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# A Critical Look at the Non-Economic Damage Cap of the HEALTH Act of 2005 and Its Impact on Consumers

Shirley Chiu

# *STUDENT ARTICLE*

# A Critical Look at the Non-Economic Damage Cap of the HEALTH Act of 2005 and its Impact on Consumers

Shirley Chiu*

## I. INTRODUCTION

According to the Bush administration, the United States is experiencing a medical malpractice insurance crisis.[1] Skyrocketing malpractice premiums are blamed for driving physicians who specialize in high risk fields, such as orthopedics, neurosurgery, obstetrics-gynecology, and general surgery, from practicing in these areas,[2] and forcing physicians in geographical regions with high malpractice insurance premiums to move to areas with lower rates.[3] Consequently, rural regions in particular are left with fewer doctors, thereby limiting patients' accessibility to health care.[4] Many critics blame large jury verdicts for the high medical malpractice premiums.[5] Additionally, trial lawyers are accused of filing frivolous

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* J.D. candidate, May 2008, Loyola University Chicago School of Law; B.A. Economics, 2002, University of Chicago. The author would like to thank her family, friends, and members of the Loyola Consumer Law Review for their helpful comments, patience, and support.

[1] Kathryn Zeiler, *Turning from Damage Caps to Information Disclosure: An Alternative to Tort Reform*, 5 YALE J. HEALTH POL'Y L. & ETHICS 385, 385 (2005) (discussing where the Bush Administration stands on damage caps).

[2] Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damage Caps*, 80 N.Y.U. L. REV. 391, 410 (2005).

[3] Warren Vieth, *President Demands Tort Reform*, L.A. TIMES, Jan. 6, 2005.

[4] *Id.*

[5] *Id.*

claims and have been blamed for the premium increases.[6]

In response, Congress recently proposed House Bill 534, the "Help Efficient, Accessible, Low-cost, Timely Healthcare" ("HEALTH") Act of 2005.[7] The bill aims to lower health care liability insurance by imposing caps on both punitive and non-economic damages, limiting attorney contingency fees, and reducing the statute of limitation on medical malpractice cases.[8] The most controversial, yet fundamental aspect of the bill, limits non-economic damages to $250,000.[9] In states that recognize punitive damages, such damages are reserved for only the most egregious cases.[10] The hope of policymakers is that curtailing large jury verdicts will lead to fewer frivolous lawsuits, which in turn should reduce doctors' exposure to medical malpractice liability and lower malpractice insurance premiums.[11] Medical malpractice litigation claims are estimated to cost the American economy $233 billion per year.[12]

Even so, the Congressional Budget Office estimates that medical malpractice lawsuits only make up less than two percent of the nation's health care spending.[13] Additionally, some legal scholars and attorneys argue that imposing caps on damages, especially those that are non-economic, may actually reduce the number of meritorious medical malpractice cases filed because costs of litigation may exceed the expected award of damages.[14]

The real economic impact of medical litigation can also be felt locally. The American Medical Association reports that as many as twenty states are experiencing full-blown medical liability crises.[15]

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[6] Mark Silva, *Bush Calls for Limits Class Action Lawsuits*, CHI. TRIB., Jan. 6, 2005, at 9.

[7] Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2005, H.R. 534, 109th Cong. (2005).

[8] *Id.*

[9] *Id.* at § 4(b).

[10] Silva, *supra* note 6.

[11] *Id.*

[12] *Id.* at 9.

[13] Geoff Boehm, *Debunking Medical Malpractice Myths: Unraveling the False Premises Behind "Tort Reform,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 357, 362 (2005).

[14] Zeiler, *supra* note 1, at 386.

[15] Sharkey, *supra* note 2, at 406.

In Illinois, Cook County alone, in 2004, entered jury awards exceeding $5 million against hospitals and doctors in medical malpractice cases, which amounted to a total of $123 million, eighty percent of which were non-economic damages.[16] Furthermore, in the first half of 2005, fourteen of the twenty-eight largest settlements in Cook County were in medical malpractice cases.[17] These settlements alone totaled $136.93 million.[18] There is concern by policymakers that such verdicts may adversely affect consumers because medical malpractice costs, including payouts and attorney's fees, decrease hospital operating margins and leave fewer dollars to improve facilities and patient care.[19] Therefore, it is not surprising that Illinois, along with Alaska, and New Hampshire recently passed legislation to address the increasing costs of medical malpractice insurance.[20]

