behavior of Some ER Physicians, Study Says. Health Care Daily. July 13, 2005.

59. <https://www.bizjournals.com/southflorida/stories/2005/05/09/story6.html>. Accessed Feb. 22, 2022.

60. 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.

61. 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.

62. Burns B., Gittleman A. Rate Increases – Just What the Doctor Ordered. Medical Professional Liability in 2020. *Medical Liability Monitor*, Annual Rate Survey Issue, Vol. 45 (10). October 2020.

63. 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.

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 will become is still uncertain; hence, the next editions of the MLM data are awaited with great anticipation.

Crisis states during this period

During the last crisis, the AMA identified the following states as crisis states: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Washington, West Virginia and Wyoming. Premiums were increasing in these states; patients were losing access to health care, and physicians were struggling to stay in practice.

For example, between 2000 and 2004, liability premiums for some ob-gyns (i) almost doubled in New Jersey and some areas in Florida and Illinois,

(ii) more than doubled in Connecticut, and (iii) more than quadrupled in some areas of Pennsylvania.⁶⁴ More than 1,600 Florida physicians gave sworn statements to a state Senate panel in August 2003 detailing how the state's medical liability crisis forced them to change their practices, including no longer providing services such as delivering babies and performing complex surgeries.⁶⁵ The only Level 1 trauma center in Las Vegas had to close temporarily due to skyrocketing liability premiums.⁶⁶ And in Philadelphia, the city lost 11 maternity wards between 1997 and 2007, with the *Philadelphia Inquirer* citing liability concerns as one of the main reasons for these closures.⁶⁷ The last liability crisis was very detrimental to patients and to physicians, and the AMA is advocating on behalf of patients and physicians constantly to prevent a recurrence of this event.

64. Guardado J. Medical Professional Liability Insurance Premiums: Changes and Levels, 2004-2009. Chicago, IL: American Medical Association; 2009. Policy Research Perspectives No. 2009-5.

65. Florida Medical Association.

66. PR Newswire, April 21, 2003.

67. Burling S. Demise of Maternity Wards is Inducing the Baby Scramble. *Philadelphia Inquirer*. May 6, 2007.

Medical professional liability insurance premiums for \$1M/\$3M policies, 2000–2004

| Obstetrics/gynecology | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|-------------|-------------|-------------|-------------|-------------|
| California (Los Angeles, Orange) | 52,874 | 52,874 | 54,563 | 60,259 | 63,272 |
| Connecticut | 63,292 | 77,533 | 94,978 | 123,470 | 148,164 |
| Florida (Miami-Dade) | 147,621 | 166,368 | 201,376 | 249,196 | 277,241 |
| Illinois (Cook, Madison, St. Clair, Will) | 78,880 | 88,928 | 102,640 | 139,696 | 147,540 |
| New Jersey | 68,000 | 68,000 | 70,720 | 102,643 | 128,304 |
| New York (Nassau, Suffolk) | 115,429 | 115,429 | 115,431 | 123,853 | 133,787 |
| Pennsylvania (Philadelphia, Delaware) | 37,556 | 45,938 | 100,045 | 134,335 | 161,211 |
| Texas (Brownsville, Laredo, El Paso) | 73,660 | 91,894 | 92,326 | 92,326 | 81,247 |
| General surgery | | | | | |
| California (Los Angeles, Orange) | 32,507 | 32,507 | 36,740 | 45,421 | 54,505 |
| Connecticut | 32,651 | 34,283 | 36,854 | 42,385 | 57,220 |
| Florida (Miami-Dade) | 110,068 | 124,046 | 174,268 | 226,542 | 277,241 |
| Illinois (Cook, Madison, St. Clair, Will) | 52,364 | 59,016 | 68,080 | 92,576 | 102,700 |
| New Jersey | 32,333 | 38,800 | 41,516 | 58,786 | 63,489 |
| New York (Nassau, Suffolk) | 62,733 | 62,733 | 65,870 | 74,211 | 80,163 |
| Pennsylvania (Philadelphia, Delaware) | 33,684 | 35,793 | 82,157 | 108,038 | 128,524 |
| Texas (Brownsville, Laredo, El Paso) | 50,911 | 67,555 | 71,200 | 71,200 | 62,656 |
| Internal medicine | | | | | |
| California (Los Angeles, Orange) | 10,097 | 10,097 | 11,164 | 12,493 | 14,237 |
| Connecticut | 7,736 | 9,863 | 13,820 | 21,420 | 28,917 |
| Florida (Miami-Dade) | 32,744 | 38,378 | 56,153 | 65,697 | 69,310 |
| Illinois (Cook, Madison, St. Clair, Will) | 19,604 | 22,060 | 26,404 | 35,756 | 38,424 |
| New Jersey | 11,359 | 12,495 | 13,620 | 20,893 | 23,818 |
| New York (Nassau, Suffolk) | 21,648 | 21,648 | 21,648 | 23,228 | 25,091 |
| Pennsylvania (Philadelphia, Delaware) | 7,390 | 7,853 | 18,429 | 24,546 | 27,505 |
| Texas (Brownsville, Laredo, El Paso) | 18,783 | 25,563 | 26,334 | 26,334 | 23,174 |

The dollar amounts in the table are examples of manual premiums for professional liability insurance that were reported in the “2001–2004 Annual Rate Survey” (October) issue of the Medical Liability Monitor (MLM). This table is an excerpt from a 2009 AMA report on MLM premiums.* It does not include all the rates reported for the geographic areas in the table, nor does it include the premiums paid by physicians in other areas of the country, which may be higher or lower. These rates reflect the manual rates for one of the state’s market share leaders. The MLM reports that these rates do not reflect credits, debits, dividends or other factors that may reduce or increase the actual rates charged to physicians. The AMA alone is responsible for the accuracy of the information in the table and believes the rates listed are a reasonable benchmark to demonstrate professional liability insurance trends for select specialties in certain geographic areas. Connecticut 2003–2004 rates are for \$1 million/\$4 million limits, and New York 2004 rates are for \$1.3 million/\$3.9 million limits. Pennsylvania premiums include PCF surcharges. To obtain the MLM survey or to verify its accuracy, visit mlmonitor.com or call (312) 944-7900.

* The MLM data were summarized by Guardado JR. in Medical Professional Liability Insurance Premiums: Changes and Levels, 2004–2009. Chicago, IL: American Medical Association, 2009. Policy Research Perspectives No. 2009-5.



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.⁶⁸

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.⁶⁹ 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.⁷⁰ 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.⁷¹ 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 ultimate⁷² 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.⁷³ 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 incurred⁷⁴ 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, Morrissey 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.⁷⁵ 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 authors found that every \$100,000 increase in a cap

68. Also see footnote 12 for two AMA reports that provide more lengthy and detailed summaries of these and related research papers.

