

THE IMPOSITION OF FEDERAL CAPS IN MEDICAL MALPRACTICE LIABILITY ACTIONS: WILL THEY CURE THE CURRENT CRISIS IN HEALTH CARE?

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I. INTRODUCTION

Today in the United States we have a medical emergency on our hands. Many physicians¹ have experienced exorbitant medical malpractice liability insurance premium increases, oftentimes as high as 100% or even 200% over the previous year.² Others have been summarily discarded by their insurance carriers.³ As a result, doctors have been left with few alternatives, including: selecting other insurers, practicing without coverage, moving to and practicing in states with lower medical malpractice insurance premiums than their own, or simply giving up medicine altogether.⁴

While this growing epidemic must be dealt with immediately, there has been no consensus on how to tackle the problem faced by the medical community and, in turn, by Americans in need of reliable health care.

Earlier this year, the American Medical Association (AMA) declared that eighteen states are currently facing a medical insurance crisis.⁵ Notwithstanding this finding, “[s]oaring premiums on medical

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1. Particularly those engaging in high-risk specialties, such as obstetrics and anesthesiology.
2. Weiss Ratings, Inc., *The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage*, <http://www.weissratings.com/malpractice.asp> (June, 2003).
3. *Id.*
4. *Id.*
5. Yank D. Coble, Jr., MD., AMA President, *AMA Survey Shows Patients Losing Access to*

malpractice insurance are a national crisis, invading the practice of medicine, threatening the availability of care, and prompting widespread public outcry.”⁶

The AMA has warned, “[y]ou know that our health care system is facing a crisis when patients have to leave their state to receive urgent surgical care, or when pregnant women cannot find an obstetrician to monitor their pregnancies and deliver their babies.”⁷ Furthermore, the AMA has cautioned Americans that:

Escalating jury awards and the high cost of defending against lawsuits, even meritless claims, are causing medical liability insurance premiums to soar . . . [and that] . . . [o]ver the past two years, many physicians have been hit with medical liability premium increases of 25 to 400 percent. As medical liability insurance becomes unaffordable or unavailable, physicians are being forced to close their practices or drop vital services—seriously affecting patient access to care. There are now 19 states in crisis, up from 12 states last year. In many other states a crisis is looming. The GAO recently studied five crisis states and found examples of reduced access to care affecting emergency surgery and newborn deliveries. We have no doubt that the GAO would have found similar access problems had it examined the other 14 crisis states. This is why AMA worked so hard to seek passage of H.R. 5 in the House, and why we continue to seek passage of similar legislation in the Senate. One of the key provisions in H.R. 5 is a \$250,000.00 limit on non-economic damages, with flexibility for states to adjust the cap to suit their circumstances. This limit on non-economic damages has worked in California, and it can work nationwide. As the GAO recently reported, medical liability insurance premium growth has been slower in states with non-economic damage caps than in states with limited reforms. Also, a recent study by the Agency for Healthcare Research and Quality (AHRQ) shows that reasonable limits on non-economic damages can improve the per capita supply of physicians. We cannot afford the luxury of waiting until the liability crisis gets worse to take action. Too many patients will be hurt. We must bring common sense back to our courtrooms so

Care, <http://www.ama-assn.org/ama/pub/article/1616-7494.html> (April 3, 2003). According to the AMA, these crisis states include: Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, New Jersey, Nevada, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington and West Virginia. (There are 18 not 19 states listed here) *Id.*

6. Weiss Ratings, *supra* note 2.

7. John C. Nelson, M.D., AMA President-Elect, *AMA To Congress: Our Nation's Liability System Threatens Patients' Access to Health Care*, <http://www.ama-assn.org/ama/pub/article/1616-8067.html>, (October 1, 2003). Excepted from Dr. Nelson's testimony before the House Government Reform Subcommittee on Wellness and Human Rights (October 1, 2003).

patients have access to physicians – in emergency rooms, delivery rooms and operating rooms.⁸

Moreover, a March 2003 study⁹ conducted by the AMA concluded:

(1) 64.8 percent of America's high-risk specialists have made changes to their practice, including no longer providing certain services, referring complex cases, closing their practice, and more; (2) 24.2 percent of high-risk specialists stopped providing certain services, including emergency and trauma care and delivering babies; 92.4 percent of high-risk specialists said that liability pressures were important in their decision to stop providing certain services; (3) 41.5 percent of high-risk specialists began referring complex cases; 34 percent of physicians surveyed in AMA crisis states began referring complex cases compared to 24 percent in non-crisis states.¹⁰

In the past six months, the ongoing debate concerning the root causes of the recent escalation in medical malpractice liability insurance rates has reached a fevered pitch. Physicians and the insurance industry place the blame on lawyers, excessive litigation and out-of-control jury awards.¹¹ The solution they propose, *to wit*, the imposition of caps on non-economic damages in medical malpractice liability cases, has found its way into numerous state legislatures, as well as the United States Congress.¹² As of June 2003, nineteen states have implemented caps on non-economic damage.¹³

The battle cry for caps has, in large part, been adopted by Republican legislators on both the state and federal level. Ultimately, however, it is the objective of the GOP to federalize caps on non-economic damages in medical malpractice liability cases, thus preempting those states opposed to caps from resisting them any longer.¹⁴

Opponents of the GOP's efforts to federalize caps include numerous Democratic state and federal legislators, the American Trial Lawyer's Association (ATLA), state trial lawyer associations, and consumer watchdog groups. These critics of federal caps acknowledge that while there is a growing epidemic in our health care system, jury

8. *Id.*

9. Coble, *supra* note 5.

10. *Id.*

11. Weiss Ratings, *supra* note 2.

12. *Id.*

13. *Id.*

14. *See infra* notes 20-30 and accompanying text.

verdicts are not the prime culprit.¹⁵ They further maintain that caps have not proven successful in either diminishing insurance premiums, or, in fact, stabilizing them in states where they have been implemented.¹⁶ Finally, opponents of caps maintain that the insurance industry is diverting the public's attention away from other, more significant causes of escalating premiums, including, *inter alia*, the rising cost of medical products, financial setbacks faced by insurers over the past four years, and industry-wide mismanagement.¹⁷

This article seeks to uncover the truth behind America's current health care emergency. In so doing, the causes behind escalating medical malpractice premiums over the past decade will be examined; attention will be focused on the issue of whether caps on non-economic damages have been successful in reducing insurance premiums in states where they have been implemented.¹⁸ Finally, an alternative approach than that taken by President Bush, Congressional Republicans, the American Medical Association, and the insurance industry, will be propounded.¹⁹

II. PRESIDENT GEORGE W. BUSH'S VISION

On January 28, 2003, President George W. Bush delivered his State of the Union Address.²⁰ During this address, he launched the opening salvo in his war to rehabilitate America's ailing health care system, a system he believes has fallen prey to "bureaucrats and trial lawyers" and "excessive litigation."²¹ The President declared:

Our . . . goal is high quality, affordable health care for all Americans. The American system of medicine is a model of skill and innovation, with a pace of discovery that is adding good years to our lives. Yet for many people, medical care costs too much—and many have no coverage at all. These problems will not be solved with a nationalized health care system that dictates coverage and rations care.

Instead, we must work toward a system in which all Americans have a good insurance policy, choose their own doctors, and seniors and low-income Americans receive the help they need. Instead of bureaucrats

15. See *infra* notes 39-40 and accompanying text.

16. See *infra* note 40 and accompanying text.

17. *Id.*

18. See *infra* notes 289-316 and accompanying text.

19. See *infra* notes 317-318 and accompanying text.

20. President of The United States, George W. Bush, *State of the Union Address*, <http://www.whitehouse.gov/news/releases/2003/01/20030128-19.html> (January 28, 2003).

21. *Id.*

and trial lawyers and HMO's, we must put doctors and nurses and patients back in charge of American medicine.

. . . .

To improve our health care system, we must address one of the prime causes of higher cost, the constant threat that physicians and hospitals will be unfairly sued. Because of excessive litigation, everybody pays more for health care, and many parts of America are losing fine doctors. No one has ever been healed by a frivolous lawsuit. I urge the Congress to pass medical liability reform.²²

III. THE PROPOSED FEDERAL LEGISLATION AIMED AT, *INTER ALIA*, FEDERALIZING CAPS ON NON-ECONOMIC DAMAGES IN MEDICAL MALPRACTICE LIABILITY CASES

A. House Resolution 5 (H.R. 5)

Within one week of the President's State of the Union Address, H.R. 5, officially titled,²³ "To Improve Patient Access to Health Care Services and Provide Improved Medical Care by Reducing the Excessive Burden the Liability System Places on the Health Care Delivery System," was introduced in the United States House of Representatives.²⁴

22. *Id.*

23. H.R. 5, 108th Cong. (2003), available at <http://www.congress.gov/cgi-bin/bdquery/z?d108:HR00005:@@L&summ2=m&>. The bill's short title was "Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003." *Id.*

24. *Id.* The bill was formally introduced on February 5, 2003. *Id.* Following its introduction, the bill proceeded along the following course:

2/5/2003: Referred to the Committee on the Judiciary, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned. Referred to House Judiciary

3/4/2003: Committee Hearings Held.

3/5/2003: Committee Consideration and Mark-up Session Held. Ordered to be Reported (Amended) by the Yeas and Nays: 15 - 13.

2/5/2003: Referred to House Energy and Commerce

2/14/2003: Referred to the Subcommittee on Health, for a period to be subsequently determined by the Chairman.

3/4/2003: Referred to the Subcommittee on Commerce, Trade and Consumer Protection. Subcommittee Consideration and Mark-up Session Held. Forwarded by Subcommittee to Full Committee (Amended) by Voice Vote.

3/6/2003: Committee Consideration and Mark-up Session Held. Ordered to be Reported (Amended) by Voice Vote.

While the bill was quite similar to H.R. 4600,²⁵ which passed the House in 2002 but never reached a vote in the Senate, H.R. 5 would apply to any “health care lawsuit,” including civil actions against manufacturers, distributors, suppliers, marketers, promoters, or sellers of

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- 3/11/2003 6:51pm: Reported (Amended) by the Committee on Judiciary. H. Rept. 108-32, Part I.
- 3/11/2003 6:52pm: Reported (Amended) by the Committee on Energy and Commerce. H. Rept. 108-32, Part II. Placed on the Union Calendar, Calendar No. 20.
- 3/12/2003 9:52pm: Rules Committee Resolution H. Res. 139 Reported to House. Rule provides for consideration of H.R. 5 with 2 hours of general debate. Previous question shall be considered as ordered without intervening motions except motion to recommit with or without instructions. Provides for 80 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on the Judiciary and 40 minutes equally divided and controlled by the chairman and ranking minority member of the Committee on Energy and Commerce. The rule waives all points of order against consideration of the bill. Measure will be considered read. The rule provides that in lieu of the amendments recommended by the Committees on the Judiciary and on Energy and Commerce now printed in the bill, the amendment in the nature of a substitute printed in the Rules Committee report (H. Rept. 108-34) shall be considered as adopted. The rule provides that H.Res. 126 is laid on
- 3/13/2003 12:05pm: Rule H. Res. 139 passed House.
- 3/13/2003 12:06pm: Considered under the provisions of rule H. Res. 139. (consideration: CR H1817-1871, H1879-1880; text of measure as reported in House: CR H1829-1832). H.AMDT.6 Amendment in the nature of a substitute reported by the House Committee on Rules (consideration: CR H1832-1834; text: CR H1832-1834). An amendment in the nature of a substitute considered as adopted pursuant to the provisions of H. Res. 139.
- 3/13/2003 12:07pm: H.AMDT.6 On agreeing to the Rules amendment (A001) Agreed to without objection.
- 3/13/2003 2:35pm: The previous question was ordered pursuant to the rule. Mr. Conyers moved to recommit with instructions to Judiciary and Energy and Commerce.
- 3/13/2003 2:46pm: The previous question on the motion to recommit with instructions was ordered without objection.
- 3/13/2003 3:06pm: On motion to recommit with instructions Failed by the Yeas and Nays: 191 - 234 (Roll no. 63) (consideration: CR H1866-1871; text: CR H1866-1869).
- 3/13/2003 3:13pm: On passage Passed by recorded vote: 229 - 196, 1 Present (Roll No. 64) (text: CR H1832-1834).
- 3/13/2003 3:13pm: Motion to reconsider laid on the table Agreed to without objection.
- 3/13/2003: Received in the Senate.
- 3/20/2003: Read the first time. Placed on Senate Legislative Calendar under Read the First Time.
- 3/21/2003: Read the second time. Placed on Senate Legislative Calendar under General Orders. Calendar No. 49.

Id.

25. H.R. 4600, 107th Cong. (2002), available at <http://thomas.loc.gov/cgi-bin/bdquery/D?d107:1:./temp/~bd69UB:@@X/bss/d107query.html>. The House of Representatives passed H.R. 4600, entitled the “Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002,” by a vote of 217 to 203, on September 26, 2002. See *Update: House Passes H.R. 4600*, 165 PRODUCTS LIABILITY ADVISORY 8 (November 2002).

drugs or medical devices, regardless of the theory of liability.²⁶

In sum, H.R. 5 limits recovery of non-economic²⁷ damages in health care lawsuits to \$250,000.²⁸ Awards for future non-economic damages would not be discounted to present value.²⁹ The statute does away with joint liability, thus, each tortfeasor's liability would be limited to his/her/its several share of any damages only, and not include the share of any other person.³⁰

As to punitive damages:

[T]he proposed law would (1) require proof by clear and convincing evidence that the defendant acted with malicious intent to injure the claimant or deliberately failed to avoid unnecessary injury that the defendant knew the claimant was substantially certain to suffer; (2) permit punitive damages to be sought only after a court finding of substantial probability that the plaintiff would prevail; (3) bar punitive damages where no compensatory damages are awarded; (4) limit the amount of punitive damages to two times the amount of economic damages awarded or \$250,000.00, whichever is greater; and (5) bar punitive awards, absent fraud or bribery, against manufacturers or distributors of medical products unless it is demonstrated that the harm resulted from a defendant's failure to comply with a specific Food and Drug Administration (FDA) requirement.³¹

Moreover, H.R. 5 limits an attorney's entitlement³² to contingent fees in a medical malpractice liability lawsuit.³³ Specifically, the maximum fee an attorney could charge a client in a medical malpractice liability action would be limited to (1) 40 percent of the first \$50,000 recovered; (2) 33 1/3 percent of the next \$50,000; (3) 25 percent of the next \$500,000; and (4) 15 percent of any recovery in excess of

26. *House Passes Bill That Would Limit Products Liability Claims Involving Medical Products*, 170 *Products Liability Advisory* 5 (April 2003).