This article will demonstrate that non-economic damage caps, like those contained in the HEALTH Act of 2005, are unlikely to lower medical malpractice premiums faced by physicians and will not resolve the problems currently plaguing doctors due to high insurance premiums. Instead, caps will help insurance companies at the expense of the most severely injured medical malpractice victims and offer little to no benefit to doctors or health care consumers. Section II of this Article provides a legal background on federal legislation curbing medical malpractice claims, and state court views toward the constitutionality of non-economic damage caps. Section III discusses the purposes and non-economic damage cap component of the proposed HEALTH Act. Section IV examines the effects and constitutionality of the proposed non-economic and punitive damages caps set forth in the HEALTH Act, on health care consumers and physicians, in addition to providing alternative solutions. Finally, Section V discusses the likely impact of non-economic damage caps on health care consumers if the HEALTH Act is passed.

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[16] Max Douglas Brown, Editorial, *Here's to Your Good Health; Until We Get Tort Reform, it's Patients Who Will Feel the Pain*, CHI. TRIB., Feb. 17, 2005, at 27.

[17] Libby Sander, *2005 Settlement Survey: Looking Ahead to Litigation Under the Med-Mal Caps*, CHI. LAWYER, Oct. 2005, at 8.

[18] *Id.*

[19] *Id.*

[20] Ass'n Trial Law. Am., *Three States Pass Medical Malpractice Legislation*, TRIAL, Aug. 2005, at 10. (stating that Alaska capped non-economic damages at $250,000, Illinois capped non-economic damages at $500,000, and New Hampshire created a three-person screening panel to review medical injury action before trial to determine whether a health care provider was negligent).

# II. BACKGROUND

## A. Federal Responses to Medical Malpractice Litigation

Medical malpractice insurance crises are not new to the United States. There has been at least one national malpractice insurance crisis resulting from high medical malpractice premiums in every decade since the 1970s.[21] In response, Congress has tried to pass a number of bills to resolve the problems caused by medical malpractice litigation.[22] Much of the proposed legislation, like the HEALTH Act of 2005, sought to cap non-economic damages at $250,000.[23] Since 1999, Congress has proposed at least five bills, each of which included a cap on non-economic damages in medical malpractice cases. In 1999, Congress introduced the Medical Malpractice Rx Act that proposed a $250,000 limit on non-economic damages. [24] The Act was referred to the subcommittee on Health and Environment and was not introduced back to the House.[25] In 2000, Congress introduced a revised version of the Health Care Liability Reform Act of 1997, which sought to impose stricter requirements on health care liability claims.[26] The bill was sent to the House Committee on the Judiciary but never made it back to the House.[27]

In more recent years, Congress introduced a sequence of Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Acts; the bills, introduced in 2002, 2003, and 2004, sought to increase accessibility and quality of health care by reducing the burden of medical liability through the enactment of a $250,000 non-economic damage cap in medical malpractice liability cases.[28] All

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[21] Alec Shelby Bayer, *Looking Beyond the East Fix and Delving into the Roots of the Real Medical Malpractice Crisis*, 5 HOUS. J. HEALTH L. & POL'Y 111, 115 (2005).

[22] *Id.*

[23] *Id.* at 124-25.

[24] Medical Malpractice Rx Act, H.R. 2242, 106th Cong. (1999).

[25] *Id.*

[26] Health Care Liability Reform Act, H.R. 5119, 106th Cong. (2000).

[27] *Id.*

[28] Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002, H.R. 4600, 107th Cong. (2002); Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2003, H.R. 5, 108th Cong. (2003); Help

three acts were eventually passed by the House and sent to the Committee on the Judiciary but they were never voted on in the Senate.[29] The HEALTH Act of 2005 has once again revived the $250,000 non-economic damage cap in medical malpractice suits, and we wait to see its fate.[30]

Aside from caps on non-economic damages, Congress has recognized that there are other probable approaches to solving the malpractice crisis and has proposed legislation to curb medical malpractice litigation in other ways. In 2004, Congress proposed the Lawsuit Abuse Reduction Act (LARA).[31] The Act sought to restore the power of Rule 11 of the Federal Rules of Civil Procedure in order to deter frivolous lawsuits and forum shopping.[32] More specifically, LARA sought to restore Rule 11's mandatory sanctions to remove its 'safe harbor' provision so that parties and attorneys could no longer avoid sanctions by withdrawing frivolous claims, to allow monetary and other sanctions for abuses of the discovery process, and to apply a 'three strikes and you're out' rule to attorneys who commit Rule 11 violations in Federal courts.[33] The Act was proposed following expressed concern that frivolous litigation, medical malpractice cases included, was out of control and needed to be mitigated.[34] The assumption was that stricter standards could prevent frivolous medical malpractice lawsuits that caused increased premiums for doctors and patients.[35] LARA, like the HEALTH Acts, was passed in the House, read twice in the Senate, and is currently with the Committee on the Judiciary.[36]

Congress has also taken steps to prevent medical malpractice

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Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2004, H.R. 4280, 108th Cong. (2003).