69. 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.

70. Thorpe KE. The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms. *Health Aff*. 2004;W4-20-W4-30.

71. Viscusi WK, Born PH. Damage Caps, Insurability, and the Performance of Medical Malpractice Insurance. *J Risk and Ins*. 2005;72(1):23–43.

72. The ultimate loss on a claim is the known amount that is actually paid out after a claim has closed.

73. 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.

74. The incurred loss on a claim is the *estimated* amount that will be paid out on a claim once it has closed.

75. Kilgore ML, Morrissey MA, Nelson LJ. Tort Law and Medical Malpractice Insurance Premiums. *Inquiry*. 2006;43:255–270.

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.⁷⁶ 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 2010.⁷⁷ 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.

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.”⁷⁸ 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.”⁷⁹ 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.⁸⁰

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%.⁸¹ 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 2029.⁸²

Finally, a 2006 literature review by the Robert Wood Johnson Foundation concluded that, “Overall, caps appear to be associated with a 23% to 31%

76. 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.

77. 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.

78. 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.

79. 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.

80. 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.

81. 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

82. 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

reduction in average awards,” and that, “the most recent controlled studies show that caps moderately constrain the growth of premiums.”⁸³



Public support for medical liability reform

The American public supports MLR. Numerous polls have confirmed this support.

- A February 2003 Gallup poll showed that 72% of Americans supported limiting the amount patients can be awarded for “pain and suffering.”
- In a 2006 Harris Interactive poll, 76% of those surveyed favored a law that would guarantee an injured patient full payment for lost wages and medical expenses and place reasonable limits on awards for “pain and suffering” in medical liability cases. Three-quarters of the Americans surveyed said they wanted their elected representatives in Washington to support comprehensive MLR.
- An October 2009 National Quorum poll found that 62% of those surveyed wanted federal representatives to support comprehensive MLR; 72% believed that affordable, high-quality care was at risk because of medical liability costs; 70% supported full payment for lost wages and medical expenses and reasonable limits on noneconomic damages, and 64% believed that medical liability lawsuits were a primary reason for rising health care costs.
- A December 2009 Rasmussen Reports poll found that 57% of voters nationwide favored limiting the amount of money a jury can award a plaintiff in a medical liability suit.
- A December 2009 Associated Press poll conducted by Stanford University found that 54% of Americans supported limits on medical liability lawsuits while only one-third indicated that they were opposed. The support for MLR was strong across political affiliation—58% of independents, 61% of Republicans and 47% of Democrats favored making it more difficult to sue.

83. Mello MM. Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms. The Robert Wood Johnson Foundation; 2006. Research Synthesis Report No. 10.

State efforts to enact caps on noneconomic damages



Background

As of January 2023, 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, and only a handful of the state caps are as strong as those in California and Texas.

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. Recognizing the limitations of a soft cap, several states, such as Alaska and Mississippi, have enacted legislation to strengthen their caps. Likewise, Nevada voters adopted a ballot initiative in 2004 to replace a cap riddled with exceptions with a hard cap of \$350,000 on noneconomic damages. A cap on noneconomic damages that is set too high will also have a limited effect. For example, prior to modifying legislation in 2003, West Virginia had a \$1 million cap on noneconomic damages, which was too high to be effective.

State caps on noneconomic damages enacted since 2000

Alaska

In Alaska, Gov. Frank Murkowski signed into law Senate Bill (S.B.) 67 on June 7, 2005. The legislation strengthened Alaska's existing cap on noneconomic damages by establishing 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.⁸⁴ 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.

Florida

After four special sessions, Florida's legislature enacted S.B. 2-D, which was signed into law by Gov. Jeb Bush on Aug. 14, 2003. In its final form, the bill did not provide the level of reforms advocated by Gov. Bush's task force or by the Florida Medical Association (FMA). In particular, the language on noneconomic damages and exceptions to the cap added during late stages of negotiations prohibited the FMA from supporting the legislation in its final form.⁸⁵

S.B. 2-D 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.

84. 80. Alaska Stat. § 09.55.549.

85. Fla. Stat. § 766.118.

In April 2006 Gov. Bush also signed legislation that repealed the doctrine of joint and several liability. Joint and several liability permits a disproportionate level of liability to be assessed to a party regardless of their level of fault in a matter, such that a defendant can be held liable for the entire amount of damages even if only marginally responsible for an injury.⁸⁶

Georgia

On Feb. 16, 2005, Gov. Sonny Purdue signed into law S.B. 3.⁸⁷ The new law established 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 \$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.⁸⁸

Idaho

On March 26, 2003, Gov. Dirk Kempthorne signed into law H.B. 92 that included a \$250,000 cap on noneconomic damages (Idaho previously had a \$400,000 cap on noneconomic damages that adjusted annually for inflation since 1988). The new cap also adjusts annually for inflation based on the average annual wage as of July 1, 2004. The cap does not apply to causes of action arising out of willful or reckless misconduct or felonious actions.⁸⁹

Iowa

On May 5, 2017, Iowa Gov. Terry Branstad signed into law Senate File 465, which included a \$250,000 cap on noneconomic damages. An amendment to the law added by Iowa's House lifted the cap for cases involving permanent impairment, substantial disfigurement or wrongful death. The law also modified Iowa's expert witness standards,

86. Gov. Bush Signs Important Fla. Tort Reform Legislation, *Ins J.* 2006. <https://www.insurancejournal.com/news/southeast/2006/04/27/67621.htm> Accessed Feb. 22, 2022.

87. Ga. Code Ann. § 51-13-1.

88. *Atlanta Oculoplastic Surgery v. Nestlehutt, et al.* 691 S.E.2d 218 (Ga. 2010)

89. Idaho Code Ann. § 6-1603.

established certificate of merit requirements, and broadened the category of “health care providers” the law encompasses.⁹⁰

Illinois

On Aug. 25, 2005, Gov. Rod Blagojevich signed into law an MLR bill that included a \$500,000 cap on noneconomic damages⁹¹ for awards in a medical liability cause of action (including wrongful death) against a physician, the physician’s business or corporate entity, and the physician’s employees or other health care professionals. The new law also established a separate \$1 million cap on noneconomic damages for awards in a medical liability cause of action (including wrongful death) against a hospital and its personnel or hospital affiliates. Both caps applied to all plaintiffs in any civil action arising out of the care at issue. The caps applied to injuries that occurred after the effective date of the act. The Illinois cap was also struck down in 2010.⁹²

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.⁹³ In 2021, the Kansas Supreme Court ruled that this cap was unconstitutional with respect to personal injury cases.⁹⁴

Maryland

Enacted in January 2005, Maryland’s H.B. 2 (2004) established a separate cap on noneconomic damages 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 began to increase \$15,000 each year.⁹⁵ The cap applies in aggregate to all claims and all defendants arising from the same medical injury. (The cap also applies in wrongful death actions if the claim involves only one claimant or beneficiary). For wrongful death claims involving two or more claimants or beneficiaries, the total cap on noneconomic damages in 2021 was \$845,000.