27. Non-economic damages are generally those damages awarded for a litigant's past and/or future pain and suffering. House Resolution 5 defines non-economic damages as: "damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature." H.R. 5, 108th Cong. (2003), available at <http://www.congress.gov/cgi-bin/bdquery/z?d108:HR00005:@@L&summ2=m&>.

28. *House Passes Bill*, *supra* note 26.

29. *Id.* In essence, the bill calls for the annuitized payout of future, non-economic damages awards in excess of \$50,000. *See id.*

30. *Id.*

31. *Id.*

32. And, presumably, an attorney's incentive to take such cases.

33. *House Passes Bill*, *supra* note 26.

\$600,000.³⁴

Other provisions of the bill would: (1) establish a limitations period³⁵ of the earlier of (a) 3 years after the date of injury, or (b) 1 year after the injury was or should have been discovered; and (2) allow evidence of collateral source benefits.³⁶

Finally, H.R. 5 seeks to preempt any contrary state law, except any law that imposes greater protections, such as a shorter statute of limitations for health care providers and health care organizations from liability, loss, or damages than those provided by the Act.³⁷ Also exempted from preemption would be any state statutory limit on the amount of damages that may be awarded in a health care lawsuit, whether or not the state limit is more or less than the limit under this Act; and any defense available to a party in a health care lawsuit.³⁸

According to a number of dissenters in the House of Representatives:³⁹

[H.R. 5] offers a “solution” prior to having discovered the root of the problem. Instead of reducing the occurrence of frivolous lawsuits, providing direct assistance to health care providers and communities, and examining every aspect of the problem, this legislation restricts the legal rights of those who have been truly wronged.

. . . .

While the rising cost of malpractice insurance is a real concern for doctors and patients alike, we have serious reservations about this proposed “solution” for three primary reasons. First, what has caused the increase in malpractice insurance premiums is not easily identified. Moreover, it is not clear that this legislation will reduce the medical malpractice premiums that providers must pay to insurance companies. Second, the scope and severity of the provisions in H.R. 5 impose unreasonable restrictions on an injured patient’s ability to hold

34. *Id.*

35. The time within which a litigant must bring a lawsuit or forever be barred from doing so. This is synonymous with the term “statute of limitations.” Limitation is defined as “a statutory period after which a lawsuit or prosecution cannot be brought in court.” BLACK’S LAW DICTIONARY 939 (7th ed. 1999).

36. *House Passes Bill*, *supra* note 26.

37. *Id.*

38. *Id.*

39. Democratic Staff of the Committee on Energy and Commerce, *Dissenting Views on H.R. 5: Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2003*, http://www.house.gov/commerce_democrats/legviews/108lvhr0005.htm (March 2003). Representatives John D. Dingell, Lois Capps, Jan Schakowsky, Frank Pallone, Jr., Ted Strickland, Hilda L. Solis, Sherrod Brown, Edward J. Markey, Henry A. Waxman, Edolphus Towns, Rick Boucher, Bart Stupak, and Mike Doyle. *Id.*

wrongdoers accountable. Third, the legislation is over-broad, protecting the interests of large corporations, such as Health Maintenance Organizations (HMO's) and drug companies, at the expense of health care providers and patients. The legislation provides nothing more than a shield for bad actors rather than meaningful reforms for overburdened doctors and providers.

To find an effective solution, we must closely examine the insurance industry and how its conduct affects medical malpractice premiums, an activity not undertaken by this Committee. We know that many factors completely unrelated to jury verdicts and the civil justice system affect insurance rates: changes in state law and regulatory requirements; competitiveness of the insurance market; the types of policies issued within the industry; interest rates; and national economic trends. Moreover, there is scant evidence to date that various state tort reforms have realized appreciable premium savings. In a comparison of states that enacted severe tort restrictions during the mid-1980's and those that resisted enacting tort reform, a recent study found no correlation between tort reform and insurance rates.

Insurance markets are subject to cycles, periods of underpricing of premiums to increase market share and book premium dollars, followed by a hardening of the market. Once the market hardens, competition intensifies, underwriting results deteriorate, and investment incomes fall. Insurance companies then need to raise premiums to cover losses. We are now in the midst of a "hard" phase of the insurance cycle and increases in malpractice premiums are consistent with overall market trends. This problem is not unique to malpractice insurance. While medical malpractice insurance premiums for the three riskiest specialties increased 10% from 2000 to 2001, auto insurance premiums saw similar increases of 8.4% during that same period.

A serious effort to provide relief to providers from high malpractice premiums would have looked at these and other issues. A number of Congressional Democrats have requested the General Accounting Office look into these questions. The Committee, however, chose to take a one-sided approach. Reps. Brown, Pallone, and Capps offered amendments that would encourage insurance reforms both on the state and federal levels. Each of those amendments was defeated on a partisan basis. Rep. Dingell offered an amendment in the nature of a substitute during the full Committee Markup of H.R. 5. The Democratic substitute would have provided direct assistance to health care providers and communities, reduced frivolous lawsuits, and established an independent advisory commission to thoroughly examine the problem and propose long-term solutions. It was also

defeated on a partisan basis.⁴⁰

Despite the above dissent, on March 13, 2003, H.R. 5 was approved by the House of Representatives by a vote of 229 to 196.⁴¹ In response to the passage of H.R. 5, the American Medical Association issued the following press release:

The American Medical Association (AMA) applauds the House of Representatives for passing true medical liability reform legislation, which includes a \$250,000.00 cap on non-economic damages. The AMA thanks Representative Greenwood (R-PA), Chairman Tauzin (R-LA), Chairman Sensenbrenner (R-WI) and Representative Cox (R-CA) for their leadership on this issue of great importance to America's patients and physicians.

By voting "yes" to medical liability reform legislation, Congress recognizes that our current medical liability system is broken and threatening access to care for millions of Americans, particularly in regard to high-risk medical care and services.

Doctors forced to move out of state, take early retirement, or stop practicing high-risk procedures because of sky-rocketing insurance premiums have left much of the nation in an access-to-care crisis or near-crisis situation.

The legislation passed by Congress today is based on a proven reform system in place in California since 1975. As a result, medical insurance premiums in California have increased only 167 percent, while premiums in the rest of the country have risen 505 percent. Capping non-economic damages at \$250,000.00 will help curb the jackpot lottery mentality that is jeopardizing patient care in this country.

The AMA, President Bush and now the House of Representatives agree – common-sense medical liability reforms are needed to protect patients' access to care. The AMA looks forward to working with the Senate to ensure passage of similar legislation that preserves access to care for all Americans.⁴²

40. *Id.*

41. *See supra*, note 24.

42. Yank D. Coble, Jr., M.D., AMA President, *AMA Applauds Passage of H.R.5*, <http://www.ama-assn.org/ama/pub/article/1617-7392.html> (March 13, 2003).

B. Senate Bill 607 (S. 607)

On March 12, 2003, S. 607, formally titled⁴³ “A Bill to Improve Patient Access to Health Care Services and Provide Improved Medical Care by Reducing the Excessive Burden the Liability System Places on the Health Care Delivery System,” was introduced in the United States Senate by Nevada Senator John E. Ensign.⁴⁴ While the bill was similar to H.R. 5, it differed from H.R. 5 to the extent that it did not address punitive damages, collateral source offsets, and the annuitized payments of future non-economic damages in excess of \$50,000.

C. Senate Bill 11 (S. 11)

Following passage of H.R. 5, in an effort to conform the Senate’s bill to that of the House, Senator Ensign substituted S. 607 with S. 11.⁴⁵ While similar in content to S. 607, S. 11 more closely followed H.R. 5 with its inclusion of provisions relating to punitive damages, collateral source offsets and the annuitized payments of future non-economic damages in excess of \$50,000.

Recently, the advancement of Senator Ensign’s bill ground to halt when its opponents successfully filibustered⁴⁶ S. 11.⁴⁷ On July 9, 2003,

43. S. 60, 108th Cong. (2003), available at <http://www.congress.gov/cgi-bin/bdquery/z?d109:SN00607:@@L&summ2=m&>. The bill’s short title was, “Help Efficient, Accessible, Low-Cost, Timely Healthcare Act of 2003.” *Id.* Following its introduction, the bill proceeded along the following course:

3/12/2003: Introduced in the Senate. Read the first time. Placed on Senate Legislative Calendar under Read the First Time.

3/13/2003: Read the second time. Placed on Senate Legislative Calendar under General Orders. Calendar No. 33.

Id.

44. *Id.*

45. *Id.* While S.11 bore the same official title as S.607, its short name was changed to “HEALTH Act of 2003,” apparently to correspond with H.R.5. *Id.*

46. U.S. Senate, *Filibuster and Cloture*, http://www.senate.gov/artandhistory/history/common/briefing/Filibuster_Clature.htm. A filibuster is an attempt to block or delay Senate action on a bill or other matter:

Using the filibuster to delay, debate or block legislation has a long history. In the United States, the term filibuster—from a Dutch word meaning “pirate”—became popular in the 1850’s when it was applied to efforts to hold the Senate floor in order to prevent action on a bill.

In the early years of Congress, representatives as well as senators could use the filibuster technique. As the House grew in numbers, however, it was necessary to revise House rules to limit debate. In the smaller Senate, unlimited debate continued [sic], since senators believed any member should have the right to speak as long as necessary.

In 1841, when the Democratic minority hoped to block a bank bill promoted by Henry Clay, Clay threatened to change Senate rules to allow the majority to close debate. Thomas Hart Benton angrily rebuked his colleague, accusing Clay of trying to stifle the

an attempt to break the filibuster, via a cloture vote, failed by 11 votes.⁴⁸ Despite its failed progress, a further vote on S. 11 was expected in the fall of 2003. It should be noted that some Senate Republicans immediately hedged their bets, stating that in the event the Senate does not pass S. 11, they will pursue “targeted amendments” aimed at relieving specific medical specialties, including obstetricians and emergency room physicians.⁴⁹

D. The United States General Accounting Office Study

In the spring of 2003, a number of House Republicans supporting limited medical malpractice damage awards requested a United States General Accounting Office (GAO) study. In response thereto, the GAO

Senate’s right to unlimited debate. Unlimited debate remained in place in the Senate until 1917. At that time, at the suggestion of President Woodrow Wilson, the Senate adopted a rule (Rule 22) that allowed the Senate to end a debate with a two-thirds majority vote—a tactic known as “cloture.”

The new Senate rule was put to the test in 1919, when the Senate invoked cloture to end a filibuster against the Treaty of Versailles. Despite the new cloture rule, however, filibusters continued to be an effective means to block legislation, due in part to the fact that a two-thirds majority vote is difficult to obtain. Over the next several decades, the Senate tried numerous times to evoke cloture, but failed to gain the necessary two-thirds vote. Filibusters were particularly useful to southern senators blocking civil rights legislation in the 1950’s and 1960’s. In 1975, the Senate reduced the number of votes required for cloture from two-thirds (67) to three-fifths (60) of the 100 member Senate.

Id.

47. S. 11, 108th Cong. (2003), available at <http://thomas.loc.gov/cgi-bin/bdquery/z?d108:SN00011:@@L&summ 2=m&>. Following its introduction, the bill proceeded along the following course:

6/27/2003: Introduced in the Senate. Read the first time. Placed on Senate Legislative Calendar under Read the First Time. Read the second time. Placed on Senate Legislative Calendar under General Orders. Calendar No. 186.

7/7/2003: Motion to proceed to consideration of measure made in Senate (consideration: CR S8871-8893, S8893-8894). Cloture motion on the motion to proceed to the measure presented in Senate (The motion to invoke cloture was filed by United States Senator from Tennessee, and Senator Majority Leader William H. Frist, M.D., a former organ transplant surgeon.).

7/8/2003: Motion to proceed to measure considered in Senate (consideration: CR S9001-9009, S9010-9043).

7/9/2003: Motion to proceed to measure considered in Senate (consideration: CR S9061-9083). Cloture on the motion to proceed to the measure not invoked in Senate by Yea-Nay Vote. 49-48. Record Vote Number: 264 (consideration: CR S9083) (The cloture rule-Rule 22-is the only formal procedure that Senate rules provide for breaking a filibuster. http://www.senate.gov/reference/reference_index_subjects/Cloture_vrd.htm).

Id.

48. *Id.*

49. Press Release, Milwaukee Journal Sentinel, *G.O.P. Focuses on Medical Malpractice Caps*, <http://www.jsonline.com/news/nat/ap/sep03/ap-congress-malpra090503.asp> (September 5, 2003).

conducted an extensive analysis of the various factors that have contributed to the dramatic increase in medical malpractice liability insurance rates over the past four years.⁵⁰ The results of the GAO's study were released in June of 2003. According to the GAO, the study was performed because:

Over the past several years, large increases in medical malpractice insurance premium rates have raised concerns that physicians will no longer be able to afford malpractice insurance and will be forced to curtail or discontinue providing certain services. Additionally, a lack of profitability has led some large insurers to stop selling medical malpractice insurance, furthering concerns that physicians will not be able to obtain coverage. To help Congress better understand the reasons behind the rate increases, the GAO undertook a study to (1) describe the extent of the increases in medical malpractice insurance rates, (2) analyze the factors that contributed to those increases, and (3) identify changes in the medical malpractice market that might make this period of rising premium rates different from previous such periods.⁵¹

Ultimately, the GAO found that:

Multiple factors, including falling investment income and rising reinsurance costs, have contributed to recent increases in premium rates in our sample states.⁵² However, GAO found that losses on medical malpractice claims—which make up the largest part of insurers' costs—appear to be the primary driver of rate increases in the long run. And while losses for the entire industry have shown persistent upward trend, insurers' loss experiences have varied dramatically across our sample states, resulting in wide variations in premium rates. In addition, factors other than losses can affect premium rates in the short run, exacerbating cycles within the medical malpractice market. For example, high investment income or adjustments to account for lower than expected losses may legitimately permit insurers to price insurance below the expected cost of paying

50. United States General Accounting Office [GAO], *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, www.gao.gov/new.items/d03702.pdf (June, 2003).

51. *Id.*

52. *Id.* These sample states included: California, Florida, Minnesota, Mississippi, Nevada, Pennsylvania, and Texas. *Id.* According to the GAO:

[This mix of states [was] based on the following characteristics: extent of any recent increases in premium rates, status as a "crisis state" according to the American medical Association, presence of caps on non-economic damages, state population, and aggregate loss ratios for medical malpractice insurers within the state.