[29] Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002, H.R. 4600, 107th Cong. (2002); Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2003, H.R. 5, 108th Cong. (2003); Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2004, H.R. 4280, 108th Cong. (2003).

[30] Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2005, H.R. 534, 109th Cong. (2005).

[31] Lawsuit Abuse Reduction Act (LARA), H.R. 4571, 108th Cong. (2004).

[32] H.R. REP. NO. 108-682, at 3 (2004).

[33] *Id.*

[34] *Id.*

[35] *Id.* at 5.

[36] H.R. 4571.

through health care education for consumers. In 2005, Congress introduced House Bill 568, the Patient Empowerment and Education Act of 2005. [37] The Act sought to educate health care consumers through public service announcements, patient safety workshops, and community outreach programs on how to safeguard themselves from medical malpractice.[38] Counseling and peer support services to victims and family members of medical malpractice were also included in the Act.[39] The bill is currently with the Subcommittee on Education Reform.[40]

### B. State Non-Economic Damage Cap Legislation and Concerns

States have also attempted to address the medical malpractice crisis by implementing their own legislation. California was one of the first states to spearhead legislation to cap non-economic damages through its Medical Injury Compensation Reform Act of 1975 (MICRA), which capped non-economic damages at $250,000.[41] A large group of states followed with similar tort reform in the 1970s, 1980s and 1990s.[42] In fact, over the last ten years, two thirds of states have passed tort reform limiting or restricting medical malpractice lawsuits.[43]Since the year 2000 alone, eight states have enacted substantial tort reform legislation that includes caps for non-economic damages in medical malpractice cases.[44] However, in states where statutes limiting non-economic damages have been enacted, courts have often scrutinized the constitutionality of the legislation, and some have overturned the capping legislation.[45]

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[37] Patient Empowerment and Education Act of 2005, H.R. 568, 109th Cong. § 3 (2005).

[38] *Id.*

[39] *Id.* at § 3(b)(3).

[40] H.R. 568.

[41] Sharkey, *supra* note 2, at 393.

[42] *Id.* at 394.

[43] Boehm, *supra* note 13, at 357.

[44] *Id.*

[45] *Id.*

### 1. Jurisdictions That Have Found Caps on Non-Economic Damages Unconstitutional

Courts have found the constitutionality of non-economic damages caps the most controversial in light of equal protection and the jury's duty to assess damages.[46] States that passed legislation to cap non-economic damages in medical malpractice cases argue that the caps are constitutional because they rationally relate to a legitimate state interest, reduce medical malpractice premiums to doctors, and in turn decrease future insurance costs to health care consumers.[47] Courts in other states disagree.

The purpose of equal protection is to prohibit class legislation from arbitrarily discriminating "against some and favoring others in like circumstances."[48] State courts have often looked to whether non-economic damage caps discriminate against those who are severely injured and otherwise entitled to more than what the cap allows. Courts traditionally apply a "rational basis test," whereby "legislation is presumed to be constitutional and will survive review if the classification scheme is rationally related to a legitimate governmental purpose."[49] For example, the Supreme Court of Alabama in *Moore v. Mobile Infirmary Association* looked to "whether the connection between the benefit sought to be conferred on society and the means employed to accomplish it."[50]

The *Moore* court held that a statute imposing non-economic damage caps created a favored class of tortfeasors based on their connections with health care. [51] Citing to several empirical studies, the court concluded that the correlation between the non-economic damage cap imposed, and the health care costs to citizens was "at best indirect and remote."[52] Furthermore, the court held that "the statute operates to the advantage not only of negligent health care providers over other tortfeasors, but of those health care providers

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[46] Carol A. Crocca, Annotation, *Validity, Construction, and Application of State Statutory Provisions Limiting Amount of Recovery in Medical Malpractice Claims*, 26 A.L.R.5th 245, §§ 3(b), 5(b) (2005).

[47] Fein v. Permanente Medical Group, 695 P.2d 665, 680 (Cal. 1985).

[48] Moore v. Mobile Infirmary Ass'n, 592 So. 2d 156, 165 (Ala. 1991).