Maine

Maine’s cap on noneconomic damages in wrongful death actions was originally enacted in 1997 but amended in 2019 (L.D. 841) to raise the cap from \$500,000 to \$750,000. Damages are payable to the estate of the deceased person only if the jury specifically makes an award payable for reasonable expenses of medical, surgical, and hospital care and treatment, and for reasonable funeral expenses. Maine also has a \$250,000 cap on punitive damages.⁹⁶

Mississippi

On June 3, 2004, the Mississippi Legislature enacted H.B. 13, a civil justice reform bill that further strengthened Mississippi’s MLR laws. Most importantly, the bill created a hard \$500,000 cap on noneconomic damages for medical liability causes of action filed against a health care provider. This provision deleted exceptions to the original 2002 law, as well as scheduled increases to the cap.⁹⁷

Missouri

On May 7, 2015, Gov. Jay Nixon signed into law S.B. 239, which reinstated Missouri’s cap on noneconomic damages. With passage of S.B. 239, 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.⁹⁸ Both are subject to an annual index of 1.7% for inflation, and the cap applies irrespective of the number of defendants. In 2021, the caps were set at \$442,574 and \$774,504 respectively.⁹⁹ In July 2021, the Missouri Supreme Court upheld the constitutionality of the noneconomic caps in the 2015 law.¹⁰⁰ The Missouri cap was previously struck down in 2012.¹⁰¹

Nevada

As a result of the passage of the “Keep Our Doctors in Nevada” initiative in 2004, Nevada has a \$350,000 cap on noneconomic damages in medical liability cases.¹⁰²

In August 2002, Nevada enacted A.B. 1, which, in part, established a \$50,000 cap on civil damages

90. Iowa Code § 147.136A; Iowa Code § 147.139; and Iowa Code § 135P.1.

91. 735 Ill. Comp. Stat. 5/2-1706.5 (now repealed).

92. *Lebron v. Gottlieb Mem’l Hosp., et. al.* 930 N.E.2d 895 (Ill. 2010)

93. Kan. Stat. Ann. 60-19a02.

94. *Hilburn v. Enerpipe*, 442 P.3d 509 (Kan. 2019)

95. Md. Code Ann., Cts. & Jud. Proc. § 3-2A-09.

96. Maine Revised Statutes 18C §2-807.

97. Miss. Code Ann. § 11-1-60.

98. Mo. Rev. Stat. § 538.210.

99. See <https://insurance.mo.gov/industry/medmal.php>

100. *Ordinola v. Univ. Physician Associates*, 625 S.W.3d 445, 453 (Mo. banc 2021)

101. *Watts v. Lester E. Cox Med. Ctr.*, 376 S.W.3d 633 (Mo. 2012)

102. Nev. Rev. Stat. § 41A.031

for claims arising from care necessitated by a traumatic event demanding immediate attention that is rendered in good faith to a patient who enters the hospital through the emergency room or trauma center. This limit does not apply to any act or omission in rendering care or assistance that occurs after the patient is stabilized (unless surgery is required within a reasonable time after the patient is stabilized) that is unrelated to the original traumatic injury, or that arose out of gross negligence or reckless, willful or wanton conduct.¹⁰³

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.

North Carolina

On July 25, 2011, the North Carolina General Assembly overrode a gubernatorial veto of S.B. 33. S.B. 33 included a cap on noneconomic damages for medical liability actions (including actions for personal injury or death), but it did not limit the recovery of economic damages. Under this legislation, the total amount of noneconomic damages that can be awarded against all defendants cannot exceed \$500,000. Further, noneconomic damage awards cannot exceed \$500,000 against individual defendants for all claims brought by all parties arising out of the same professional services. Under the bill, the cap is indexed for inflation on Jan. 1 of every third year, beginning with Jan. 1, 2014, and 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.¹⁰⁴

Ohio

On Jan. 10, 2003, Gov. Robert Taft signed into law S.B. 281, an MLR bill to address the growing crisis in Ohio. Among other provisions, the bill established 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 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.¹⁰⁵

Oklahoma

On April 5, 2011, Gov. Mary Fallin signed H.B. 2128. The act established a cap on noneconomic damages in Oklahoma. The act became effective on Nov. 1, 2011 and applied to all civil actions filed on or after this date. Under the law, in any civil action arising from a claim for bodily injury, the amount of compensation that the trier of fact could award a plaintiff for economic loss could not be subject to any limitation. However, in such actions, a trier of fact could award a plaintiff a maximum of \$350,000 for noneconomic damages, regardless of the number of parties against whom the action was brought or the number of actions brought. There was no limit on the amount of noneconomic damages that could be awarded in a claim for bodily injury resulting from negligence if a judge and jury found, by clear and convincing evidence, that the defendant's acts or failures to act were:

- In reckless disregard for the rights of others
- Grossly negligent
- Fraudulent
- Intentional or with malice

The law did not apply to actions brought under the Governmental Tort Claims Act or to actions for wrongful death.¹⁰⁶

In 2019, however, the Oklahoma Supreme Court held that Oklahoma's cap on noneconomic damages was unconstitutional.¹⁰⁷

103. *Id.* at § 41.503

104. N.C. Gen. Stat. § 90-21.19

105. Ohio Rev. Code Ann. § 2323.43.

106. Oklahoma House Bill 2128 (2011)

107. *Beason v. I. E. Miller Servs., Inc.*, 441 P.3d 1107 (Okla. 2019)

South Carolina

Signed into law by Gov. Mark Sanford on April 4, 2005, S.B. 83 established a \$350,000 cap on noneconomic damages¹⁰⁸ in a medical liability action against a single health care provider or single health care institution. If the award is against more than one health care provider or more than one institution, the total award for noneconomic damages cannot exceed \$1.05 million, with each defendant not liable for more than \$350,000. The cap applies separately to each claimant and adjusts annually based on an increase or decrease in the Consumer Price Index.