Id.

claims. However, because of the long lag between collecting premiums and paying claims, underlying losses may be increasing while insurers are holding premium rates down, requiring large premium rate hikes when the increasing trend in losses is recognized. While these factors may explain some events in the medical malpractice market, the GAO could not fully analyze the composition and causes of losses at the insurer level owing to a lack of comprehensive data.⁵³

GAO's analysis also showed that the medical malpractice market has changed considerably since previous hard markets. Physician-owned and/or operated insurers now cover around 60 percent of the market, self-insurance has become more widespread, and states have passed laws designated to reduce premium rates. As a result, it is not clear how premium rates might behave during soft or hard markets.⁵⁴

Furthermore, the GAO recommended that no "executive action"⁵⁵ be taken. It did, however, suggest:

[T]o further the understanding of conditions in current and future medical malpractice markets, Congress may wish to consider encouraging the National Association of Insurance Commissioners and state insurance regulators to identify and collect additional, mutually beneficial data necessary for evaluating the medical malpractice insurance market.⁵⁶

As to the issue of availability to medical care, the GAO found that there were "localized but not widespread access problems,"⁵⁷ however, it added that these particular instances were often in rural locations where keeping physicians has always been a problem.⁵⁸

Finally, GAO investigators found that the reports of physicians moving to other states, retiring, or closing practices in response to the purported "crisis" complained of by the AMA were, in fact, not

53. *Id.* More specifically, in addition to claims, the GAO found that rate increases were caused by the following three factors:

(1) decreases in investment income as interest rates form bonds decreased; (2) competition for market shares that "for some insurers" did not cover their ultimate losses on that business and; (3) reinsurance rates increased rapidly, starting in 2001, raising insurers' overall costs.

See Massachusetts Medical Society Online, *GAO Reports on Causes of Medical Malpractice Rate Increases*, http://www.massmed.org/pages/GAO_report_July_2003.asp (August 1, 2003).

54. GAO, *supra* note 50.

55. *Id.*

56. *Id.*

57. *Id.*

58. *Id.*

accurate.⁵⁹

Despite the results of the GAO study, the GOP is expected to move forward in its quest for federal medical malpractice caps.⁶⁰

IV. THE STATES' APPROACH

“Since 1975, 19 states have implemented these caps at various levels ranging from \$250,000.00 to \$1 million.”⁶¹ A more detailed analysis of how each state and the District of Columbia has dealt with the issue of caps in medical malpractice liability cases is set forth below.

59. GAO, *supra* note 50.

60. *Id.*

61. See Weiss Ratings, *supra*, note 2 and accompanying text. The following chart is excerpted from the Weiss Ratings study. This chart sets forth those states that have enacted caps in medical malpractice liability actions.

State	Cap (\$)	Year Adopted
Alaska	500,000	1997 ²
California	250,000	1975
Colorado	250,000	1998
Hawaii	375,000	1976
Idaho	682,000	1990*
Indiana	1,000,000	1990
Kansas	250,000	1994
Louisiana	500,000	1975
Maryland	805,000	1986*
Massachusetts	500,000	1997
Michigan	624,000	1993*
Missouri	547,000	1988*
Montana	250,000	1997
New Mexico	600,000	1996
North Dakota	500,000	1996
Utah	250,000	1996
Virginia	1,000,000	1992
West Virginia	1,000,000	1986
Wisconsin	350,000	1995* ³

*Caps are adjusted annually for inflation.

Alaska's cap applies to incidents occurring before August 1997. *Id.* After August 1997: the cap is the greater of \$400,000 or life expectancy times \$8,000 except in the case of severe disfigurement or physical impairment in which the cap is the greater of \$1 million or life expectancy times \$25,000. *Id.*

Wisconsin's cap applies to damages from all health care providers except in wrongful death cases. *Id.* Damages in wrongful death are limited to \$500,000 for the death of a minor and \$350,000 for the death of an adult. *Id.*

A. Alabama

The Alabama legislature passed the Medical Liability Act of 1987 to limit a plaintiff's recovery in a medical malpractice suit to \$400,000, including punitive damages.⁶² The Alabama Supreme Court, however, held the statute to be unconstitutional, but the statute has not been repealed.⁶³ The Court has also held to be unconstitutional a \$250,000 cap on punitive damages,⁶⁴ applicable to all cases except wrongful death and those alleging a pattern of intentional wrongful conduct, actual malice, or defamation.⁶⁵ The legislature has since addressed the issue and passed a cap on punitive damages in all civil actions to not exceed compensatory damages or \$500,000, whichever is greater.⁶⁶ Except, when the claim is for wrongful death or physical injury, punitive damages shall not exceed \$1,500,000.⁶⁷

62. ALA. CODE § 6-5-544 (2003) (stating, "plaintiff shall not seek recovery in any amount greater than the amounts described herein for noneconomic losses"). See generally, *Symposium on Tort Reform: VIII. Medical Malpractice: A Plaintiff Attorney's Perspective*, 24 CUMB. L. REV. 515 (1994) (reviewing specific provisions from the Medical Liability Act of 1987 that apply to the medical profession); *Symposium on Tort Reform: IX. Medical Malpractice: A Defense Attorney's Perspective*, 24 CUMB. L. REV. 531 (1994) (criticizing the Alabama Supreme Court for overruling the \$400,000 damage cap in *Moore v. Mobile Infirmary Ass'n*, 592 So. 2d 156 (Ala. 1991)).

63. See *Moore v. Mobile Infirmary Ass'n*, 592 So. 2d 156 (Ala. 1991). The Alabama Supreme Court reasoned, the correlation between the damage caps and "the reduction of health care costs to the citizens of Alabama was, at best, indirect and remote." *Id.* at 168. The court went on to conclude that the unfair burden placed on "catastrophically injured victims of medical malpractice against the indirect and speculative benefit that may be conferred upon society, represents an unreasonable exercise of police power." *Id.* at 170. Therefore, the section violates the equal protection component of the Constitution of Alabama. *Id.* Another section of the Medical Liability Act of 1987 was § 6-5-547, which attempted to place a 1,000,000 limit on wrongful death actions brought against health care providers. ALA. CODE § 6-5-547 (2003). The Alabama Supreme Court, however, declared this section unconstitutional because it was similar to *Moore v. Mobile Infirmary Ass'n* as unreasonable "class legislation." *Smith v. Schulte*, 671 So. 2d 1334 (Ala. 1995) (overruled on different grounds in *Ex parte Apicella*, 809 So. 2d 865 (Ala. 2001)).

64. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Alabama*, <http://www.mcandl.com/alabama.html> (revised May 17, 1998); see *Moore*, 592 So.2d at 156; Ala. Code § 6-11-21 (1993).

65. *Id.*; see *Henderson v. Alabama Power Co.*, 627 So. 2d 878 (Ala. 1993).

66. ALA. CODE § 6-11-21 (2003). The statute lists three exceptions where the punitive damage cap does not apply: in an action against a small business defendant, punitive damages shall not exceed \$50,000 or 10% of the business' net worth; in actions for wrongful death or intentional infliction of physical injury, punitive damages shall not exceed three times compensatory damages or \$1,500,000. *Id.*

67. *Id.* The Alabama legislature rewrote §6-11-21 in 1999 to provide caps on punitive damages to apply "in all civil actions", but listed three situations when the punitive damage cap does not apply. *Mobile Infirmary Medical Ctr. v. Hodgen*, 2003 Ala. LEXIS 338, *30 (Ala. 2003). This was in response to the Alabama Supreme Court declaring the old version, which placed a general cap on punitive damages, unconstitutional in *Henderson v. Alabama Power Co.*, 627 So. 2d 878 (Ala. 1993). *Id.* § 6-11-21 as amended "has been recognized as a complete replacement of the

A series of judicial decisions holds that all damages in wrongful death cases are considered punitive, and not compensatory.⁶⁸ Punitive damages may be awarded in cases of simple negligence, with no requirement of willful or wanton behavior by defendants.⁶⁹ The punitive damages are assessed jointly and severally against all liable defendants, regardless of their degrees of culpability, and with no right of contribution.⁷⁰ The awarding of punitive damages for simple negligence has been upheld as constitutional under state law, case law, and federal law.⁷¹

B. Alaska

In an action to recover damages for personal injury based on negligence, accruing before August 7, 1997, damages for non-economic losses are limited to compensation for pain, suffering, inconvenience, physical impairment, and loss of enjoyment of life, and are limited to \$500,000 per plaintiff.⁷² The \$500,000 limit does not apply to damage awards for severe disfigurement or physical impairment.⁷³

In an action to recover damages for personal injury or wrongful death, accruing on or after August 7, 1997, all damage claims for non-economic losses are limited to compensation for pain, suffering, inconvenience, physical impairment, disfigurement, loss of enjoyment of life, and loss of consortium.⁷⁴ The amount of the basic cap is the greater of \$400,000 or the plaintiff's life expectancy, in years, multiplied by \$8,000.⁷⁵ In a personal injury action, when the damages are awarded for severe permanent physical impairment or severe disfigurement, damages

old statutory restrictions on punitive damages." *Id.* In *Hodgen*, the Court ultimately upheld the statute by affirming the trial court's judgment on the condition that it was lowered to meet the \$1,500,000 punitive damage cap. *Id.*

68. McCullough, *Alabama*, *supra* note 64; see *Savannah & Memphis R.R. v. Schearer*, 58 Ala. 672, 680 (Ala. 1877); *Tatum v. Schering Corp.*, 523 So. 2d 1042 (Ala. 1988); *Killough v. Jahandarfarid*, 578 So. 2d 1041 (Ala. 1991) (minor decedent). Alabama's wrongful death statutes do not indicate this treatment by the courts. McCullough, *Alabama*, *supra* note 64; see Ala. Code § 6-5-391 (Supp. 1997) (for minors); § 6-5-410 (1993).

69. McCullough, *Alabama*, *supra* note 64; see *Black Belt Wood Co. v. Sessions*, 514 So. 2d 1249 (Ala. 1986).

70. *Id.*

71. *Id.*; see *Killough v. Jahandarfarid*, 578 So. 2d 1041 (Ala. 1991); see *Louis Pizitz Dry Goods Co. v. Weldell*, 274 U.S. 112 (1927).

72. ALASKA STAT. § 09.17.010 (Michie 1996); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Alaska*, <http://www.mcandl.com/alaska.html> (revised February 6, 1998).

73. *Id.*

74. ALASKA STAT. § 09.17.010 (Michie 1997); McCullough, *Alaska*, *supra* note 72.

75. *Id.*

may not exceed the greater of \$1,000,000 or the plaintiff's life expectancy, in years, multiplied by \$25,000.⁷⁶ The amended statute clarifies that multiple injuries sustained by one claimant resulting from one incident are treated as a single injury, invoking only one cap, and that consortium claims do not open up a second cap.⁷⁷

Alaska also has a new cap on punitive damages, applicable to claims accruing on or after August 7, 1997.⁷⁸ Ordinarily punitive damages will be limited to the greater of three times the compensatory damages awarded to the plaintiff or \$500,000.⁷⁹ However, if the defendant was motivated by financial gain and the adverse consequences of his conduct were actually known, the limit is the greatest of four times the compensatory damages awarded to the plaintiff, four times the financial gain that the defendant received, or \$7,000,000.⁸⁰

C. Arizona

Arizona does not place a cap on the amount of damages recoverable in a medical malpractice action.⁸¹ The Arizona constitution prohibits enacting any law that limits the damages recoverable for personal injury or death.⁸²

D. Arkansas

Although Arkansas does not have a provision that specifically limits the amount of damages in a medical malpractice action, the legislature passed the Civil Justice Reform Act of 2003, which places a limit on punitive damages.⁸³ Judgments for plaintiffs in medical

76. *Id.*

77. *Id.*

78. ALASKA STAT. § 09.17.020 (Michie 2003); McCullough, *Alaska*, *supra* note 72. The finder of fact first must determine if punitive damages are allowed in the action. ALASKA STAT. § 09.17.020 (Michie 2003). To award punitive damages, the plaintiff must prove by clear and convincing evidence that the defendant's conduct was either outrageous, including acts done with malice or bad motive, or evidenced reckless indifference to the interest of another person. *Id.* After it has been determined that punitive damages can be awarded, a separate proceeding must be conducted to determine the amount of punitive damages to be awarded. *Id.*

79. *Id.*; McCullough, *Alaska*, *supra* note 72.

80. *Id.*

81. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Arizona*, <http://www.mcandl.com/arizona.html> (revised February 6, 1998).

82. ARIZ. CONST. of 1911, art. II, § 31.

83. ARK. CODE ANN. § 16-55-208 (2003). The statute places a punitive damage limit of "(1) \$250,000 or (2) three times the amount of compensatory damages awarded in the action, not to exceed \$1,000,000." *Id.* The statute creates an exception to when the section will not apply—when the fact finder "(1) determines by clear and convincing evidence that, at the time of the injury, the

malpractice actions that exceed \$100,000 are to be paid by periodic payments as determined by the court, rather than by a lump sum payment.⁸⁴ All medical malpractice injury cases must be brought within two years after the cause of action accrues.⁸⁵

E. California

In California, damages for non-economic losses, defined as compensation for pain, suffering, inconvenience, physical impairment, disfigurement and other non-pecuniary injury, are limited to \$250,000.⁸⁶ The cap applies whether the action is for personal injury or wrongful death, allowing only one \$250,000 recovery in a wrongful death case.⁸⁷ There is authority for allowing separate caps for the patient and a spouse claiming loss of consortium.⁸⁸ The cap on non-economic damages has been held to be constitutional.⁸⁹

F. Colorado

Damages for medical malpractice against a hospital or physician may not exceed \$1,000,000 per patient, including any claim for derivative non-economic loss or injury by any other claimant.⁹⁰ Not more than \$250,000 may be attributable to non-economic loss or injury.⁹¹ However, if the court finds that the future economic damages

defendant intentionally pursued a course of conduct for the purpose of causing injury or damage; and (2) determines that the defendant's conduct did, in fact, harm the plaintiff." *Id.*

84. ARK. CODE ANN. § 16-114-208 (2003). The statute states that damages may include compensation for actual economic losses including "the cost of reasonable and necessary medical services, rehabilitation services, custodial care, loss of services, and loss of earnings or earning capacity." *Id.*

85. ARK. CODE ANN. § 16-114-203 (2003). If the medical injury involves a foreign object in the body that could not have reasonably been discovered, the action can be brought within one year from the date of discovery. *Id.*

86. CAL. CIVIL CODE §3333.2 (West 1997). For a more detailed analysis of California's medical malpractice cap law, see § V, *infra*.

87. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: California*, <http://www.mcandl.com/california.html> (revised February 6, 1998); see *Yates v. Pollock*, 239 Cal. Rptr. 383 (Cal. App. Dep't Super. Ct. 1987).

88. *Id.*; see *Atkins v. Strayhorn*, 273 Cal. Rptr. 231 (Cal. App. Dep't Super. Ct. 1990).

89. *Id.*; see *Fein v. Permanente Medical Group*, 695 P.2d 665 (Cal. 1985) (also upholding the modification of the collateral source rule).