[49] Zdrojewski v. Murphy, 657 N.W.2d 721, 738 (Mich. Ct. App. 2002).

[50] *Moore*, 592 So. 2d at 167.

[51] *Id.* at 166-67, 169, Crocca, *supra* note 46, at § 3(b).

[52] *Moore*, 592 So. 2d at 168.

who are most irresponsible."[53] Likewise, the Illinois Supreme Court in *Wright v. Central DuPage Hospital* overturned a state provision that capped non-economic damages in medical malpractice claims at $500,000 on the grounds that the provision was arbitrary and constituted a special law that was unconstitutional.[54]

Similarly, the New Hampshire Supreme Court in *Carson v. Maurer* found that the limitations on non-economic damages prevents adequate compensation to patients with meritorious claims and offers nothing to eliminate non-meritorious claims.[55] The limitation distinguishes between "malpractice victims with non-economic losses that exceed $250,000, and those with less egregious non-economic losses."[56] The court concluded that "restrictions on recovery may encourage physicians to enter into practice and remain in practice, but do so only at the expense of claimants with meritorious claims."[57]

State courts have also recognized that "the right to a trial by jury is a fundamental constitutionally guaranteed right" and therefore "a jury's verdict may not be set aside unless the verdict is flawed, thereby losing its constitutional guaranteed protection."[58] In fact, some courts have been reluctant to interfere with a jury's award of non-economic damages and punitive damages. For example, the *Moore* court held that the authority to interfere with a jury's findings on the amount of damages should be exercised with great caution, particularly in cases involving imprecise measurements of damages.[59] Moreover, the court believed that a jury's "constitutionally protected *factfinding function*" is impaired by the damages limitation because it "prevents the jury from applying the facts.[60] The court stated that a jury's assessment may be changed only when it is flawed by "bias, passion, prejudice, corruption, or improper motive" leaving it no longer constitutional.[61]

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[53] *Id.* at 169.

[54] Wright v. Central DuPage Hospital, 63 Ill.2d 313, 329-30 (1976), Crocca, *supra* note 46, at § 17(b).

[55] Carson v. Maurer, 424 A.2d 825, 837 (N.H. 1980).

[56] *Id.* at 837.

[57] *Id.*

[58] *Moore*, 592 So. 2d at 161.

[59] *Moore,* 592 So. 2d at 160, Crocca *supra* note 46, at § 5(b).

[60] *Moore,* 592 So. 2d at 164.

[61] *Moore,* 592 So. 2d at 160, Crocca *supra* note 46, at § 5(b).

### 2. Jurisdictions that Found Non-Economic Damage Caps Constitutional

Alternatively, other courts have held provisions capping non-economic damages in medical malpractice cases constitutional. Some courts that have upheld statutes capping non-economic damages on equal protection grounds concluded that non-economic damage caps on medical malpractice cases further a legitimate governmental purpose. Applying the rational basis test, the California Supreme Court in *Fein* held that a statute limiting non-economic damages did not violate equal protection because it did not limit a victim's recovery for out-of-pocket medical expenses and lost earnings and was "rationally related to a legitimate state interest." [62] The court reasoned that by enacting legislation to cap non-economic damages, the legislature was acting in response to the rising costs of medical malpractice insurance which threatened to "curtail the availability of medical care in some parts of the state and creating the . . . possibility that many doctors would practice without insurance, leaving patients who might be injured by such doctors with the prospect of uncollectible judgments."[63] Additionally, in regard to the pain and suffering aspect of non-economic damages, the court held that "money damages are at best only imperfect compensation for such intangible injuries and such damages are generally passed on to, and borne by, innocent consumers."[64] Furthermore, the court reasoned that it is difficult for medical malpractice plaintiffs to collect judgments for *any* of their damages, pecuniary and non-pecuniary, and that it was in the public interest "to attempt to obtain some costs savings by limiting non-economic damages."[65]

Similarly, in *Zdrojewski v. Murphy*, the Michigan Appellate Court applied a traditional rational basis test to a statute capping non-economic damages and held that because it was rationally related to a legitimate government purpose the statute did not violate a plaintiff's right to equal protection.[66] The purpose of the statute was to control

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[62] Fein v. Permanente Medical Group, 695 P.2d 665, 683 (Cal. 1985), Crocca, *supra* note 46, at § 3(a).

[63] *Fein*, 695 P.2d at 680.

[64] *Id.* at 681.