Tennessee

On June 16, 2011, Gov. Bill Haslam signed the Tennessee Civil Justice Act of 2011 (H.B. 2008/S.B. 1522). The bill established 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.¹⁰⁹

108. S.C. Code Ann. § 15-32-220.
109. Tenn. Code Ann. § 29-39-102

Texas

On June 11, 2003, Gov. Rick Perry signed H.B. 4 into law. The bill contained sweeping tort reforms, many of which exclusively address medical liability litigation against physicians. Of these reforms, perhaps the most important is the hard cap of \$250,000 on 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. The law also places a hard cap of \$250,000 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.¹¹⁰ 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.

The law states that 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. The law also states 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

110. Tex. Civ. Prac. & Rem. Code Ann. § 74.301.

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 laws that place limits on noneconomic damages in medical and health liability cases.¹¹¹

The final vote was 51.1% in favor of Proposition 12 and 48.9% against.¹¹²

Utah

On March 23, 2010, Gov. Gary Herbert signed S.B. 145, which contained three amendments to Utah’s Health Care Malpractice Act.¹¹³ The amendments included a \$450,000 hard cap on noneconomic damages. Under the bill, in a liability action against a health care provider, an injured plaintiff may recover noneconomic losses to compensate for pain, suffering and inconvenience. The amount of damages awarded for noneconomic loss may not exceed \$450,000 for causes of action arising on or after May 15, 2010. The previous, inflation-adjusted cap stayed in effect for causes of action arising between July 1, 2002, and May 14, 2010.

West Virginia

On March 11, 2003, Gov. Bob Wise signed into law H.B. 2122. As enacted, the bill contained a number of reforms including 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.¹¹⁴

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 that surgery is required as a result of the patient’s emergency condition.

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

If the physician who provided care to the patient when the patient was presented with an emergency condition provides follow-up care to the same patient and a medical condition arises during the course of this follow-up care that is directly related to the original emergency condition, there is a rebuttable presumption that the medical condition was the result of the original emergency condition and, therefore, the cap applies. There is also a

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

112. Tex. Const. Art. III, § 66

113. Utah Code Ann. § 78B-3-410.

114. W. Va. Code § 55-7B-8.

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

On March 22, 2006, Gov. Jim Doyle signed A.B. 1073. This law limits noneconomic damages in medical liability cases to \$750,000¹¹⁵ for each occurrence. The bill 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.

A.B. 1073 came in response to a Supreme Court of Wisconsin decision in 2005 that struck down the state's previous cap on noneconomic damages.¹¹⁶

Results from the states

California's solution: MICRA

In 1975 California enacted the Medical Injury Compensation Reform Act (MICRA), which largely eliminates the lottery aspect of medical liability litigation in that state. California's experience with MICRA shows that MLR works. 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%¹¹⁷ According to the National Association of Insurance Commissioners, while total direct premiums earned in the rest of the United States rose by 854% between 1976 and 2020, the increase in California premiums was 30% of that amount (257%).¹¹⁸

According to HHS, "The percentage of claims resolved through settlement and arbitration has increased in California, saving money for injured patients,"¹¹⁹ and "premiums for specialists in Los Angeles are substantially less than for specialists in metropolitan areas in states without reforms such as Florida, Illinois and Nevada."¹²⁰ For example, an obstetrician/gynecologist in Los Angeles might pay \$49,804 per year for liability insurance while the same obstetrician/gynecologist could pay \$186,772 in New York.¹²¹

In 2022, California enacted A.B. 35, MICRA Modernization legislation, which passed through the California Legislature with nearly unanimous support. Previously, MICRA limited recovery of noneconomic damages to \$250,000, regardless of the number of defendants. The new law increased the existing limit 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. The new law also creates 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 non-economic damages, the new law makes adjustments to periodic payments and limits on attorney contingency fees and establishes a new statute that ensures protections for benevolent gestures and statements of fault by health care providers. At

115. Wis. Stat. § 893.55

116. *Ferdon ex rel. Petrucelli v. Wis. Patients Comp. Fund*, 701 N.W.2d 440 (Wis. 2005).

117. Pace NM, Golinelli D, Zakaras L. Capping Noneconomic Awards in Medical Malpractice Trials xxiv. RAND Corp: 2004.

118. National Association of Insurance Commissioners (NAIC). Report on Profitability by Line by State in 2020. 2021. <https://content.naic.org/sites/default/files/publication-pbl-pb-profitability-line-state.pdf>. Accessed Jan. 31, 2022.

119. Office of the Assistant Sec'y for Planning and Evaluation. Update on the Medical Litigation Crisis: Not the Result of the "Insurance Cycle." Office of the Assistant Sec'y for Planning and Evaluation, U.S. Dep't of Health and Human Services; 2002. [hereinafter Insurance Cycle]

120. Id.

121. *Medical Liability Monitor* (October 2010). Note: California – \$1 million/\$3 million limits; New York – \$1.3 million/\$3.9 million limits.

the request of either party, periodic payments can be used for future economic damages starting at \$250,000 (presently at \$50,000). A.B. 35 also creates 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 civil complaint being filed or arbitration demand being made; 33% contingency fee limit for claims resolved **after** civil complaint is filed or arbitration demand is made.

Finally, A.B. 35 establishes 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.

A.B. 35 was supported by a broad and diverse coalition—including physicians, the California Medical Association, community health centers, dentists, hospitals, nurses and hundreds of other organizations dedicated to affordable, accessible health care. The willingness of all to work together on this historic compromise was noted and appreciated.

Illinois

In 2010 the Illinois Supreme Court ruled that the state's cap on noneconomic damages was unconstitutional.¹²² This was a highly disappointing decision based on the positive results stemming from the 2005 law. According to the Illinois Department of Insurance, the state saw these results after the 2005 law:

- A decrease in medical malpractice premiums—gross premium paid to medical malpractice insurers declined from \$606,355,892 in 2005 to \$541,278,548 in 2008
- An increase in competition among companies offering medical malpractice insurance—in 2008, 19 companies offering coverage to physicians/surgeons each collected more than \$500,000 in premiums, an increase over 14 such companies in 2005
- Entry into Illinois of new companies offering

medical malpractice insurance—in 2008, five companies collected more than \$22,000,000 in combined physicians/surgeons premiums (and at least \$1,000,000 each in premiums)—that did not offer medical malpractice insurance in 2005¹²³

According to Milliman Inc., Illinois medical liability carriers faced an 18% jump in costs based on this ruling.¹²⁴

Mississippi

In Mississippi, the Mississippi State Medical Association reports that the liability climate has improved significantly since the enactment of MLR. Liability premiums decreased for the largest liability carrier by 5% in 2006, 10% in 2007, 15.5% in 2008, 20% in 2009 and 10% in 2010. Insured physicians also received significant refunds during this time period as well. This is in stark contrast to the crisis years when premiums increased 12.5% in 2000, 11.1% in 2001, 10% in 2002, 45% in 2003 and 19.4% in 2004.¹²⁵