90. COLO. REV. STAT. ANN. § 13-64-302 (West 1997); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Colorado*, <http://www.mcandl.com/colorado.html> (revised February 6, 1998).

91. *Id.* Effective July 1, 2003, this damages limitation increases to \$300,000, to adjust for inflation, applying to acts or omissions occurring on or after July 1, 2003. COLO. REV. STAT. ANN. § 13-64-302 (West 1997).

exceed this cap, and to impose the limitation would be unfair, it may award damages in excess of the limit.⁹² This damage cap was held to be constitutional in *Scholz v. Metropolitan Pathologists, P.C.*⁹³ The court also held that the medical malpractice damage cap superceded the general statutory cap applicable to other types of cases.⁹⁴

Punitive damages may not exceed the amount of actual damages awarded.⁹⁵ However, the court may increase the punitive damage award to an amount three times the amount of actual damages if the defendant has continued the behavior or repeated the action which is the subject of the claim in a willful and wanton manner, or if the defendant has further aggravated the plaintiff's damages by acting in a willful and wanton manner during the pendency of the action.⁹⁶ Punitive damages shall not be imposed when the injury results from the use of an approved drug or product used in accordance with standards of prudent health care professionals.⁹⁷

G. Connecticut

Connecticut does not impose a cap on damages recoverable in medical malpractice actions.⁹⁸

H. Delaware

Delaware does not place a limit on the damages a claimant may recover.⁹⁹

I. District of Columbia

The District of Columbia does not place a cap on the amount of damages recoverable in a medical malpractice action.¹⁰⁰

92. *Id.*

93. 851 P.2d 901 (Colo. 1993).

94. *Id.*; COLO. REV. STAT. ANN. § 13-21-102.5 (West 1997).

95. COLO. REV. STAT. ANN. § 13-21-102 (West 1997); McCullough, *Colorado*, *supra* note 90.

96. *Id.*

97. COLO. REV. STAT. ANN. § 13-64-302.5 (West 1997); McCullough, *Colorado*, *supra* note 90.

98. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Connecticut*, <http://www.mcandl.com/connecticut> (revised February 6, 1998).

99. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Delaware*, <http://www.mcandl.com/delaware> (revised February 6, 1998).

100. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: District of Columbia*, <http://www.mcandl.com/dc.html> (revised February 6, 1998).

J. Florida

After an acrimonious battle between Florida Governor Jeb Bush and the Florida State Senate in the past legislative session, the Florida House and Senate finally reached agreement on medical malpractice reform:

The disagreement began with the Governor and the House insisting upon a \$250,000.00 cap on non-economic damages, and the Senate being critical of any cap on damages. Subsequently, the House increased its proposed cap to \$1 million, with the Senate deciding to back a “pierceable” cap. The “pierceable” cap would allow non-economic damages to be granted in the range of \$250,000.00 to \$1 million, but would allow the collection of up to \$4 million dollars in cases of catastrophic injury or death.¹⁰¹

The compromise bill passed the legislature on August 13, 2003.¹⁰² Essentially, the bill caps non-economic damages at \$500,000 per physician and \$750,000 per hospital or healthcare facility.¹⁰³ There are two important exceptions:

The first exception provides more protection for emergency room physicians, capping their non-economic damages at \$150,000.00 per physician and \$300,000.00 total (from all practitioners). The second exception allows malpractice victims in the most egregious cases to collect a total of \$2.5 million in non-economic damages — \$1 million from physicians (by suing multiple doctors) and \$1.5 million from hospitals or other health care facilities (by suing multiple facilities).¹⁰⁴

Generally, punitive damages may not exceed the greater of three times the claimant’s compensatory damages or \$500,000.¹⁰⁵ If the fact finder determines that the wrongful conduct was motivated solely by unreasonable financial gain and the unreasonably dangerous nature of the conduct was actually known by the defendant, it may award punitive damages not to exceed the greater of four times the amount of compensatory damages or \$2,000,000.¹⁰⁶ Furthermore, if the fact finder determines that at the time of the injury the defendant had a specific

101. American Osteopathic Association, *State Government Affairs: Florida Passes PLI Reform Legislation*, <http://www.aoa-net.org/Government/stateaffairs/floridaupdate.htm> (August 2003).

102. *Id.* The compromise bill is the common name of Senate Bill 2d and House Bill 1d. *Id.*

103. *Id.*

104. *Id.*

105. FLA. STAT. ANN. §768.73 (West 1999).

106. *Id.*

intent to harm the claimant, then there is no cap on punitive damages.¹⁰⁷

In addition to its new law, which imposes caps, Florida's voluntary arbitration scheme also provides a cap on non-economic damages under certain circumstances.¹⁰⁸ Florida provides that a court may require, upon motion of either party, that the claim be submitted to non-binding arbitration.¹⁰⁹ There is also a process where the parties can submit to voluntary binding arbitration.¹¹⁰

A proceeding for voluntary binding arbitration is an alternative to a jury trial.¹¹¹ The Florida system provides that parties may submit to voluntary binding arbitration for the determination of damages, which gives the defendant an option to limit non-economic damages in return for admitting liability.¹¹² Once this option is chosen, it is the exclusive means by which to seek recovery.¹¹³ If a defendant refuses to accept the claimant's offer to arbitrate, the claimant, if successful at trial, is entitled to pre-judgment interest and up to 25 percent of the award in attorneys' fees.¹¹⁴ If a claimant refuses to accept a defendant's offer to arbitrate, his recovery will be limited to economic damages, including past and future medical expenses and 80 percent of lost wages, plus no more than \$350,000 in non-economic damages.¹¹⁵ If the claimant accepts the offer to arbitrate, recovery will be limited to economic damage, including past and future medical expenses and 80 percent of lost wages, plus no more than \$250,000 in non-economic damages, plus attorneys' fees.¹¹⁶ The damage cap in the arbitration statute has been held to be constitutional.¹¹⁷ A state appellate court decision held that an arbitrator can award no more than \$250,000 for a single wrongful death claim, regardless of the number of claimants.¹¹⁸ The Florida supreme court

107. *Id.*

108. McCullough, Campbell & Lane, *Medical Malpractice Law: Florida*, <http://www.mcandl.com/florida.html> (revised February 6, 1998).

109. FLA. STAT. ANN §766.107 (West 1997).

110. FLA. STAT. ANN §766.207 (West 2003).

111. FLA. STAT. ANN §766.209 (West 2003). If neither party requests or agrees to voluntary binding arbitration, the claim proceeds to trial. *Id.*

112. FLA. STAT. ANN §766.209 (West 2003); McCullough, *Florida, supra* note 108. Upon the completion of a pre-suit investigation with preliminary reasonable ground for a medical negligence claim, the parties may elect to have damages determined through binding arbitration. FLA. STAT. ANN §766.209 (West 2003).

113. McCullough, *Florida, supra* note 108.

114. *Id.*

115. *Id.*

116. FLA. STAT. ANN §766.209 (West 2003); McCullough, *Florida supra* note 108.

117. *University of Miami v. Echarte*, 618 So. 2d 189 (Fla. 1993), *cert. denied*, 510 U.S. 915 (1993); McCullough, *Florida, supra* note 108.

118. *St. Mary's Hosp. v. Phillipe*, 699 So.2d 1017 (Fla. Dist. Ct. App. 1997); McCullough,

found that the cap on non-economic damages of \$250,000 per incident in a voluntary arbitration under § 766.207 applies to each claimant.¹¹⁹

K. Georgia

Georgia does not place a cap on the amount of compensatory damages that may be awarded.¹²⁰ However, punitive damages are capped at \$250,000, unless the claimant can successfully demonstrate that the defendant had an intent to harm.¹²¹

L. Hawaii

Hawaii limits damages recoverable for pain and suffering to \$375,000.¹²² This limitation does not apply to intentional torts, torts relating to environmental pollution, toxic and asbestos related torts, torts relating to aircraft accidents, or strict and products liability torts.¹²³

M. Idaho

Non-economic damages for personal injury or wrongful death may not exceed \$250,000.¹²⁴ The \$250,000 cap has been adjusted on July 1 of each year since 1988 by the rate of increase or decrease in average wages in Idaho.¹²⁵ The limitation on non-economic damage awards is inapplicable to causes of action arising out of willful or reckless misconduct and to causes of action arising out of acts constituting a felony under state or federal law.¹²⁶ Punitive damages are not to exceed the greater of \$250,000 or an amount which is three times the compensatory damages.¹²⁷ In addition, Idaho law gives judges more power than the law of most states to reduce damages that are unsupported or unjustified, or is so unreasonably disproportionate to the

Florida, supra note 108.

119. *St. Mary's Hosp. v. Phillipe*, 769 So.2d 961 (Fla. 2000).

120. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Georgia*, <http://www.mcandl.com/georgia.html> (revised February 6, 1998).

121. GA. CODE ANN. § 51-12-5.1 (1992); McCullough, *Georgia, supra* note 120.

122. HAW. REV. STAT. § 663-8.7 (1995); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Hawaii*, <http://www.mcandl.com/hawaii.html> (revised February 6, 1998).

123. HAW. REV. STAT. § 663-10.9 (1995).

124. IDAHO CODE § 6-1603 (Michie 2003).

125. IDAHO CODE § 6-1603 (Michie 2003). McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Idaho*, <http://www.mcandl.com/idaho.html> (revised February 6, 1998).

126. *Id.*

127. IDAHO CODE § 6-1604 (Michie 2003).

loss or damage suffered to be unconscionable.¹²⁸

N. Illinois

Illinois has no cap on compensatory damages, but punitive damages are not allowed.¹²⁹ In 1995, the Illinois legislature passed a \$500,000 limit on non-economic damages in medical malpractice cases, but this was specifically held unconstitutional in *Best v. Taylor Machine Works*.¹³⁰ The *Best* decision did not invalidate a pre-existing statute prohibiting punitive damages in medical malpractice cases.¹³¹

O. Indiana

The limits on recoveries in medical malpractice claims against qualified providers have increased substantially under new legislation scheduled to take effect in cases arising out of acts of malpractice that occur on or after July 1, 1999.¹³² For claims accruing prior to January 1, 1990, the total amount recoverable for an injury or death of a patient may not exceed \$500,000.¹³³ As of January 1, 1990, the maximum recoverable was increased to \$750,000.¹³⁴ For claims accruing on or after July 1, 1999, the total cap on damages against all is \$1,250,000.¹³⁵ A health care provider qualified under the statute is not liable for an amount in excess of \$250,000.¹³⁶ The original version of the cap was held to be constitutional in *Johnson v. St. Vincent Hospital*.¹³⁷

P. Iowa

Iowa does not place a cap on the amount of damages recoverable in a medical malpractice action.¹³⁸

128. IDAHO CODE § 6-807 (Michie 1997).

129. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Illinois*, <http://www.mcandl.com/illinois.html> (revised August 31, 2002); see 735 ILL. COMP. STAT. ANN. § 5/2-1115.1 (West Supp. 2002). In all cases where the plaintiff seeks damages for medical or hospital malpractice, no punitive damages are allowed. *Id.*

130. 689 N.E.2d 1057 (Ill. 1997).

131. *Id.*; see 735 Ill. Comp. Stat. Ann. § 5/2-1115 (West 1992).

132. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Indiana*, <http://www.mcandl.com/indiana.html> (revised July 30, 1999).

133. IND. CODE ANN. § 34-18-14-3 (West Supp. 1998); McCullough, *Indiana supra* note 132.

134. *Id.*

135. *Id.*

136. *Id.*

137. 404 N.E.2d 585, 598-602 (Ind. 1980); McCullough, *Indiana, supra* note 132.

138. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Iowa*, <http://www.mcandl.com/iowa.html> (revised February 6, 1998).

Q. Kansas

In any personal injury action, non-economic damages are limited to a total of \$250,000 per plaintiff as against all defendants.¹³⁹ If the action is tried to a jury, the court should not instruct the jury about this limitation, and if the jury awards non-economic damages in excess of the limit, the judge should enter an award of \$250,000.¹⁴⁰ This statute has been interpreted to mean that separate claims brought within a single action should be aggregated under the cap, not treated separately.¹⁴¹ In wrongful death actions, damages are limited to \$250,000, except for pecuniary loss sustained by an heir at law.¹⁴² Both of these limitations have been upheld as constitutional.¹⁴³ The Supreme Court of Kansas held that statutes setting an absolute cap in medical malpractice actions, rather than a cap on non-pecuniary damages only, were unconstitutional in *Kansas Malpractice Victims Coalition v. Bell*.¹⁴⁴

In any civil action, punitive damages are limited to the lesser of the defendant's highest gross income for the prior five years or \$5,000,000.¹⁴⁵ If the court determines this amount is clearly inadequate to penalize the defendant, the court may award up to 50 percent of the net worth of the defendant.¹⁴⁶ If the court finds the profitability of the defendant's misconduct exceeds the limitation, the limitation on that amount of punitive damages which the court may award shall be an amount equal to one and one half times the profit instead.¹⁴⁷ The judge, not the jury, determines the amount of punitive damages.¹⁴⁸ Punitive damages are not available in a wrongful death case.¹⁴⁹

139. KAN. STAT. ANN. § 60-19a02 (1994); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Kansas*, <http://www.mcandl.com/kansas.html> (revised September 4, 2002).

140. *Id.*

141. Hoover v. Innovative Health of Kansas, Inc., 988 P.2d 287 (Kan. 1999); McCullough, *Kansas*, *supra* note 139.

142. KAN. STAT. ANN. § 60-1903 (Supp. 2001); McCullough, *Kansas*, *supra* note 139.

143. Samsel v. Wheeler Transp. Serv., Inc., 789 P.2d 541 (Kan. 1990); Leiker v. Gafford, 778 P.2d 823 (Kan. 1989); McCullough, *Kansas*, *supra* note 139.

144. 757 P.2d 251 (Kan. 1988); McCullough, *Kansas*, *supra* note 139.

145. KAN. STAT. ANN. § 60-3702 (1994); McCullough, *Kansas*, *supra* note 139.

146. KAN. STAT. ANN. § 60-3702 (1994).

147. *Id.*; McCullough, *Kansas*, *supra* note 139.

148. *Id.*

149. Smith v. Printup, 938 P.2d 1261 (Kan. 1997) (also holding statute constitutional); McCullough, *Kansas*, *supra* note 139.