[65] *Id.*

[66] Zdrojewski v. Murphy, 657 N.W.2d 721, 739 (Mich. Ct. App. 2002),

the increases in health care costs by reducing liability of the medical provider and malpractice insurance premiums, while maintaining affordable health care in the state.[67] The court affirmed the lower court ruling that "controlling health care costs is a legitimate governmental purpose."[68]

Courts have also upheld caps on non-economic damages on due process grounds. The California Supreme Court held that as long as the measure is rationally related to a legitimate state interest, the legislature has broad power to determine the measure and timing of damages.[69] "[W]e know of no principle of California—or federal—constitutional law which prohibits the Legislature from limiting the recovery of damages in a particular setting in order to further a legitimate state interest."[70]

Finally, some courts have held that non-economic damage caps in medical malpractice cases do not violate the right to a jury's assessment of damages, and that "in certain circumstances, a trial court may reduce a jury verdict without violating the right to a jury determination of damages."[71] In *Zdrojewski v. Murphy*, the plaintiff appeared to challenge the right of the legislature to limit her remedy and contended that the Constitution "guarantees her not only the right to have a jury determine her damages, but the unfettered right to recover precisely what the jury awarded." [72] The court disagreed with the plaintiff and held that the legislature has the authority to limit remedies in tort actions. The court further noted that the limitations of the statute impeded neither on the plaintiff's ability to present her case to a jury nor the jury's ability to determine the factual extent of plaintiff's damages.

Additionally, The Missouri Supreme Court in *Adams v. Children's Mercy Hospital* held that under common law, a substantive right for a jury to determine damages does not exist.[73] The *Adams* court concluded that the cap on non-economic damages

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Crocca, *supra* note 46, at § 3(a).

[67] *Zdrojewski*, 657 N.W.2d at 738.

[68] *Id.*

[69] *Fein*, 695 P.2d at 680.

[70] *Id.* at 682.

[71] *Zdrojewski*, 657 N.W.2d at 737.

[72] *Id.* at 736.

[73] Adams v. Children's Mercy Hosp., 832 S.W.2d 898, 907 (Mo. 1992), Crocca, *supra* note 46, at § 5(a).

did not infringe on the right to a jury trial because what constitutes a permissible remedy is a matter of law, and the court applies the limitation on non-economic damages only after the jury completes its constitutional task of determining damages.[74]

### 3. Medical Malpractice Reforms in Illinois

The Illinois Supreme Court has twice thrown out state laws limiting damages in the last three decades.[75] In 1976, the non-economic damage cap for medical malpractice cases was declared unconstitutional by the Illinois Supreme Court in *Wright v. Central Du Page Hospital.*[76] Two decades later, in 1997, the court also rejected a state law that placed a $500,000 on non-economic damages in *all* tort lawsuits.[77] Recently, in August 2005, the governor of Illinois signed into law Senate Bill 475, a new medical malpractice reform bill.[78] The purpose of the bill is to prevent physicians practicing in high-risk specialties and facing high medical malpractice insurance premiums from leaving Illinois, as has been the case in recent years.[79] The bill hopes to achieve this through increased state oversight of physicians, increased state regulation of medical liability insurance carriers, reduction of frivolous medical malpractice litigation, and enforcement of caps on non-economic damages.[80]

In hopes of curbing medical malpractice premiums, the new legislation limits non-economic damages against physicians to $500,000 and non-economic damages against hospitals to $1,000,000.[81] Additionally, the bill expands health care accessibility by providing immunity, except for willful and wanton misconduct,

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[74] *Adams*, 832 S.W.2d at 907.

[75] Christi Parsons, *Trial Lawyers Target Cap on Malpractice,* CHI. TRIB., Aug. 25, 2005, at C1.

[76] Wright v. Cent. DuPage Hosp. Ass'n, 347 N.E.2d 736, 736 (Ill. 1976).

[77] Parsons, *supra* note 75.

[78] Ill. S.B. 475, Pub. L. No. 94-0677 (codified in scattered sections of 215 Ill. Comp. Stat., the Illinois Insurance Code, 225 Ill. Comp. Stat, the Medical Practice Act of 1987, and 735 Ill. Comp. Stat. § 5/2-1706.5) (effective Aug. 25, 2005); Parsons, *supra* note 75.

[79] Parsons, *supra* note 75.

[80] Ill. S.B. 475 § 101.