An article based on data from the Medical Assurance Company of Mississippi (MACM) also shows that the Mississippi reforms have had a beneficial impact. It concluded that the average number of lawsuits per year against MACM-insured physicians dropped 56% (from 318 to 140) from the five-year period that preceded the reforms to the five-year period that followed them.¹²⁶

Missouri

According to the Missouri State Medical Association, since 2005 when Missouri's MLR provisions went into effect:

- The number of claims filed fell 61.6% (67.2% in the physician sector).
- The number of claims open at year end fell 47.1% (48.2% for physicians).
- The average indemnity fell 22.1%.
- The insurance industry's total losses fell 31.9%, and incurred losses fell 69.9%.
- Defense expenses fell 54.2%.
- In the three years leading up to tort reform,

123. Illinois Department of Insurance—Press Release Feb. 20, 2010.

124. Illinois Med-Mal Ruling to Boost Insurers' Costs 18%. *Crain's*. Feb. 22, 2010. <https://www.chicagobusiness.com/article/20100222/NEWS03/200037194/illinois-med-mal-ruling-to-boost-insurers-costs-18-study>. Accessed Feb. 22, 2022.

125. Mississippi State Medical Association Correspondence – 2010.

126. Behrens MA. Medical Liability Reform: A Case Study of Mississippi. *Obstet Gynecol.* 2011;118(2):335–339.

122. *Lebron v. Gottlieb Mem'l Hosp., et. al.* 930 N.E.2d 895 (Ill. 2010).

Missouri lost 225 physicians. Since the first full year of MLR, the state added 486 new licensed physicians.

- One new mutual company and two new stock companies entered the Missouri market since MLR was enacted.
- Medical Liability Alliance announced a 6% across-the-board rate reduction in July 2007; PPIA implemented a 14% reduction in base rates in Jan. 1, 2008, and some stock companies offered as much as 50% in credits over their filed rates in some instances.
- Despite gaining nearly 500 physicians, Missouri saw a \$13 million decrease in medical liability insurance premiums between 2006 and 2008. And for all health care providers, the reduction was \$25.7 million.¹²⁷
- However, as noted above, the Supreme Court of Missouri struck down this cap and in 2015 Missouri enacted a statutory \$400,000 cap on noneconomic damages and a higher cap of \$700,000 for catastrophic personal injury or death. Both are subject to an annual index of 1.7% for inflation.

Nevada

Nevada reforms have stabilized Nevada's liability climate. One example is the Independent Nevada Doctors Insurance Exchange, which lowered its premiums for internists and surgeons by more than 20% in 2007.¹²⁸ Rates have held steady since this decrease.

Ohio

In Ohio, a 2011 study of medical professional liability claims found that:

- Medical liability lawsuits in the state were down 41% since 2005
- Since 2006 premium rates decreased 31%
- Ohio had 15 liability carriers in 2011—an increase from five in 2003¹²⁹

In addition, 75% of the claims closed in Ohio in 2011 were closed without payment.¹³⁰

Texas

The liability climate in Texas has improved dramatically since the passage of Proposition 12 and the state's 2003 landmark liability reforms. According

to the Texas Medical Association¹³¹:

- The Texas physician workforce outpaced population growth.
- Texas added nearly 10,354 more physicians with in-state licenses than could be accounted for by population growth. This growth rate in the physician workforce produced the opportunity for 36.7 million more patient visits per year than likely would have occurred absent tort reform.
- The number of geriatricians more than doubled.
- The ranks of rural obstetricians grew nearly twice as fast as the state's rural population.
- Twenty-eight rural Texas counties added at least one obstetrician, including 11 counties that previously had none.
- Forty rural counties that did not have an emergency medicine physician had one.
- Nineteen counties that did not have a cardiologist had one. Fourteen of those counties were rural.
- Twenty-nine rural counties added at least one general surgeon, and 10 counties added their first general surgeon.
- Five Texas counties added their first neurosurgeon. Two of those counties were rural.

An article based on data from an academic medical center also showed that the Texas tort reforms had a beneficial impact. According to that data, the prevalence of lawsuits filed per 100,000 general surgery procedures decreased from 40 before reform to eight after reform. Liability and defense costs per year in the general surgery group were reported to have fallen from \$595,000 per year before tort reform to only \$515 per year after tort reform.¹³²

Some groups voiced concerns that caps on noneconomic damages had a disproportionate effect on the elderly. A 2011 working paper by researchers typically opposed to tort reform found that is not the case. Based on Texas closed claim data, the authors concluded that after 2003, there was a similar drop in claims and payouts per claim for elderly and non-elderly adults.¹³³

131. Texas Medical Association. Proposition 12 Produces Healthy Benefits. <https://app.texmed.org/tma.archive.search/5238.html>. Accessed Feb.22, 2022.

132. Stewart RM, Geohegan K, Myers JG. Malpractice Risk and Cost Are Significantly Reduced after Tort Reform, 212. *J Am Coll Surg*. 2011;212:463–467.

133. Paik M. How Do the Elderly Fare in Medical Malpractice Litigation, Before and After Tort Reform? Evidence from Texas, 1988–2007. Institute for Policy Research Northwestern University, Working Paper Series WP-11-03. <https://www.ipr.northwestern.edu/our-work/working-papers/2011/ipr-wp-11-03.html#:~:text=During%20the%20pre%2Dreform%20period,of%20the%20adult%20nonelderly%20rate.&text=Thus%2C%20although%20tort%20reform%20had,disparate%20impact%20on%20the%20elderly>. Accessed Feb. 22, 2022.

127. Missouri State Medical Association Correspondence – 2010

128. *Medical Liability Monitor*. Rate Survey Edition. October 2007.

129. Ohio Department of Insurance. Ohio 2011 Medical Professional Liability Closed Claim Report. <https://insurance.ohio.gov/about-us/reports>. Accessed Feb. 22, 2022.

130. Id.

West Virginia

Results have been positive for West Virginia physicians since its reforms were enacted, too. According to the West Virginia Offices of the Insurance Commissioner, as award values became more predictable and claims dropped, insurance rates declined.¹³⁴ The average premium dropped from \$40,034 in 2004 to \$24,959 in 2011.¹³⁵ Further, the state saw an increase in the number of licensed physicians from 5,182 in 2003 to 6,282 in 2013.¹³⁶



Successful ballot initiatives

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

Florida

Voters approved constitutional Amendment 3, stating that an injured claimant who enters into a contingency-fee agreement with an attorney for a medical liability claim is entitled to no less than 70% of the first \$250,000 and 90% of any damage award over \$250,000.¹³⁷ Subsequently, the Florida Supreme Court issued a rule that permits patients to waive this requirement.¹³⁸

Voters also approved two amendments sponsored by trial attorneys. One of them, Amendment 7, gives the public access to any records made or received by a health care provider or facility related to an adverse medical incident.¹³⁹ The Florida Legislature attempted to permit only prospective access to records,¹⁴⁰ but the Florida Supreme Court ruled that access is granted retroactively.¹⁴¹

134. West Virginia Offices of the Insurance Commissioner. State of West Virginia, Medical Malpractice Report Insurers with 5% Market Share. 2012.