R. *Kentucky*

Kentucky does not impose a statutory cap on damages recoverable in medical malpractice actions.¹⁵⁰

S. *Louisiana*

In Louisiana, there is no damage cap for those not insured by the state, but qualified health care providers have their liability limited to \$100,000.¹⁵¹ Punitive damages are not recoverable in Louisiana, except as specifically authorized by statute.¹⁵²

T. *Maine*

Maine does not impose a cap on the amount of damages that may be collected in a medical malpractice action.¹⁵³ Non-economic damages in a wrongful death action are limited to \$400,000 and punitive damages are limited to \$75,000.¹⁵⁴

U. *Maryland*

Maryland limits non-economic damages for any personal injury cause of action for medical malpractice accruing after July 1, 1986.¹⁵⁵ The limit was originally \$350,000, but for causes of actions arising on or after October 1, 1994, the limit has been increased to \$500,000.¹⁵⁶ Beginning October 1, 1995, and every October 1 thereafter, the limit on non-economic damages is increased by \$15,000.¹⁵⁷ Non-economic damages in personal injury actions include pain, suffering, inconvenience, physical impairment, disfigurement, loss of consortium, and other non-pecuniary damages, but not punitive damages.¹⁵⁸ The cap

150. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Kentucky*, <http://www.mcandl.com/kentucky> (revised February 6, 1998).

151. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Louisiana*, <http://www.mcandl.com/louisiana.html> (revised February 6, 1998); see *Billiot v. B.P. Oil Co.*, 645 So.2d 604 (La. 1994).

152. *Id.*

153. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Maine*, <http://www.mcandl.com/maine.html> (revised February 6, 1998).

154. ME. REV. STAT. ANN. tit. 18-A, § 2-804 (West 1999).

155. MD. CODE ANN., Cts. and Jud. Proc. § 11-108 (Supp. 1997); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Maryland*, <http://www.mcandl.com/maryland.html> (revised February 6, 1998).

156. *Id.*

157. *Id.*

158. *Id.*

on non-economic damages applies to each “direct victim” of the tort and all those claiming injury by or through him.¹⁵⁹ The statute has been found not to violate Maryland’s constitution.¹⁶⁰

Prior to the 1994 amendment, the statute had been found not to apply to wrongful death cases.¹⁶¹ However, the statute now provides that the cap applies to wrongful death cases, and that the total recovery of all beneficiaries in a wrongful death case cannot exceed 150 percent of the cap.¹⁶²

V. *Massachusetts*

In Massachusetts, in a medical malpractice case, the jury is instructed that if it finds the defendant liable, it is not to award the plaintiff more than \$500,000 for pain and suffering, loss of companionship, embarrassment, and other items of general damages, unless it determines that there is

a substantial or permanent loss or impairment of a bodily function or substantial disfigurement, or other special circumstances in the case which warrant a finding that imposition of such a limitation would deprive the plaintiff of just compensation for the injuries sustained.¹⁶³

W. *Michigan*

Michigan limits non-economic damages, including pain, suffering, inconvenience, physical impairment, and physical disfigurement, in a medical malpractice action.¹⁶⁴ The maximum for all plaintiffs, resulting from the negligence of all defendants, was set at \$280,000 in 1993.¹⁶⁵ In instances of paralysis due to brain or spinal cord injury, impairment of cognitive capacity, or loss of reproductive ability, in which case the limit

159. *Oaks v. Connors*, 660 A.2d 423 (Md. 1995) (a single cap applies to the injured person’s claim and the spouse’s consortium claim); McCullough, *Maryland*, *supra* note 155.

160. *Murphy v. Edmonds*, 601 A.2d 102 (Md. 1992); McCullough, *Maryland*, *supra* note 155.

161. *United States v. Streidel*, 620 A.2d 905 (Md. 1993); McCullough, *Maryland*, *supra* note 155.

162. MD. CODE ANN., Cts. & Jud. Proc. § 11-108 (Supp. 1997); McCullough, *Maryland*, *supra* note 155.

163. MASS. GEN. LAWS ch. 231, § 60H (West 2000). This standard can often be met, so the cap should not be relied on. *Id.* McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Massachusetts*, <http://www.mcandl.com/massachusetts.html> (revised February 6, 1998).

164. MICH. COMP. LAWS ANN. § 600.1483 (West 1996); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Michigan*, <http://www.mcandl.com/michigan.html> (revised August 31, 2002).

165. *Id.*

was \$500,000.¹⁶⁶ These caps are increased annually with the cost of living, and as of 2002 were \$349,700 and \$624,500.¹⁶⁷ The jury is not to be advised of the damage limits, but any jury award in excess of these amounts must be reduced by the court.¹⁶⁸

The current statutory caps apply only to causes of action arising on or after April 1, 1994.¹⁶⁹ The statute, before it was amended in 1994, had a major exception to the cap, including death or loss of a vital bodily function, and the latter exception was interpreted broadly.¹⁷⁰ The statutory cap on non-economic damages was held constitutional.¹⁷¹ The current statute makes no specific reference to wrongful death, and it has been held that the wrongful death act governs, precluding the application of the medical malpractice cap.¹⁷²

X. Minnesota

Minnesota has not enacted a cap on the damages that can be awarded in a medical malpractice case.¹⁷³

Y. Mississippi

In October 2002, Mississippi enacted a law capping non-economic damages for claims for causes of action filed before July 1, 2011, at \$500,000.¹⁷⁴ For claims for causes of action filed on or after July 1, 2011, but before July 1, 2017, the limit increases to \$750,000.¹⁷⁵ For claims for causes of action filed on or after July 1, 2017, the limit increase to \$1,000,000.¹⁷⁶ The statutory scheme requires cases to be filed only in the county where the cause of action occurred, shortening the statute of limitations for suing nursing homes from three to two

166. *Id.*

167. *Id.*

168. MICH. COMP. LAWS ANN. § 600.6304(5) (West 2000); McCullough, *Michigan*, *supra* note 164.

169. *Tobin v. Provid. Mem'l Hosp.*, 624 N.W.2d 548 (Mich. 2001); McCullough, *Michigan*, *supra* note 164.

170. *Lewis v. Krogol*, 582 N.W.2d 524 (Mich. Ct. App. 1998), *cert. denied* 598 N.W.2d 632 (Mich. 1999); McCullough, *Michigan*, *supra* note 164.

171. *Zdrojewski v. Murphy*, 657 N.W.2d 721 (Mich. Ct. App. 2002).

172. *Jenkins v. Patel*, 662 N.W.2d 453 (Mich. Ct. App. 2003).

173. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Minnesota*, <http://www.mcandl.com/minnesota> (revised February 6, 1998).

174. MISS. CODE ANN. § 11-1-60 (2003); Insurance Information Institute, *Hot Topics and Insurance Issues: Medical Malpractice*, <http://www.iii.org/media/hottopics/insurance/medicalmal/> (September 2003).

175. *Id.*

176. *Id.*

years, and other provisions.¹⁷⁷

Z. *Missouri*

In any medical malpractice action for damages for personal injury or death, a claimant's recovery of non-economic damages from any one defendant is limited by statute.¹⁷⁸ The limitation amount is adjusted on January 1 of each year in accordance with a standard index of inflation.¹⁷⁹ For 2004, the cap was approximately \$565,000 from any one defendant.¹⁸⁰ The cap is calculated annually by the Director of the Division of Insurance and published in the Missouri Register.¹⁸¹ The damage cap, together with other tort reform measures, has been held to be constitutional.¹⁸²

It should be noted, “[f]ollowing Missouri Governor Bob Holden’s [recent] veto of a tort reform bill that contained a number of provisions unrelated to medical malpractice, the Missouri State Medical Association now says it would support legislation dealing solely with medical malpractice concerns.”¹⁸³

AA. *Montana*

For medical malpractice causes of action arising on or after October 1, 1995, Montana limits the award for past and future damages for non-economic loss to \$250,000.¹⁸⁴ Non-economic damages is defined as subjective, non-monetary loss, including but not limited to, physical and mental pain and suffering, emotional distress, inconvenience, loss from physical impairment or disfigurement, loss of companionship or consortium, and injury to reputation or humiliation.¹⁸⁵ The cap applies only once to an injury even if caused by a series of acts and more than

177. Ins. Info. Inst., *supra* note 174.

178. MO. ANN. STAT. § 538.210 (West 1988); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Missouri*, <http://www.mcandl.com/missouri.html> (revised February 6, 1998).

179. *Id.*

180. *Missouri Register*, Mo. Reg., Vol. 29, No. 6 (March 15, 2004).

181. MO. ANN. STAT. § 538.210 (West 1988); McCullough, *Missouri*, *supra* note 178.

182. *Adams v. Children’s Mercy Hosp.*, 832 S.W.2d 898 (Mo. 1992), *cert. denied*, 506 U.S. 991 (1992); McCullough, *Missouri*, *supra* note 178.

183. Ins. Info. Inst., *supra* note 174.

184. MONT. CODE ANN. § 25-9-411 (1997); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Montana*, <http://www.mcandl.com/montana.html> (revised February 6, 1998).

185. *Id.*

one health care provider.¹⁸⁶ The jury is not instructed about the cap and any award that exceeds it is reduced by the court.¹⁸⁷

BB. Nebraska

Nebraska does not generally impose limits on compensatory damages in medical malpractice actions.¹⁸⁸ Special rules apply to health care providers that qualify for state-sponsored excess insurance.¹⁸⁹ It is a fundamental rule of law in Nebraska that punitive, vindictive, or exemplary damages are not allowed.¹⁹⁰

CC. Nevada

In May 2003, Nevada Gov. Kenny Guinn signed into law a bill that prohibits medical malpractice insurers from using any financial loss sustained through investments as justification for increasing premiums paid by doctors.¹⁹¹ The law also includes a provision that prohibits medical malpractice insurers from basing rates for obstetricians on the number of babies they deliver in a year.¹⁹²

In July 2002, the state passed Assembly Bill 1, limiting non-economic damages to \$355,000, adopting new joint and several liability standards for economic damages, and limiting physician liability in

186. *Id.*

187. *Id.*

188. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Nebraska*, <http://www.mcandl.com/nebraska.html> (revised February 6, 1998).

189. NEB. REV. STAT. § 44-2829 (1993). Nebraska provides an excess liability fund for the benefit of qualified health care providers. *Id.* To qualify for coverage by the excess liability fund, a health care provider must file proof of financial responsibility and pay a surcharge. NEB. REV. STAT. § 44-2824 (Supp. 1996). Physicians establish their financial responsibility by obtaining professional liability insurance in the amount of \$200,000 per occurrence and \$600,000 in the aggregate. *Id.* Hospitals establish their financial responsibility by obtaining insurance in the amount of \$200,000 per occurrence and \$1,000,000 in the aggregate. *Id.* Hospitals run by the University of Nebraska may prove financial responsibility by establishing a self-insurance trust. NEB. REV. STAT. § 44-2827.01 (1993). Once a health care provider has qualified under the Act, the Act becomes the exclusive method of recovery, unless the claimant has elected in writing prior to treatment not to come under the provisions of the Act. NEB. REV. STAT. §§ 44-2821 and 44-2840 (1993 & Supp. 1996). The total amount recoverable under the Nebraska Hospital-Medical Liability Act for any occurrence resulting in injury or death is \$1,250,000 (or \$1,000,000 if the occurrence took place prior to 1993). NEB. REV. STAT. § 44-2825 (1993). The liability of a single qualified health care provider is limited to \$200,000 per patient. *Id.* The excess liability fund pays the damages in excess of \$200,000 for each defendant, up to the amount of the cap. *Id.*

190. *Miller v. Kingsley*, 230 N.W.2d 472 (Neb. 1975).

191. *Ins. Info. Inst.*, *supra* note 174.

192. *Id.*

government and non-profit trauma facilities to \$50,000.¹⁹³

DD. New Hampshire

The New Hampshire legislature has placed a \$250,000 limitation on medical malpractice damages.¹⁹⁴ The New Hampshire Supreme Court, however, has declared the medical malpractice damage cap unconstitutional.¹⁹⁵ The legislature has also attempted to place an \$875,000 limitation on personal injury actions,¹⁹⁶ but the court overruled the statute.¹⁹⁷ New Hampshire has outlawed punitive damages, unless punitive damages are expressly provided by statute.¹⁹⁸

Damages recoverable in a wrongful death action may not exceed \$50,000, except where the party recovering is a spouse, child, parent, or any dependent relative.¹⁹⁹ Damages are never awarded for loss of society and companionship in death cases, except that effective January 1, 1998, such damages may be awarded to a surviving spouse, up to a limit of \$150,000.²⁰⁰

EE. New Jersey

New Jersey has recently been a hot bed for protest by physicians, with the issue of caps and insurance reform coming to a head following a physicians' strike in 2003:

In a shift of position, New Jersey, Insurance Commissioner Holly Bakke says that she favors dropping, for the time being, any attempt to cap non-economic damages in medical malpractice cases and supports subsidies to help doctors pay for their insurance. She also suggests that reimbursement for doctors needs attention, noting that while doctors used to be able to pass their insurance costs along to patients in the past, they can no longer do so because most are under contracts with

193. A.B. 1, 2002 Nevada Laws, 18th Sp. Sess. (Nev. 2002); Jerome Harleston, *Medical Malpractice Tort Reform*, <http://www.cga.state.ct.us/2002/olrdata/ins/rpt/2002-R-0782.htm>.

194. N.H. REV. STAT. ANN. § 507-C:7 (1997).

195. See *Carson v. Maurer*, 424 A.2d 825 (N.H. 1980) (holding the statute violates the state's equal protection clause: "[I]t arbitrarily and unreasonably discriminates in favor of the class of health care providers. Although the statute may promote the legislative objective of containing health care costs, the potential cost to the general public and the actual cost to many medical malpractice plaintiffs is simply too high.").

196. N.H. REV. STAT. ANN. § 508-4-d (1997).

197. See *Brannigan v. Usitalo*, 587 A.2d 1232 (N.H. 1991) (concluding that the statute violates the equal protection component of the state's constitution).

198. N.H. REV. STAT. ANN. § 507-16 (2003).

199. N.H. REV. STAT. ANN. § 556-13 (1997).

200. N.H. REV. STAT. ANN. § 556-12 (Supp. 1997).

HMO's. And she wants insurers to look more carefully at the fact that a small percentage of doctors are responsible for a disproportionate number of claims and that doctors in particularly risky specialties, e.g. obstetrics and neurosurgery, are penalized for taking on the risks. She noted that the medical malpractice insurance crisis has been slightly alleviated by the increasing number of claims-made policies now available in the state. An earlier proposal to set a \$300,000.00 limit on insurers' liability for non-economic damages in malpractice cases, with damage awards over \$300,000.00 being paid from a fund created through a surcharge on doctors, lawyers and employers is dead.²⁰¹

Current law says that for actions filed on or after October 27, 1997, no defendant is liable for any punitive damages in any action for an amount in excess of five times the liability of that defendant for compensatory damages, or \$350,000, whichever is greater.²⁰²

FF. New Mexico

New Mexico created a statutory scheme which limited liability for health care providers that met qualification requirements.²⁰³ In medical malpractice actions against a qualified health care provider tried before a jury, a \$600,000 limit applies to all damages, with the exception of punitive damages and damages for medical expenses.²⁰⁴ For incidents prior to April 1, 1995, the limit is \$500,000.²⁰⁵ The \$600,000 limit on damages does not include future medical expenses, which are not covered by monetary damages.²⁰⁶ If the jury finds that a plaintiff

201. Ins. Info. Inst., *supra* note 174.

202. N.J. STAT. ANN. § 2A:15-5.14(b) (West Supp. 1997); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: New Jersey*, <http://www.mcandl.com/newjersey> (revised February 6, 1998).