[81] *Id.* at § 2-1706.5 (codified at 735 Ill. Comp. Stat. § 5/2-1706.5).

beyond free medical clinics, to retired physicians who provide free medical services and imposes harsher punishments and disincentives for malpractice.[82]

In order to reduce frivolous lawsuits, the bill requires that before a case can be brought against a physician or hospital, another doctor must certify that the action has merit.[83] Additionally, the new legislation institutes the "Sorry Works!" pilot program requiring hospitals and physicians to promptly acknowledge and apologize for mistakes in patient care and promptly offer fair settlements.[84] The new legislation also helps health care consumers by increasing the statute of limitations from five to ten years for disciplinary actions and requires that the Illinois Department of Financial and Professional Regulation publish doctors' public profile and disciplinary actions on the Internet for health care consumers.[85]

Finally, the legislation hopes to stabilize medical malpractice prices through increased competition between insurance companies. Under SB 475, the Secretary of the Department of Financial and Professional Regulation is authorized, in some instances, to deny increases in medical malpractice rate increases.[86] If an insurance company files a request for a medical malpractice insurance rate increase greater than six percent, public hearings on the proposed increase will be mandatory.[87] By controlling increases in medical malpractice rates, the law intends to make the malpractice insurance business more competitive, and therefore more attractive to companies that have felt closed out.[88] It is hoped that increased competition will stabilize rates.[89]

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[82] *Id.* at § 30 (codified as amended at 745 Ill. Comp. Stat. § 49/30).

[83] *Id.* at § 2-622 (codified at 735 Ill. Comp. Stat. § 5/2-622).

[84] *Id.* at § 405.

[85] Ill. S.B. 475, Pub. L. No. 94-0677 § 22 (codified as amended at 225 Ill. Comp. Stat. 60/220, *Id.* at § 24.1 (codified at 225 Ill. Comp. Stat. 60/24.1).

[86] *Id.* at § 155.18 (codified as amended at 225 Ill. Comp. Stat. 5/155.18).

[87] *Id.* at § 115.18(c)(2).

[88] Press Release, Ill. Office of the Governor, *Gov. Blagojevich Signs Medical Malpractice Reform: Legislation Designed to Improve Access to Physician Care in Illinois* (Aug. 25, 2005) (on file with author).

[89] *Id.*

## III. The HEALTH Act of 2005

On the national level, Congress has proposed the HEALTH Act of 2005 in an attempt to lower the costs of health care liability, ensure only meritorious health care injury claims, improve availability of health care services, and provide an increased sharing of information in the health care system.[90] The purposes of the bill are to lower unintended injury and improve patient care through implementing "reasonable, comprehensive, and effective" health care liability reforms.[91] Such improvements aim to ensure receipt of fair and adequate compensation by people with meritorious health care injury claims, improve fairness and cost effectiveness of the current health care liability system, and provide greater information sharing within the health care system.[92]

The Act sets forth three key reasons as to why our nation's health care liability system needs reform. First, the current justice system adversely affects patients' access to health care services, improved patient care, and efficient health care costs.[93] Second, that the health care liability litigation system negatively affects interstate commerce by contributing to the high cost of health care and premiums for health care liability insurance.[94] Third, the large number of individuals who receive government health care benefits and the large number of health care providers who provide items or services have a significant affect on the amount, distribution, and use of federal funds.[95]

The HEALTH Act of 2005, like its predecessors, limits recovery to medical malpractice victims. The legislation establishes a $250,000 limitation on non-economic damages, but not economic damages, in health care liability cases.[96] Punitive damages may be awarded in states that allow for them but "only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was

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[90] H.R. 534 § 2(a)(2), 109th Cong. (2005).

[91] *Id.* at § 2(b).

[92] *Id.*

[93] *Id.* at § 2(a)(1).

[94] *Id.* at § 2(a)(2).

[95] H.R. 534 § 2(a)(3).

[96] *Id.* at § 4(b)-(c).

substantially certain to suffer."[97] Punitive damages are capped at $250,000 or twice the amount of economic damages, whichever is greater.[98] Additionally the jury is not to be informed of the maximum award for non-economic damages or if applicable, punitive damages.[99] In determining punitive damages, the trier of fact must consider only the severity and duration of harm caused by the defendant, the profitability of action to the doctor, the medical procedure rendered, the potential criminal penalties imposed, and the amount of any civil fines assessed against the party as a result of the conduct.[100] Furthermore, the Act abolishes joint and several-liability in medical malpractice cases so that defendants are only responsible for their own percentage of fault.[101]

In an effort to maximize victims' compensation under the new legislation, the Act also stipulates fixed percentages of attorneys' contingency fees, depending on the level of total monetary recovery.[102] Contingency fees must adhere to the following limitations:

(1) 40 percent of the first $50,000 recovered by the claimant(s).