135. *Id.*

136. West Virginia Offices of the Insurance Commissioner, State of West Virginia, Medical Malpractice Report Insurers with 5% or more of the Medical Malpractice market share in West Virginia. November 2015. <https://www.wvinsurance.gov/Portals/0/2015%20Med%20Mal%20report%20.pdf?ver=2016-01-26-131027-940>. Accessed on Feb. 24, 2022.

137. Fla. Const. Art. I, § 26

138. Fla. Bar eg. R. 4-1.5

139. Fla. Const. Art. X, § 25

140. Fla. Stat. § 381.028

141. *Fla. Hosp. Waterman, Inc. v. Buster*. 984 So.2d 478. (Fla. 2008).

The other, Amendment 8, denies licensure to a physician who has been “found to have committed” three or more incidents of medical liability.¹⁴² The language “found to have committed” means a finding of a physician’s medical liability by either: (1) a final judgment of a court; (2) a final administrative agency decision; or (3) a decision resulting from binding arbitration. “Found to have committed” does not, therefore, include settlements of medical liability claims. Nor does it include a report to a medical liability insurance carrier that a claim has, or will be, filed. Further, such qualifying incidents must be proven by clear and convincing evidence.¹⁴³

Nevada

Voters approved the “Keep our Doctors in Nevada” initiative (Question 3), which amended Nevada’s MLR statute to include MICRA-style reforms.¹⁴⁴ The approved initiative amended Nevada’s existing MLR statute by: (1) deleting exceptions to Nevada’s \$350,000 cap on noneconomic damages in medical liability cases; (2) strengthening the existing joint and several liability reform law by applying it to both economic and noneconomic damages; (3) requiring periodic payment of future damages over \$50,000 at the request of either party; (4) placing limits on attorney contingency fees; and (5) strengthening Nevada’s existing statute of limitations.

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

Wyoming

In Wyoming voters approved one constitutional amendment¹⁴⁵ and defeated another. The approved amendment, Amendment C, allows the legislature to pass laws creating medical screening panels or other alternative dispute resolution systems in medical liability cases. Amendment D, which was defeated, would have allowed the legislature to enact a cap

142. Fla. Const. Art. X, § 26

143. Fla. Stat. § 456.50.

144. Nev. Rev. Stat. Ann. § 41A.035.

145. Wyo. Const. Art. 10, § 4.

on noneconomic damages in medical liability cases. Wyoming is currently one of five states where the state constitution explicitly prohibits the legislature from enacting limits on damages.¹⁴⁶

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



Federal efforts on liability reform

While stakeholders are attempting to address the medical liability crisis at the state level, a federal solution is also needed. Many state liability reform laws have been nullified by activist state courts or stripped of their most effective provisions under state constitutions that limit reform. The following outlines the most recent federal efforts to achieve national liability reform.

Activities in the 117th Congress

The Accessible Care by Curbing Excessive lawSuitS Act (ACCESS Act) was reintroduced on Dec. 15, 2022, as H.R. 9584. As noted below, the bill improves patient access to health care services and provides improved medical care by reducing the excessive burden the liability system places on the health care delivery system. The bill includes comprehensive reforms modeled after California and Texas, including a cap on noneconomic damages, notice of intent to sue, affidavit of merit, expert witness qualifications and communications following unanticipated outcomes.

The Good Samaritan Health Professionals Act was reintroduced on Sept. 10, 2021, as H.R. 5239. The bill protects health care professionals who volunteer during a federally declared disaster from liability exposure and help ensure that needed medical volunteers are not turned away due to confusion

and uncertainty about the application of state Good Samaritan laws.

The Coronavirus Provider Protection Act of 2021 was introduced on as H.R. 3021. This bill would provide 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.

Activities in the 116th Congress

The Accessible Care by Curbing Excessive lawSuitS (ACCESS) Act of 2019 was introduced on July 9, 2019, as H.R. 3656. The bill improves patient access to health care services and provides improved medical care by reducing the excessive burden the liability system places on the health care delivery system. The bill includes comprehensive reforms modeled after laws in California and Texas, including a cap on noneconomic damages, notice of intent to sue, affidavit of merit, expert witness qualifications and communications following unanticipated outcomes.

The Safeguarding America’s Frontline Employees to Offer Work Opportunities Required to Kickstart the Economy (SAFE TO WORK) Act was introduced on July 27, 2020, as S. 4317. This bill provides targeted and limited liability relief to physicians and other health care professionals who have delivered care during the pandemic by creating a federal right of action for all coronavirus-related medical liability suits, preempting state laws and lawsuits on the issue unless state law provides greater liability protection.

Congress also extended liability protection to volunteer health care providers treating COVID-19 in the CARES ACT, signed into law March 27, 2020. All care provided by a volunteer health care provider within their scope of licensing or certification in response to the COVID-19 public health emergency are protected from civil liability for those activities unless they constitute gross negligence or reckless conduct.

Activities in the 115th Congress

The AMA continues to strongly support a comprehensive federal liability reform package based on the model of California state liability

146. *Id.*

protections in order to ensure accessible and affordable care for patients. On Feb. 24, 2017, the Protecting Access to Care Act (PACA), H.R. 1215, was introduced in the House of Representatives. It includes key elements of comprehensive reform, including a flat cap on noneconomic damages of \$250,000, a limitation on attorneys' contingency fees, a three-year statute of limitations, collateral source offset from damages, and protection from product liability and class action lawsuits for medical products approved by the FDA. In committee mark-up, additional reforms from the Accessible Care by Curbing Excessive Lawsuits Act of 2017 (H.R. 1704) were added to PACA. These include allowing a physician to apologize, certificate of merit, notice of intent and additional expert witness requirements. On June 28, 2017, PACA was passed in the House of Representatives by a vote of 218–210. It has not been introduced into the Senate.