203. N. M. STAT. ANN. § 41-5-5 and 41-5-6 (Michie 1996 and Supp. 1997).

204. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: New Mexico*, <http://www.mcandl.com/newmexico.html> (revised February 6, 1998). Under New Mexico law, a patient's compensation fund, established pursuant to N.M. STAT. ANN. § 41-5-25 (Michie Supp. 1997), is financed by a surcharge on all qualified health care providers. *Id.* The excess over \$200,000 per occurrence of any judgment obtained in a medical malpractice action against a qualified health care provider will be paid by the patient's compensation fund. N.M. Stat. Ann. § 41-5-6 (Michie 1996); McCullough, *New Mexico, supra*. However, the patient's compensation fund does not cover a health care provider's liability for punitive damages. *Id.* To qualify under the plan, a health care provider must pay the surcharge and carry liability insurance with limits of \$200,000 per occurrence or deposit an equivalent amount of security with the Superintendent of Insurance. N.M. STAT. ANN. § 41-5-5 (Michie 1996); McCullough, *New Mexico, supra*; see N.M. Stat. Ann. § 41-5-6 (Michie 1996).

205. McCullough, *New Mexico, supra* note 204.

206. N.M. STAT. ANN. § 41-5-7 (Michie 1989 & Supp. 1997); McCullough, *New Mexico, supra* note 204.

requires future medical care, the expense of that care must be paid as incurred.²⁰⁷

GG. New York

New York does not limit the amount of damages recoverable in medical malpractice actions.²⁰⁸

HH. North Carolina

North Carolina generally does not limit the compensatory damages recoverable in medical malpractice actions.²⁰⁹ However, for actions filed on or after January 1, 1996, punitive damages are limited to three times compensatory damages or \$250,000, whichever is greater.²¹⁰

II. North Dakota

In a wrongful death action or a physical injury action, the trier of fact may award compensation for economic and non-economic damages, but the statute does not explicitly limit either award.²¹¹ The court may review awards in excess of \$250,000 for reasonableness upon request from the party responsible for the damages.²¹² The moving party must establish that the amount of economic damages awarded did not bear a reasonable relation to the economic damage incurred.²¹³ If the court determines that the economic damages awarded were unreasonable, the court must reduce the award to “reasonable economic damages.”²¹⁴

For claims arising after April 1, 1995, there is a \$500,000 cap on

207. *Id.*

208. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: New York*, <http://www.mcandl.com/newyork> (revised February 6, 1998).

209. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: North Carolina*, <http://www.mcandl.com/northcarolina.html> (revised February 6, 1998).

210. N.C. GEN. STAT. § 1D-25 (1995); McCullough, *North Carolina*, *supra* note 209.

211. N.D. CENT. CODE § 32-03.2-04 (2003). “Economic damages” refers to “damages arising from medical expenses, and medical care, rehabilitation services, custodial care, loss of earnings and earning capacity, loss of income or support, burial costs, cost of substitute domestic services, loss of employment or business or employment opportunities and other monetary losses.” *Id.* Non-economic damages refer to “damages arising from pain, suffering, inconvenience, physical impairment, disfigurement, mental anguish, emotional distress, fear of injury, loss of society and companionship, loss of consortium, injury to reputation, humiliation, and other nonpecuniary damage.” *Id.*

212. *Id.*

213. *Id.*

214. *Id.*

non-economic damages in medical malpractice cases.²¹⁵ This applies regardless of the number of defendants, the number of theories, or the number of family members who sue.²¹⁶ Punitive damages are limited to twice compensatory damages or \$250,000.²¹⁷

JJ. Ohio

In 1997, the Ohio legislature passed a series of civil reform legislation to place damage caps on non-economic damages, but the Ohio Supreme Court struck down the legislation as unconstitutional.²¹⁸ Recently, the Ohio legislature responded by passing a new series of legislation to place limitations on medical malpractice damages.²¹⁹ A medical malpractice claim must be commenced within one year after the cause of action accrued.²²⁰ But if the injury could not have reasonably been discovered within a four-year window, the person must bring the action within one year after the person discovered the injury.²²¹ In a medical malpractice claim, there is no limitation on compensatory damages that represent economic loss, but there is a \$250,000 limitation on damages that represent non-economic damages.²²² In the alternative, non-economic damages must not exceed an amount “equal to three times the plaintiff’s economic loss[,] . . . to a maximum of \$350,000 for each plaintiff or a maximum of \$500,000 for each occurrence.”²²³

215. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: North Dakota*, <http://www.mcandl.com/northdakota.html> (revised February 6, 1998); see N.D. CENT. CODE § 32-62-02 (1996).

216. *Id.*

217. *Id.*; see N.D. CENT. CODE § 32-03.2-11 (Supp. 1997).

218. See *Ohio Academy of Trial Lawyers v. Sheward*, 751 N.E.2d 1062 (Ohio 1999) (holding the civil justice reform legislation (Am.Sub.H.B. No. 350) unconstitutional on the grounds that it violated the “one-subject” rule—“no bill shall contain more than one subject, which shall be clearly expressed in its title,” and the legislation violated separation of powers by overstepping its legislative bounds). See also, *Morris v. Savoy*, 578 N.E.2d 765 (Ohio 1991) (concluding a cap on general damages was unconstitutional because it “does not bear a real and substantial relation to public health or welfare and further because it is unreasonable and arbitrary”).

219. OHIO REV. CODE ANN. §§ 2323.43, 2305.113 (2003).

220. OHIO REV. CODE ANN. § 2305.113 (2003).

221. *Id.*

222. OHIO REV. CODE ANN. § 2323.43 (2003).

223. *Id.* The statute also makes an exception that non-economic damages “shall not exceed \$500,000 for each plaintiff or \$1,000,000 for each occurrence if the noneconomic losses of the plaintiff are for either of the following: (a) Permanent and substantial physical deformity, loss of use of a limb, or loss of a bodily organ system; (b) Permanent physical functional injury that permanently prevents the injured person from being able to independently care for self and perform life sustaining activities.” *Id.*

KK. Oklahoma

Oklahoma limits punitive damages in medical malpractice cases.²²⁴ In cases of reckless disregard of the rights of others, punitive damages are limited to \$100,000.²²⁵ In cases of intentional and malicious acts, punitive damages are limited to the greater of \$500,000, twice compensatory damages, or the benefit derived by defendant from his conduct.²²⁶ If the jury finds by clear and convincing evidence that the defendant acted intentionally and with malice toward others or the court finds that there is evidence beyond a reasonable doubt that the defendant acted intentionally with malice and threatened human life, the cap does not apply.²²⁷ The court will reduce punitive damages if it finds that the defendant has already paid punitive damages in Oklahoma for the same misconduct.²²⁸

LL. Oregon

The Oregon legislature established a \$500,000 damage cap for non-economic damages in all civil actions arising out of bodily injury, death, or property damage.²²⁹ The Oregon Supreme Court, however, found the non-economic damage cap to be unconstitutional because it violated a victim's right to a trial by jury.²³⁰

Punitive damages cannot be awarded against a health care practitioner, but the provision does not apply to hospitals or health care providers.²³¹ In an action where punitive damages are awarded, 40 percent of the punitive damages are paid to the prevailing party, of

224. OKLA. STAT. ANN. tit. 23, § 9.1 (West 2003).

225. OKLA. STAT. ANN. tit. 23, § 9.1 (West 2003); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Oklahoma*, <http://www.mcandl.com/oklahoma.html> (revised February 6, 1998).

226. *Id.*

227. *Id.*

228. *Id.*

229. OR. REV. STAT. § 18.560 (2001). The statute specifies that it does not apply to punitive damages. *Id.*

230. *See* *Lakin v. Senco Prod., Inc.*, 987 P.2d 463 (Or. 1999) (concluding that the noneconomic damage cap is unconstitutional because when a jury awards a verdict greater than the \$500,000 limit, the statute "prevents the jury from having its full and intended effect"). Therefore, "to permit the legislature to override the effect of the jury's determination of noneconomic damages would 'violate' plaintiffs' right to 'Trial by Jury.'" *Id.* The Oregon Supreme Court made it clear, however, that it did not overrule *Greist v. Phillips*, 906 P.2d 789 (Or. 1995), which held that there was no right to trial by jury in a wrongful death action because a wrongful death claim was not recognized at common law, but was rather created by statute. *Id.* at 77.

231. OR. REV. STAT. § 18.550 (2001).

which not more than 20 percent may be paid for attorneys' fees.²³² The remaining 60 percent must be paid to the Criminal Injuries Compensation Account.²³³ The Oregon Supreme Court has held the punitive damages statute to be constitutional.²³⁴ Punitive damages can only be awarded in a civil action if it can be proven by clear and convincing evidence that the party acted with malice or a "reckless . . . indifference to a highly unreasonable risk."²³⁵

MM. Pennsylvania

While Pennsylvania does not impose a cap on compensatory damages it is

one of the states most seriously affected by the medical malpractice liability insurance crisis, continues to grapple with the problem. The Pennsylvania Department of Insurance released a new study showing that medical malpractice insurers lost \$18 million in their operations in the state last year. The analysis shows that even after accounting for reserves, malpractice insurance underwriters in Pennsylvania incurred losses in 2002 for the fourth consecutive year. The state authorities said that the malpractice underwriters earned \$46.4 million in investment income last year while paying out \$345.9 million in claims, \$136.9 million in legal costs and \$81.1 million for taxes and other operating expenses. In response, Governor Ed Rendell has proposed state subsidies of \$200 million to help doctors pay for insurance over the next three years. Doctors in the state buy the first \$500,000.00 of coverage from private insurers and the second \$500,000.00 from the state's catastrophic insurance MCARE Fund.²³⁶

Effective January 25, 1997, punitive damages against individual physicians shall not exceed 200 percent of compensatory damages, except in cases of intentional misconduct.²³⁷ Under current law, 25 percent of punitive damages in medical malpractice cases must be paid

232. OR. REV. STAT. § 18.540 (2001).

233. *Id.*

234. *See DeMendoza v. Huffman*, 51 P.3d 1232 (Or. 2002) (holding that §18.540 does not violate the Oregon Constitution).

235. OR. REV. STAT. § 18.537 (2001).

236. Ins. Info. Inst., *supra* note 174.

237. PA. STAT. ANN. tit. 40, § 1303.505(d) (LEXIS 2003); Pa. Stat. Ann. tit. 40 § 1301.812-A(g) (LEXIS archives) (repealed 2002); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Pennsylvania*, <http://www.mcandl.com/pennsylvania.html> (revised May 30, 2003). Punitive damages, when awarded, shall not be less than \$100,000, unless a lower verdict amount is returned by the trier of fact. PA. STAT. ANN. tit. 40, § 1303.505(d) (LEXIS 2003).

into a special, state sponsored Fund rather than to the prevailing party.²³⁸

NN. Rhode Island

Rhode Island does not permit punitive damages in any action brought by or against the executor or administrator of an estate.²³⁹ There is a \$250,000 minimum recovery in any wrongful death action.²⁴⁰

OO. South Carolina

South Carolina does not impose a cap on the amount of damages that a claimant can recover in a medical malpractice case.²⁴¹

PP. South Dakota

In any action for damages for personal injury or death in a medical malpractice action in South Dakota, the total general damages may not exceed \$500,000.²⁴² This section formerly provided for a cap of \$1,000,000 on all damages, whether economic or non-economic.²⁴³ The cap on all damages, however, was found to violate the state constitution.²⁴⁴ The court also held that the cap applied separately to the

238. *Id.*; see PA. STAT. ANN. tit. 40, § 1303.505(e) (LEXIS 2003).

239. R.I. Gen. Laws § 9-1-8 (1997); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Rhode Island*, <http://www.mcandl.com/rhodeisland.html> (revised February 6, 1998).

240. R.I. Gen. Laws § 10-7-2 (1997).

241. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: South Carolina*, <http://www.mcandl.com/southcarolina.html> (revised February 6, 1998). However, South Carolina has established a Patients' Compensation Fund to benefit licensed health care providers. *Id.* The Fund is responsible for the payment of that portion of any medical malpractice or general liability judgment or settlement which exceeds \$100,000 per incident and \$300,000 in the annual aggregate. S.C. CODE ANN. § 38-79-420 (Law. Co-op. Supp. 1997). All health care providers can participate in the Fund. S.C. CODE ANN. § 38-79-440 (Law. Co-op. 1989). As members, the health care provider must pay an annual fee. S.C. CODE ANN. § 38-79-450 (Law. Co-op. 1989). Upon being served with a complaint, the health care provider must notify the Fund's Board of Governors of the action. S.C. CODE ANN. § 38-79-480 (Law. Co-op. 1989). If the board determines that the damage amounts may exceed \$200,000, the Fund can appear and actively defend the Fund. *Id.* The insurer providing liability insurance to the health care provider must provide an adequate defense so as to prevent impairment of the Fund. *Id.* Settlements that exceed \$200,000 must be approved by the Board of Governors. *Id.*

242. S.D. CODIFIED LAWS § 21-3-11 (Michie Supp. 1997); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: South Dakota*, <http://www.mcandl.com/southdakota.html> (revised May 23, 1998). Damages awarded for non-economic injury such as pain and suffering. *Id.*

243. S.D. CODIFIED LAWS § 21-3-11 (Michie Supp. 1986).

244. *Knowles v. United States*, 544 N.W.2d 183 (S.D. 1996). The *Knowles* decision automatically revived the form of the act as it existed prior to being amended in 1985, at which time it provided for a \$500,000 cap on general damages. *Id.*

personal injury claim of the infant plaintiff and to his parents' claim for medical expenses and loss of services.²⁴⁵

QQ. Tennessee

Tennessee does not place a cap on the amount of damages recoverable in a medical malpractice action.²⁴⁶

RR. Texas

In September 2003, the Texas legislature replaced its former damage cap provisions with a new set of medical malpractice provisions.²⁴⁷ In a medical malpractice claim involving a physician or health care provider, other than a health care institution, non-economic damages are limited to \$250,000.²⁴⁸ In a medical malpractice action against one health care institution, non-economic damages are likewise limited to \$250,000.²⁴⁹ If a final judgment is rendered against more than one health care institution, non-economic damages are limited to \$250,000 for each health care institution, but not to exceed \$500,000 inclusive of all health care institutions involved.²⁵⁰

In a wrongful death action based on medical malpractice, non-economic damages are limited to \$500,000 regardless of the number of physicians, health care providers, or separate causes of action.²⁵¹ This limit will be adjusted according to an increase or decrease in the

245. *Id.*

246. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Tennessee*, <http://www.mcandl.com/tennessee> (revised February 6, 1998).