(2) 33 1/3 percent of the next $50,000 recovered by the claimant(s).

(3) 25 percent of the next $500,000 recovered by the claimant(s).

(4) 50 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.[103]

The Act not only aims to lower medical malpractice premiums by enforcing damage caps but also encourages speedy resolution of claims.[104] The legislation sets the statute of limitations

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[97] *Id.* at § 7(a)

[98] *Id.* at § 7(b)(2).

[99] *Id.* at § 4(c). (requiring that when the award is in excess of $250,000, it must be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction must be made before accountting for any other reduction in damages required by law).

[100] H.R. 534 § 7(b)(1)(A)-(F)

[101] *Id.* at § 4(d). (indicating that the trier of fact is responsible for proportioning each party's percentage of fault).

[102] *Id.* at § 5(a).

[103] *Id.*

[104] *Id.* at § 3.

to three years after manifestation of the date of injury or one year after the patient discovers the injury.[105]

# IV. ANALYSIS

## A. Overall Effectiveness of Damage Caps Imposed Under the HEALTH Act of 2005

Although some studies have shown that tort reform may lower medical malpractice premiums, the evidence as to which particular elements of the reform actually lower premiums is heavily debated. Many states that previously suffered from medical malpractice crises have already passed legislation with reforms similar to those in the HEALTH Act. [106] Some of these states have seen slower growth in medical malpractice premium prices than states that did not enact damage caps.[107] It is possible that the implementation of the HEALTH Act may slow the growth rate of medical malpractice premiums but not necessarily lower the malpractice premium levels. The damage caps proposed to benefit physicians and consumers may result in increased revenues for insurance companies at the expense of those who benefit the most from non-economic damages—the most severely injured medical malpractice victims.[108]

One certain and expected result of damage caps is that insurance companies will suffer smaller losses.[109] Recent research by Kip Viscusi and Patricia Born found that insurance companies' losses in states that have enacted caps on non-economic damages have been reduced by sixteen to seventeen percent compared to states without such measures.[110] Furthermore, insurance companies in states that enacted tort reform, other than non-economic damage caps, experienced losses that were twenty-four to twenty-five percent less

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[105] H.R. 534 § 3.

[106] U.S. Gen. Accountability Office, Publ'n No. GAO-03-702, *Medical Malpractice Insurance: Multiple Factors have Contributed to Increased Premium Rates*, at 15-16 (June 2003).

[107] *Id.*

[108] Boehm, *supra* note 13, at 361.

[109] W. Kip Viscusi & Patricia H. Born, *Damage Caps, Insurability, and the Performance of Medical Malpractice Insurance*, 72 J. RISK & INS. 23, 32 (2005).

[110] *Id.*

than states that did not enact additional measures.[111] However, whether damage caps will lead to lower insurance premiums is controversial, given the variations across data used in empirical studies, and the difficulties in isolating the effects of non-economic damage caps when other sorts of tort reform have also been enacted.[112]

## B. Effectiveness of Damage Caps in Lowering Medical Malpractice Premiums

The main issue surrounding the proposed legislation's objective, to lower physicians' medical malpractice premiums and increase consumers' access to health care, is its underlying assumption that a causal relationship exists between premium prices and the actual scope and magnitude of medical malpractice lawsuits.

It is true that states that have enacted previous caps on non-economic damages did experience a slower growth in medical malpractice premiums.[113] In fact, a 2003 study by the Government Accountability Office ("GAO") reported that states with legislative caps on non-economic damages and where applicable, punitive damages, experienced an average percentage growth in premium rates of slightly less than ten percent compared with twenty-nine percent in states without non-economic damage caps.[114] Nevertheless, the GAO cautioned against making causal arguments that the damage caps cause lower malpractice insurance premiums.[115]

The GAO's concern is supported by evidence that malpractice insurance fell below the national average in sixteen out of thirty-one states without damage caps.[116] However, seventeen out of the

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[111] *Id.* at 30-32 (stating that other reforms include limits on attorney contingency fees, modifications to joint and several liability rules, establishment of requirements for structured and periodic payments, fees for frivolous lawsuits, and modifications of the collateral source rule).

[112] *Zeiler*, *supra* note 1, at 392.

[113] Sharkey, *supra* note 2, at 408 (citing to the August 2003 GAO study covering Florida, Mississippi, Nevada, Pennsylvania, and West Virginia).

[114] *Id.*

[115] *Id.* (explaining that multiple factors that affect premiums make it hard to statistically justify that damage caps really lower premiums).