The Good Samaritan Health Professionals Act was introduced on March 30, 2017, as H.R. 1876 and S. 781 with 26 cosponsors. The bill protects health care professionals who volunteer during a federally declared disaster from liability exposure and help ensure that needed medical volunteers are not turned away due to confusion and uncertainty about the application of state Good Samaritan laws. On May 17, 2017, the House's Energy and Commerce Subcommittee on Health held a hearing examining four bills that advance public health that included H.R. 1876. On Feb. 14, 2018, the full Energy and Commerce Committee held a mark-up session and voice voted the bill out of committee. The Act was a part of the House version of the reauthorization of the Pandemic and All-Hazards Preparedness Act but never made it into the Senate version.

The Sports Medicine Licensure Clarity Act was reintroduced on Jan. 5, 2017, as H.R. 302 with 39 cosponsors. President Trump signed into law on Oct. 5, 2018, the FAA Reauthorization Act of 2018 (P.L. 115-254), which included the Act (originally introduced on Jan. 5, 2017, as H.R. 302). The bill, which was supported by the AMA, 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. Prior to providing such services,

the medical professional must disclose to the malpractice insurer the nature and extent of the service. This extension of malpractice coverage does not apply at a health care facility or while a medical professional is transporting the injured individual to a health care facility.

Athletes include individuals participating in a sporting event for which the individual may be paid, participating in a sporting event that is sponsored or sanctioned by a national governing body, or for whom a high school or university provides a medical professional.

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. Having actively supported this bill in previous Congresses, the AMA is now working with other stakeholders to update the HEALTH Act and secure appropriate sponsorship in Congress so that it garners additional support.

Activities in the 114th Congress

The Family Health Care Accessibility Act, S. 2151, was included in the final version of the 21st Century Cures Act, which was passed by Congress and signed into law on Dec. 13, 2016 (Public Law No: 114-255). This legislation provides Federal Tort Claims Act (FTCA) medical malpractice liability coverage to all qualified health care professionals who volunteer at community health centers—or through offsite programs or events carried out by such centers—by deeming them employees of the Public Health Service. This legislation extends the Patient Protection and Affordable Care Act's provision of FTCA coverage to officers, governing board members, employees and contractors of free clinics to also apply to volunteers sponsored by these clinics. The legislation was introduced on Oct. 7, 2015, by Sens. John Thune (R-S.D.) and Robert Casey (D-Pa.).

The House passed the Sports Medicine Licensure Clarity Act (H.R. 921) on Sept. 12, 2016, by a voice vote. This legislation ensures that athletic trainers are covered by their liability insurance when they

provide care services to their team while traveling. This legislation was originally introduced in the House on Feb. 12, 2015, by Reps. Brett Guthrie (R-Ky.), Cedric Richmond (D-La.), and Steve Womack (R-Ark.) as H.R. 921. On March 10, 2015, Sens. John Thune (R-S.D.) and Amy Klobuchar (D-Minn.) introduced a companion bill in the Senate as S. 689.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on April 16, 2015, permanently repealing the Medicare sustainable growth rate (SGR) formula. 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. The AMA strongly supported this language and its inclusion in the SGR repeal legislation and is pleased that this MLR effort garnered bipartisan support and was enacted into law.



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.¹⁴⁷ Courts in Indiana, Louisiana, Nebraska, New Mexico and Virginia upheld caps that encompass both economic

and noneconomic damages.¹⁴⁸

Courts in the following states struck down caps on damages: Alabama, Florida, Georgia, Illinois, Kansas, Oklahoma, Oregon and Washington.¹⁴⁹ More details on recent cases follow.

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.¹⁵⁰

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.¹⁵¹ 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.¹⁵²

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.

147. 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).

148. *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).

149. 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. Nestlehtutt*, 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).

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

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

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

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.”¹⁵³

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.¹⁵⁴

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.¹⁵⁵ The court went on to hold that caps on personal injury noneconomic damages do not pass what 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.¹⁵⁶ 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.¹⁵⁷ 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.¹⁵⁸ 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.¹⁵⁹ 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.

Louisiana

In 2007 the Louisiana Supreme Court reinstated the state’s cap on total damages in medical liability cases.¹⁶⁰ The \$500,000 cap¹⁶¹ (excluding future medical care) was struck down by the 3rd Circuit Court of Appeals in 2006.¹⁶² 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.¹⁶³

Maryland

In 2010 Maryland’s highest court ruled that the cap

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

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

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

156. *Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt*, 691 S.E.2d 218 (Ga. 2010).

157. *Lebron v. Gottlieb Mem. Hosp.*, 930 N.E.2d 895 (Ill. 2010).

158. Remittitur is the process by which excessive jury verdicts are reduced by a court.

159. *Plank v. Comm. Hosp. of Indiana, et al.*, 981 N.E.2d 49 (Ind. 2013).

160. *Arrington v. Galen-Med*, 947 So. 2d 724 (La. 2007).

161. La. R.S. 40:1299.42

162. *Arrington v. ER Physicians Group*, 940 So.2d 777 (La. Ct. App. 2006).

163. *Oliver v. Magnolia Clinic, et al.*, 85 So.3d 39 (La. 2012).

on noneconomic damages in general tort claims is constitutional.¹⁶⁴ It based this decision on the legal doctrine of *stare decisis*, meaning that the court based its decision on prior legal decisions.¹⁶⁵

Michigan

On Aug. 18, 2005, the U.S. Court of Appeals for the 6th Circuit upheld Michigan's cap on noneconomic damages.¹⁶⁶ Specifically, the court held the cap does not violate the Seventh Amendment or Equal Protection Clause of the U.S. Constitution.¹⁶⁷

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 2005.¹⁶⁸ 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.¹⁶⁹

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 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 2021, the caps were set at \$442,574 and \$774,504 respectively.¹⁷⁰ In July 2021, the Missouri Supreme Court upheld the constitutionality of the noneconomic caps in the 2015 law.¹⁷¹

New Mexico

In March 2021, the New Mexico Supreme Court upheld the constitutionality of the existing cap of \$600,000 on noneconomic damages.¹⁷² Note, however, that in 2021, the New Mexico Governor signed H.B. 75 into law. H.B. 75, a revision to the New Mexico Medical Malpractice Act, raises the cap of \$600,000 to \$750,000 beginning Jan. 1, 2022, for independent physicians.

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.¹⁷³ As discussed in more detail above, 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.¹⁷⁴

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.¹⁷⁵

Tennessee

In June 2021, the Tennessee Supreme Court upheld the constitutionality of Tennessee's cap of \$750,000 on noneconomic damages.¹⁷⁶

Texas

In March 2012, in a one-page ruling, a federal judge upheld Texas' \$250,000 cap on non-economic damages.¹⁷⁷ 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. In Texas, the plaintiffs sought relief in federal court because of the state's constitutional amendment that permits caps; however, the federal judge rejected their claims and ruled that the cap should stay in effect.