247. TEX. CIV. PRAC. & REM. CODE ANN. §§ 74.301, 74.302, 74.303 (2004). These statutes replaced former TEX. REV. CIV. STAT. ANN. art. 4590i, §§ 11.02 and 11.03. *See also*, Rose v. Doctors Hospital, 801 S.W.2d 841 (Tex. 1990) (concluding that since a wrongful death claim is based on statutory law and not common law, the "open court" provision does not bar the Medical Liability Act's damage cap provisions). In *Upton County v. Brown*, 960 S.W.2d 808 (Tex. App. 1997), the court noted that Rose was superseded by the Texas legislature in §§ 71.002, 71.021 to the extent that Rose concluded at common law, a personal injury claim expired at the claimant's death and the decedent's survivors did not have a cause of action. *Id.* at 815. *See also*, Lucas v. United States, 757 S.W.2d 687 (Tex. 1988) (holding that the former damage cap provisions were only unconstitutional when applied to common-law claims); Horizon/CMS Healthcare Corp. v. Auld, 34 S.W.3d 887 (Tex. 2000) (limiting the Lucas holding to apply only to common-law claims); Detar Hospital, Inc. v. Estrada, 694 S.W.2d 359 (Tex. App. 1985) (holding former Texas statute §4590i unconstitutional because the statute's absolute limitation on damages "is an unreasonable infringement on a plaintiff's constitutionally guaranteed right to obtaining full redress for injuries caused by another's wrongful conduct").

248. TEX. CIV. PRAC. & REM. CODE ANN. § 74.301 (2004).

249. *Id.*

250. *Id.*

251. TEX. CIV. PRAC. & REM. CODE ANN. § 74.303 (2004).

consumer price index.²⁵²

The Texas legislature has also placed a cap on punitive damages that are to be considered separately from other compensatory damages.²⁵³ Punitive damages are limited not to exceed two times the amount of economic damages plus an amount equal to any non-economic damages found by the jury, however, not to exceed \$750,000.²⁵⁴ The punitive damage limitation does not apply to certain felonies.²⁵⁵

Prior to 2003, Texas limited damages in a medical malpractice action for wrongful death to \$500,000, in 1977 dollars.²⁵⁶ This amount was adjusted annually for inflation.²⁵⁷ As of 2002, it was valued at approximately \$1,300,000.²⁵⁸ The statute was intended to apply to all medical malpractice cases, but has been held to be unconstitutional except with respect to wrongful death.²⁵⁹

Moreover, before 2003, Texas law limited punitive damages in cases arising after September 1, 1995, to two times the amount of economic damages, plus an amount equal to non-economic damages found by the jury, not to exceed \$750,000, or \$200,000, whichever is greater.²⁶⁰ This was formerly four times actual damages or \$200,000, whichever is greater.²⁶¹ The cap on punitive damages does not apply in cases of certain felonies, including fraudulent destruction or concealment of written records.²⁶²

SS. *Utah*

Utah limits damages recoverable for non-economic loss, to compensate for pain, suffering, and inconvenience.²⁶³ In an action arising before July 1, 2001, non-economic damages may not exceed

252. *Id.*

253. TEX. CIV. PRAC. & REM. CODE ANN. § 41.008 (2004).

254. *Id.* If there are not non-economic damages found, punitive damages must not exceed \$250,000. *Id.*

255. *Id.*

256. TEX. REV. CIV. STAT. ANN. art. 4590i, § 11.02 (West Supp. 1998); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Texas*, <http://www.mcandl.com/texas.html> (revised August 13, 1999).

257. TEX. REV. CIV. STAT. ANN. art. 4590i, § 11.04 (West Supp. 1998).

258. McCullough, *Texas*, *supra* note 256.

259. *Rose v. Doctors Hosp.*, 801 S.W.2d 841 (Tex. 1990); McCullough, *Texas*, *supra* note 256.

260. TEX. CIV. PRAC. & REM. CODE ANN. § 41.008 (West 1997).

261. TEX. CIV. PRAC. & REM. CODE ANN. § 41.007 (West 1991) (repealed 1995).

262. TEX. CIV. PRAC. & REM. CODE ANN. § 41.008 (West 1997).

263. UTAH CODE ANN. § 78-14-7.1 (2001); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Utah*, <http://www.mcandl.com/utah.html> (revised May 21, 1999).

\$250,000.²⁶⁴ For an action arising on or after July 1, 2001 and before July 1, 2002, the limit is adjusted for inflation to \$400,000.²⁶⁵

TT. Vermont

Vermont does not place a cap on the amount of damages a claimant may recover in a medical malpractice action.²⁶⁶

UU. Virginia

Virginia places a maximum recovery limit on all damages in medical malpractice cases.²⁶⁷ For claims arising out of acts or omissions prior to August 1, 1999, the total amount recoverable for any injury to, or death of, a patient shall not exceed the limitation on recovery set forth in the statute as it was in effect when the act or acts of malpractice occurred.²⁶⁸ For acts or omissions on or after August 1, 1999, and before July 1, 2000, the cap is \$1.5 million.²⁶⁹ The statute provides that the cap is increased by \$50,000 every July 1.²⁷⁰ Two final increases of \$75,000 beginning in 2007 will bring the damage cap to \$2 million for acts or omissions on or after July 1, 2008.²⁷¹ The Virginia Supreme Court has twice considered this legislation and held that it does not violate the U.S. or Virginia constitutions.²⁷² A settlement with one defendant reduces the maximum liability of the others, as the cap limits the total amount recoverable for an injury to a patient, regardless of the number of theories or defendants.²⁷³ This includes punitive damages.²⁷⁴ In cases arising prior to March 28, 1994, when the definition of "health care provider" was broadened, a physician's professional corporation may be subject to uncapped liability.²⁷⁵

264. *Id.*

265. *Id.* Beginning July 1, 2002, and each July 1 thereafter, the limit for damages shall be adjusted for inflation by the state treasurer. *Id.*

266. McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Vermont*, <http://www.mcandl.com/vermont.html> (revised February 6, 1998).

267. VA. CODE ANN. §8.01-581.15 (2003); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Virginia*, <http://www.mcandl.com/virginia> (revised June 2, 2003).

268. *Id.*

269. *Id.*

270. *Id.*

271. *Id.*

272. Pulliam v. Coastal Emergency Serv., Inc., 509 S.E.2d 307 (Va. 1999); Etheridge v. Med. Ctr. Hosp., 376 S.E.2d 525 (Va. 1989); McCullough, *Virginia*, *supra* note 267.

273. Fairfax Hosp. Sys. v. Nevitt, 457 S.E.2d 10 (Va. 1995).

274. Bulala v. Boyd, 389 S.E.2d 670 (Va. 1990).

275. VA. CODE ANN. § 8.01-581.1 (LEXIS 2003); Schwartz v. Brownlee, 482 S.E.2d 827 (Va. 1997).

Virginia limits punitive damages to \$350,000.²⁷⁶ This cap has also been found constitutional.²⁷⁷

VV. Washington

Washington limited non-economic damages for personal injury or death to an amount determined by multiplying 0.43 by the average annual wage and by the life expectancy of the person incurring the non-economic damages.²⁷⁸ However, the Supreme Court of Washington has held that this cap on non-economic damages is an unconstitutional infringement of the right to trial by jury.²⁷⁹

WW. West Virginia

Prior to 2003, West Virginia juries were instructed that the maximum they could award against a health care provider for non-economic loss was \$1,000,000.²⁸⁰ While this statute was held to be constitutional,²⁸¹ in March 2003:

West Virginia Governor Bob Wise signed into law a bill that caps medical malpractice pain and suffering awards at \$250,000.00, except in cases of wrongful death or bodily impairment, when the cap is \$500,000.00. Another provision in the bill calls for a doctor-owned and managed physicians' mutual insurance company to be up and running no later than July 1, 2004.²⁸²

XX. Wisconsin

The Wisconsin legislature has established a non-economic damage cap in medical malpractice actions of \$350,000 to be adjusted to reflect changes in the consumer price index.²⁸³ The Wisconsin Court of

276. VA. CODE ANN. § 8.01-38.1 (LEXIS 2003).

277. McCullough, *Virginia*, *supra* note 267; *see* Wackenhut Applied Tech. Ctr., Inc. v. Sygnatron Prot. Sys., Inc., 979 F.2d 980 (4th Cir. 1992).

278. WASH. REV. CODE ANN. § 4.56.250 (West 1988).

279. *Sofie v. Fireboard Corp.*, 771 P.2d 711 (Wash. 1989); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Washington*, <http://www.mcandl.com/washington.html> (revised February 6, 1998).

280. W. VA. CODE § 55-7B-8 (1994); McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: West Virginia*, <http://www.mcandl.com/westvirgina.html> (revised February 6, 1998).

281. *Robinson v. Charleston Area Med. Ctr.*, 414 S.E.2d 877 (W. Va. 1991).

282. *Ins. Info. Inst.*, *supra* note 174.

283. WIS. STAT. ANN. § 895.55. The statute also places a statute of limitations for a medical malpractice claim of three years from the date of the injury or one year from the date the injury was

Appeals has held the medical malpractice non-economic damage cap to be constitutional.²⁸⁴

Damages for wrongful death are limited by a separate wrongful death statute, even when the wrongful death was caused by medical malpractice.²⁸⁵ The Wisconsin wrongful death statute was amended for cases after April 28, 1998 to increase the damage cap to \$500,000 for the death of a minor and \$350,000 for the death of an adult.²⁸⁶

YY. Wyoming

The Wyoming Constitution provides, “[n]o law shall be enacted limiting the amount of damages to be recovered for causing the injury or death of any person.”²⁸⁷ Thus, Wyoming does not limit the amount of damages one may recover in a medical malpractice action.²⁸⁸

V. THE FAILURE OF CAPS IN CALIFORNIA: A CASE STUDY

As noted above, California enacted a medical malpractice cap law, entitled “The Medical Injury Compensation Reform Act” (MICRA), in 1975. MICRA:

- (1) placed a \$250,000.00 cap on the amount of compensation paid to malpractice victims for their non-economic injuries;
- (2) eliminated the collateral source rule that forces those found liable for malpractice to pay all the expenses incurred by the victim;
- (3) permitted those found liable for malpractice to pay the compensation they owe victims on an installment plan basis;
- (4) imposed a short statute of limitations on malpractice victims (generally, three years);
- (5) established a sliding

discovered. *Id.*

284. See *Guzman v. St. Francis Hosp., Inc.*, 623 N.W.2d 776 (Wis. Ct. App. 2000) (holding the non-economic damage cap unconstitutional because “there is a rational relationship between the prospective application of the cap on the recovery of noneconomic damages (affecting all plaintiffs from the effective date of the cap forward) and the legislature’s goal of preserving health-care services in Wisconsin”). In *Martin v. Richardson*, 531 N.W.2d 70 (Wis. 1995), the Wisconsin Supreme Court held that a previous non-economic damage cap was unconstitutional because its retroactive application would result in minimal reduced payouts to plaintiffs. *Id.* at 588.

285. WIS. STAT. ANN. § 895.55. Furthermore, “[i]f damages in excess of the limit under § 895.04 are found, the court shall make any reduction required under § 895.045 and shall reward the lesser of the reduced amount or the limit under §895.04.” *Id.*

286. WIS. STAT. ANN. § 895.04. When a jury awards damages that are in excess of the damage cap, the court shall reduce the award to the maximum amount. *Id.* See also, 1997 WIS. ACT 89.; *Neiman v. Am. Nat’l Prop. & Cas. Co.*, 613 N.W.2d 160 (Wis. 2000) (holding the retroactive damage increase provision of §895.04 was unconstitutional).

287. WYO. CONST. art. 10, § 4; McCullough, Campbell & Lane, *Summary of Medical Malpractice Law: Wyoming*, <http://www.mcandl.com/wyoming> (revised February 6, 1998).

288. *Id.*

scale for attorneys' fees that discouraged lawyers from accepting serious or complicated medical malpractice cases.²⁸⁹

Following MICRA's enactment, malpractice liability insurance premiums continued to rise. "By 1988, twelve years after the passage of MICRA, California medical malpractice premiums had reached an all-time high – 450% higher than 1975, when MICRA was enacted."²⁹⁰ In fact, "[d]uring the mid 1980's, California malpractice premiums increased by more than 20% annually."²⁹¹

While insurers maintained that the increase was due to court challenges to MICRA, following the California Supreme Court's decision to validate the damage cap in 1985: "malpractice premiums increased more dramatically in 1986 than any year since the passage of MICRA. Between 1985, when the cap was upheld, and 1988, malpractice premiums soared 47%."²⁹²

Facing yet another crisis in its health care system, California enacted California Insurance Code § 1861.01, commonly known as Proposition 103. Proposition 103 "explicitly required insurance premium rollbacks of up to 20%."²⁹³ "[M]edical malpractice rates in California began to fall immediately after the passage of Proposition 103, and within three years . . . total medical malpractice premiums had dropped by 20.2% from the 1988 high. After adjusting for inflation, the premium drop . . . actually [amounted to] 30.7%."²⁹⁴

With Proposition 103 firmly in place, medical malpractice liability premiums initially fell, and then stabilized.²⁹⁵ Since the inception of Proposition 103, the annual variations in medical malpractice premiums in California have been "significantly less drastic and, as a result of the regulatory process, [became] far more predictable under the regulated system than ever before."²⁹⁶

Based upon the foregoing data, one may reasonably conclude that the stability achieved in medical malpractice insurance premiums in the state of California since 1988 is attributable to the regulation of insurance rates, and not to caps on non-economic damage awards.

289. The Foundation for Taxpayer and Consumer Rights, *How Insurance Reform Lowered Doctors' Medical Malpractice Rates in California: and How Malpractice Caps Failed*, www.consumerwatchdog.com (March 7, 2003) [hereinafter FTCCR].

290. *Id.*

291. *Id.*

292. *Id.*

293. *Id.*

294. *Id.*

295. *Id.*

296. *Id.*

VI. THE WEISS STUDY: CAPS DO NOT RESULT IN A REDUCTION OF MEDICAL MALPRACTICE PREMIUMS

While caps on medical malpractice insurers do reduce the burden on such insurers, statistically, caps do not lead to a reduction in medical malpractice insurance premiums.²⁹⁷

On June 2, 2003, Weiss Ratings Inc., a private ratings agency, and one of the nation's top five raters of life/health insurers,²⁹⁸ released the results of a study entitled, "The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage." The study relied upon data provided by the National Practitioner Data Bank, and it "compared the median payouts in the 19 states with caps to those in the 32 states without caps for the period between 1991 and 2002."²⁹⁹

Weiss found:

297. Weiss Ratings, *supra* note 2.

298. United States General Accounting Office, *Comparison of Private Agency Ratings for Life/Health Insurers*, http://www.weissratings.com/gao_study.asp (September 1994). At the request of the Rep. Cardiss Collins, Chairwoman of the House Subcommittee on Commerce, the U.S. General Accounting Office undertook a comparison of the rating systems of the five major raters of life/health insurers – A.M. Best (Best), Duff & Phelps (D&P), Moody's, Standard and Poor's (S&P) and Weiss Research (Weiss) over the period August 31, 1989, to June 30, 1992, to determine which raters were first to report the vulnerability of financially impaired or insolvent insurers. *Id.* According to the GAO:

United States Government Insurer ratings could not be easily compared across the five rating agencies because they did not all use the same approach and methods to rate insurer financial health. Rating scales and descriptions of ratings varied by agency and over time. Weiss placed far less reliance than the other agencies on analysts' judgment. Coverage differed – Weiss was the only agency to rate more than half of all insurers. Finally, Weiss and Moody's were less likely than the other agencies to assign insurers their top ratings.

Best and Weiss provided the most comprehensive coverage of life/health insurers; between them, they rated the majority of financially impaired life/health insurers. Weiss' ratings reflected financial vulnerability first three times more often than Best in the cases we compared. On average, Weiss' ratings reflected financial vulnerability 8 months earlier than Best. The other agencies – D&P, Moody's and S&P – rated, at most, five of the life/health insurers that became financially impaired during our comparison period. These five, among the six largest such insurers, were also rated by Best and Weiss. Weiss was the first to assign a vulnerable rating in five of the six cases; Moody's – which rated only two of the six insurers—was first in the sixth case. In no case was Best, S&P, or D&P first to reflect financial vulnerability for these six insurers. In four of these cases, Best did not assign a vulnerable rating until after the first public regulatory action. Our results are not projectable and apply only to the time period of less than 3 years that the data cover.

Id.

299. Weiss Ratings, *supra* note 2.

Payouts reduced. In states without caps, the median payout for the entire 12-year period was \$116,297.00, ranging from \$75,000.00 on the low end to \$220,000.00 on the high end. In states with caps, the median was 15.7% lower, or \$98,079.00, ranging from \$50,000.00 to \$190,000.00. Since caps in many states were not imposed until late in the 12-year period, this represents a significant reduction.

Growth in payouts slowed substantially. The median payout in the 32 states without caps increased by 127.9%, from \$65,831.00 in 1991 to \$150,000.00 in 2002. In contrast, payouts in the 19 states with caps increased at a far slower pace by 83.3%, from \$60,000.00 in 1991 to \$110,000.00 in 2002.³⁰⁰

Weiss interpreted this data to mean that “caps do accomplish their intended purpose of lowering the average amount insurance companies must pay out to satisfy medical malpractice claims.”³⁰¹

However, it was found that despite lowering the insurers’ payout obligations, “insurers continue to increase premiums at a rapid pace, regardless of caps.”³⁰²

This conclusion was drawn by Weiss “using 1991 to 2002 data published by the Medical Liability Monitor.”³⁰³ More specifically, Weiss examined “the median medical malpractice premiums paid by doctors in three high-risk specialties—internal medicine, general surgery, and obstetrics/gynecology.”³⁰⁴ In so doing, Weiss found:

1. States with caps had sharper increases in median annual premiums. Since the insurers in the states with caps reaped the benefit of lower med mal payouts, one would expect that they’d reduce the premiums they charged doctors. At the very minimum, they should have been able to slow down the rate of premium increases. Surprisingly, the data show they did precisely the opposite:

- In the 19 states with caps, the median annual premium increased by 48.2%, from \$20,414 in 1991 to \$30,246 in 2002.
- In the 32 states without caps, the median annual premium actually increased at a slower pace—by 35.9%, from \$22,118 in 1991 to \$30,056 in 2002.

Thus, on average, doctors in states with caps actually suffered a

300. Weiss Ratings, *supra* note 2.

301. *Id.*

302. *Id.*

303. *Id.*

304. *Id.*

significantly larger increase than doctors in states without caps.

2. A smaller proportion of states with caps were able to contain premium increases. In some states, the median annual premiums remained flat or even declined at various times during the period. Was this related to the imposition of caps? In the overwhelming majority of states, the answer is clearly “no.” Indeed. . .

- Among the 19 with caps, only two states, or 10.5%, experienced flat or declining med mal premiums following the imposition of caps.
- Meanwhile, among the 32 without caps, the record was actually much better: Six states, or 18.7%, experienced flat or declining premiums.

3. Premiums in states with caps are more likely to exceed national median. Focusing on the most recent data, we find that:

- In 47.4% of the states with caps (9 out of 19), 2002 median premiums were below the national median premium of \$30,093.
- Meanwhile, in 50% of the states without caps (16 out of 32), 2002 median premiums were *below* the national median.

In short, the results clearly invalidate the expectations of cap proponents. To review the surprising facts:

- Insurers in states with caps raised their premiums at a significantly faster pace than those in states without caps.
- Even with the imposition of caps, insurers in nearly nine out of ten states continued to raise rates, while insurers in states without caps were actually more likely to hold or cut their premium rates.
- In states with caps, insurers are more likely to charge med mal premiums exceeding the national median than those in states without caps.

Based upon the above findings, Weiss concluded that such “counter-intuitive”³⁰⁵ results “can lead to only one conclusion: there are other, far more important factors driving the rise in medical malpractice premiums than caps or medical malpractice payouts.”³⁰⁶

305. Weiss Ratings, *supra* note 2.

306. *Id.*

VII. OTHER FACTORS CONTRIBUTING TO THE ESCALATION OF MEDICAL MALPRACTICE PREMIUMS

According to the Weiss study, six factors are significant in driving up medical malpractice insurance premiums, “each of which may be exerting a greater impact on premiums than the presence or absence of caps.”³⁰⁷ These factors include:

- (1) medical cost inflation; (2) the cyclical nature of the insurance market; (3) the need to shore up reserves for policies in force; (4) a decline in investment income; (5) overall financial safety considerations; and (6) the supply and demand of coverage.³⁰⁸

As to medical cost inflation, Weiss noted that the inflation rate in the 12-year period studied was 75 percent.³⁰⁹ “However, throughout the country, insurers had a general tendency to let their premium increases lag behind the pace of medical inflation. This was most likely due to the extended soft market experienced by the entire property and casualty insurance industry in the 1990’s, explained below.”³¹⁰

Next, with respect to the cyclical nature of the insurance market, Weiss maintained that such market

is historically and fundamentally cyclical, with periods of rising premium rates followed by periods of steady or declining premiums. In the declining portion of the cycle—“a soft market”—insurers relax their underwriting standards and underprice their products in order to retain or gain market share.

The most recent soft market lasted longer than usual—12 years, from 1987 to 1999—probably because of the raging bull market in stocks. Insurers made so much money in their investments they were able to aggressively underprice their policies, deliberately lose money in their underwriting, and still turn a profit overall. As a result, losses in their core operations, more than offset by surging gains from the stock market boom, were largely overlooked by the industry and regulators alike.

All that changed when the stock market boom turned to bust. Property and casualty insurers had to confront the ramifications of their loose underwriting practices: not enough money in premiums collected to cover anticipated claims. That’s when they began to seriously tighten

307. Weiss Ratings, *supra* note 2.

308. *Id.*

309. *Id.*

310. *Id.*

underwriting standards and raise premium rates.³¹¹

Concerning the need for insurers to shore up reserves for policies in force, Weiss noted:

When insurers write a new policy, they look at past claims experience, make some actuarial assumptions, and place a portion of that policy's premium into a reserve to cover expected future claims. A prudent insurer will make conservative assumptions and err on the side of having more in reserve than it ultimately needs to pay claims. At the end of each year, the insurer then evaluates its reserves for each block of business and determines if a change is warranted to either add or subtract reserves.

Data reported to the National Association of Insurance Commissioners (NAIC) show that med mal insurers have been consistently under-reserving since 1997—to the tune of \$4.6 billion through December 31, 2001. The under-reserving came to a head in 1999, at the tail end of the soft market. That's when loose underwriting practices caught up with the insurers, as claims rose to a higher level than expected. Thus, even before the bull market ended in the stock market, insurers were coming under increasing pressure to boost their reserves to make up for past shortfalls.

There's only one place these funds could come from—the company's capital; and there was only one way the company could maintain or build its capital—by making more profits. Thus, premium increases were inevitable.³¹²

With respect to the decline in insurers' investment income, Weiss found:

Until 2000, most of the additional profits insurers needed could be covered by rising investment income and gains from the booming stock market. But during the three-year bear market from 2000 to 2002, as large stock market gains turned to even larger stock market losses, insurers were confronted with double trouble:

- (1) After just one year of premium increases, they still had barely begun to restore their reserves.
- (2) Now, aggravating their difficulties, they also needed to compensate for stock market losses. With falling stock prices and declining interest rates, investment income⁷ for the entire property/casualty industry fell 23% in 2001 compared to 2000, and then another 2.5% in 2002; and we must assume that med mal insurers suffered a similar

311. Weiss Ratings, *supra* note 2.

312. *Id.*

decline. Indeed, investment income is particularly critical for lines of business like med mal where the duration of claims payouts typically span several years.³¹³

Thus, it was the combination of two powerful forces—under-reserving throughout most of the 1990s plus the rapid fall in investment income in the 2000s—that largely drove the unusually rapid premium increases, not only in med mal, but in many other property and casualty lines as well.³¹⁴

Addressing the issue of insurers' financial safety, Weiss opined: "[I]f insurers do not replace capital that has been used to shore up reserves, the financial strength of the company deteriorates, ultimately leading to the possibility of financial failure."³¹⁵

Finally, turning to the supply and demand of coverage, the Weiss study found that:

Press reports have highlighted the plight of physicians around the country who are closing up shop because their med mal insurer is pulling out of the local market.

To help determine if this is an industry-wide problem, for each year between 1991 and 2002, we counted the number of insurers that are writing new med mal policies and/or renewing existing policies.

The number of carriers providing med mal coverage nationwide increased from 244 in 1991 to a peak of 274 in 1997. Since 1997, however, the number of carriers declined steadily to a low of 241 in 2001, recovering slightly to 247 in 2002.

Compared to 1991, therefore, there has actually been a modest *increase* in the number of med mal carriers—from 244 to 247.

However, doctors are currently feeling the pressures of diminished supply reflected in the declining trend since 1997. Moreover, in certain regions and in certain medical specialties, there is abundant anecdotal evidence that certain med mal insurers have pulled out or discontinued coverage.³¹⁶

313. Weiss Ratings, *supra* note 2.

314. *Id.*

315. *Id.*

316. *Id.*

VIII. ALTERNATIVES TO CAPS

If caps are ineffective in driving down medical malpractice liability premiums, then what can be done to solve the current crisis in health care? The Weiss study lays out a five step approach that targets the root causes leading to the dramatic escalation of medical malpractice liability insurance premiums:

1. Legislators must immediately put on hold all proposals involving non-economic damage caps until convincing evidence can be produced to demonstrate a true benefit to doctors in the form of reduced med mal costs. Right now, consumers are being asked to sacrifice not only large damage claims, but also critical leverage to help regulate the medical profession—all with the stated goal that it will end the med mal crisis for doctors. However, the data indicate that, similar state legislation has merely produced the worst of both worlds: The sacrifice by consumers plus a continuing—and even worsening—crisis for doctors. Neither party derived any benefit whatsoever from the caps.
2. Regulators must review and revise their parameters for approving rate increases. The big lesson to be learned from the past decade is that it's dangerous to count on volatile investments—especially common stocks—to compensate for poor operations.
....
3. Insurance companies must never again allow marketing to divert or pervert prudent actuarial analysis and planning. Consumers and medical professionals can accept rate increases provided they are spread out evenly over time, and provided they are given good value for their premium dollars in terms of claims paying ability and stability. They cannot accept rate increases that are designed to cover up, or compensate for, serious mismanagement.
4. The medical profession must assume more responsibility for policing itself, while states must be more pro-active in reviewing the licenses of individual practitioners who have a significantly higher-than-average number of claims against them in their specialty, in proportion to their level of activity. These individuals greatly increase the risk associated with their specialties, pushing med mal premiums up for all doctors in that sector. States must also make major strides to share data on high-risk doctors. At the very minimum, they must cease licensing doctors who have lost their licenses in other states, often due to high-cost medical mistakes.

5. Consumers must not relinquish their right to sue for non-economic damages until the medical profession and/or state and federal governments provide more adequate supervision and regulation of doctors, hospitals, and other health care providers.³¹⁷

In sum, the Weiss study concludes that caps “will not make a significant dent in the problem, and may even have adverse impacts. It is no substitute for longer-term, fundamental solutions that address the actual factors behind the medical malpractice crisis.”³¹⁸

IX. CONCLUSION

It is undeniable that caps on non-economic damage awards have resulted in lower claim payouts for insurers. However, as California’s MICRA experiment and the GAO and Weiss studies have demonstrated, this has not translated into a reduction in medical malpractice premiums for physicians. The failure of caps to effectively drive down the cost of medical malpractice liability insurance is directly related to the fact that caps merely address one of several factors that have caused the dramatic escalation of medical malpractice liability insurance rates over the past decade.

In short, “broad market forces prevailing in the property/casualty industry have driven — and continue to drive — medical malpractice premiums up, evidently overwhelming any reduction in jury awards.”³¹⁹

Thus, “by focusing on caps as a solution:”³²⁰

[T]he insurance companies and their supporters are diverting the public’s attention away from long years of mismanagement by an industry that continually allowed actuarial prudence to take a back seat to marketing strategy.

The insurers, insurance regulators and insurance legislators are avoiding a much-needed post-mortem on what really went wrong in the property and casualty industry in general and in the med mal sector in particular.³²¹

At this juncture, what is needed is less hysteria, and more of a focus on what is driving the current crisis in health care. Until legislators and the special interests they represent recognize that greater reform, regulation and policing is warranted in both the medical and insurance

317. Weiss Ratings, *supra* note 2.

318. *Id.*

319. *Id.*

320. *Id.*

321. *Id.*

industries, the current epidemic will continue to fester.