Utah

In an opinion issued Nov. 5, 2004, the Utah Supreme Court upheld Utah's cap on noneconomic damages¹⁷⁸ 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.¹⁷⁹ 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.

164. *DRD Pool Serv. v. Freed*, 5 A.3d 45 (Md. 2010).

165. *Oaks v. Connors*, 660 A.2d 423 (Md. 1995); *Murphy v. Edmonds*, 601 A.2d 102 (Md. 1992).

166. MCLS § 600.1483 (2008).

167. *Smith v. Botsford General Hosp.* 419 F.3d 513 (6th Cir. 2005).

168. *Watts v. Lester E. Cox Med. Ctr.*, 376 S.W.3d 633 (Mo. 2012).

169. *Adams By and Through Adams v. Children's Mercy Hosp.*, 832 S.W.2d 898 (Mo. banc 1992).

170. See <https://insurance.mo.gov/industry/medmal.php>

171. *Ordinola v. Univ. Physician Associates*, 625 S.W.3d 445, 453 (Mo. banc 2021).

172. *Siebert v. Okun*, 485 P.3d 1265 (2021).

173. *Woods v. Unity Health Center, Inc.*, 196 P.3d 529 (Okla. 2008).

174. *Beason v. I. E. Miller Servs., Inc.*, 441 P.3d 1107 (Okla. 2019).

175. *Busch v. McInnis Waste Sys., Inc.*, 366 Or. 628 (2020).

176. *Yebuah v. Ctr. for Urological Treatment, PLC*, 624 S.W.3d 481, 491 (Tenn. 2021).

177. *Watson v. Hortman, et. al.*, 844 F.Supp.2d 795 (E.D. Texas 2012).

178. Utah Code Ann. § 78-14-7.1

179. *Judd v. Drezga*, 103 P.3d 135 (Utah 2004).

West Virginia

On June 22, 2011, the West Virginia Supreme Court of Appeals upheld the state's cap on noneconomic damages.¹⁸⁰ 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.¹⁸¹

Judicial support for caps on noneconomic damages

Favorable state case law establishes a rationale for supporting legislative reforms.¹⁸²

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
- 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 upon the legitimate purpose of the legislature.

Due process clause

Court analysis of due process challenges in some cases also has 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, as was done with the caps.

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 AMA and the State Medical Societies.¹⁸³

180. *MacDonald v. City Hospital*, 715 S.E.2d 405 (W. Va. 2011).

181. *Mayo v. Wisconsin Injured Patients and Families Compensation Fund*, 914 N.W.2d 678 (Wis. 2018).

182. See cases cited *supra*, note 123.

183. <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 are able to 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 could:

- 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 not 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.

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 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 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.¹⁸⁴

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.

¹⁸⁴. Fla. Stat. § 458.3175

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 he or she has 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.

Early disclosure and compensation

In recent years, early disclosure and compensation (EDC) programs have received increasing attention as an innovative option that health systems might use to address adverse events and the risk management concerns that result from them. Several states, including Iowa,¹⁸⁵ Massachusetts¹⁸⁶ and Oregon,¹⁸⁷ have enacted legislation to support such initiatives. Several of the health systems that are implementing such programs have reported positive results. An example of an EDC program is the one operated by the University of Michigan Health System (UMHS).¹⁸⁸ UMHS follows three basic principles in its program:

- Compensate quickly and fairly when unreasonable medical care causes injury
- Defend medically reasonable care vigorously
- Reduce patient injuries (and, therefore, claims) by learning from patients' experiences

Federal funding has facilitated the implementation of new EDC programs and the expansion of ongoing programs in several states. These expanded efforts will help to answer some of the key questions about EDC programs, including whether or not they will increase the frequency of liability claims; whether they can succeed in states without traditional liability reforms; if they can be expanded outside of large integrated health system settings; and will they be sustainable if and when the liability climate worsens in a state.

Federal grants

As part of its health system reform efforts, the AMA urged the Obama administration and Congress to fund demonstration projects on innovative reforms, such as health courts, safe harbors for the practice of evidence-based medicine, and early disclosure and compensation models.

In 2009 the Obama administration announced that it was providing \$25 million in funding to establish medical liability and patient safety demonstration grants and planning grants that would be available to states and health systems. The demonstration grants spanned three years and were intended for programs that are ready to be implemented. The Agency for Healthcare Research and Quality (AHRQ) was charged with implementing the programs. After a thorough application and review process, AHRQ awarded \$23.2 million in grant funding, providing seven demonstration grants (\$19.7 million total) and 13 planning grants (\$3.5 million total). To highlight a few models, early disclosure and compensation models were implemented in Illinois, Massachusetts, New York and Washington. The New York grant established a special docket with several elements that a health court model would include, such as specially trained judges. Finally, Oregon used its grant to review the safe harbor concept.

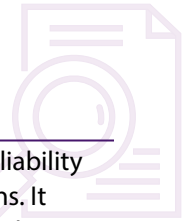
The final grant programs concluded in the summer of 2015. AHRQ then contracted with JBA/RAND to conduct a comprehensive evaluation of the program to look at the effects of various types of reforms, focusing on issues of patient safety, liability premiums and the number of medical liability lawsuits. General observations from the

185. Iowa Code Title IV, Chapter 135P.

186. Mass. Gen. Laws ch 231, § 60L.

187. Or. Rev. Stat. § 31.250.

188. For a detailed analysis of the UMHS program, please see Boothman RC, Blackwell AC, Campbell DA, et al. A Better Approach to Medical Malpractice Claims? The University of Michigan Experience. *J. Health & Life Sci. L.* 2009;2(2):125–159. med.umich.edu/newsroom/boothman%20et%20al.pdf. Accessed Feb. 22, 2022.



evaluation include that grantees who sought to improve communication learned that the beliefs, preferences and behaviors of physicians play a key role in facilitating or impeding the adoption of new practices and processes. Additionally, taking the time to identify areas of shared agreement and concern regarding communication between patients and providers can help hone communication improvement efforts.

Based on expert input and lessons learned from the grant initiative, AHRQ developed the Communication and Optimal Resolution (CANDOR), which is a process that health care institutions and practitioners can use to respond in a timely, thorough and just way when unexpected events cause patient harm. The CANDOR process is a more patient-centered approach that emphasizes early disclosure of adverse events, and a more proactive method to achieving an amicable and fair resolution for the patient/family and involved health care providers.

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, such as health courts, safe harbors, and early disclosure and compensation models, as a way to complement traditional reforms. This AMA effort is occurring at both the federal and state levels.

Please visit ama-assn.org/state-liability for more information on the AMA's medical liability reform efforts. ama-assn.org/join

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