[116] Kevin J. Conway, *Tort Reform Won't Lower Malpractice Premiums*, CHI. TRIB., Jan. 11, 2005, at 14.

nineteen states with damage caps have raised their medical malpractice premium rates, and in half of the states where caps have increased insurance rates, such increases have been above the national average.[117] Despite statutory reform, total medical malpractice costs for physicians and hospitals increased at a higher rate than inflation.[118]

It is difficult to directly measure the influence of non-economic damage caps because there are multiple factors that impact medical malpractice premium levels.[119] According to the GAO, other factors that have contributed to increases in medical malpractice premiums in the past include "insurers' losses, declines in investment income, a less competitive climate, and climbing reinsurance rates."[120] Furthermore, a report completed in 2003, by Weiss Ratings, Inc., an independent rating agency for insurance companies, identifies several factors driving up premiums, each of which may have a greater impact on premiums than the presence or absence of caps.[121] These factors include inflation of medical costs, the insurance market's cyclical nature, the need to shore up reserve for policies in force, a decline in investment income, overall financial safety considerations, and the supply and demand of coverage.[122] Also, the presence of other sorts of tort reform makes it difficult to isolate effects of non-economic damage caps.[123] More importantly, empirical work that relies on simple regression analysis can be problematic if the implementation of caps is endogenous to perceived market conditions that are related to medical malpractice premiums.[124] For these reasons, reliance on the empirical results of most statistical studies is controversial.[125]

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[117] *Id.*

[118] Moore v. Mobile Infirmary Ass'n, 592 So. 2d 156, 167 (Ala. 1991) (citing to a GAO study which suggested remote relationship between damage caps and total cost of health care), Crocca, *supra* note 46, at § 3(b).

[119] *Zeiler*, *supra* note 1, at 390.

[120] U.S. Gen. Accountability Office, *supra* note 106, at 6.

[121] Lucinda Finley, *The Hidden Victims of Tort Reform: Women, Children, & the* Elderly, 53 EMORY L.J. 1263, 1272 (2004).

[122] *Id.*

[123] *Zeiler*, *supra* note 1, at 392.

[124] *Id.* at 393 (discussing an explanation by Professor Albert Yoon as to the problems with simple regression analysis).

[125] *Id.* at 390.

Some experts argue that increases in insurance rates are responses to the broader economic cycle and not out-of-control jury verdicts.[126] Insurance profits are derived from investment income, or the investment of the paid premiums in a "float."[127] In a "soft market," where the investment market is strong and interest rates are high, insurance companies profit significantly by investing in float and may under price policies to attract more money from premiums to invest.[128] When the market declines or interest rates drop in a "hard market," insurance companies may raise rates in efforts to curtail coverage.[129] In hard markets, insurance rates for doctors increase significantly while claims and payouts remained flat.[130] As recently as 2004, insurers continued to raise premiums, including in states where tort reform was enacted, even though claims and payouts have dropped and investment markets have begun to improve.[131]

Other reports also provide mixed results regarding the significance of non-economic caps on malpractice premiums. The variance in results is likely caused by difficulties in measuring the influence of caps on medical malpractice insurance due to the multiple factors that potentially cause increases in malpractice premiums.[132] The significance of the effects of non-economic damage caps on premiums differs across studies when different factors thought to affect medical malpractice premiums are controlled for in the empirical analysis.[133] Research by Professor Frank Sloan found that damage caps did not significantly affect premiums or annual percentage change in premiums for doctors in any of the three fields of medicine tested.[134] Another study by Born and Viscusi controlled for differences in state regulation of insurers and found that non-economic damages did not significantly affect medical malpractice premiums.[135] Similarly, Professor Vasanthakumar Bhat

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[126] Boehm, *supra* note 13, at 364-65.

[127] *Id.* at 364.

[128] *Id.*

[129] *Id.* at 364-65.

[130] *Id.*

[131] Boehm, *supra* note 13, at 365.

[132] Zeiler, *supra* note 1, at 392.

[133] *Id.* at 391.

[134] *Id.*

[135] *Id.*

found that including both non-economic and economic damage caps as explanatory variables significantly decreased the price of premiums.[136] Nevertheless, when only non-economic damage caps were controlled for, there was no significant affect on premium levels.[137]

A more recent study, conducted by Professor Catherine Sharkey found that once the severity of the injury and other socio-demographic variables were controlled for, non-economic damage caps had little or no affect on the size of overall compensatory damage verdicts or judgments.[138] Sharkey's findings suggest that in cases of severe injury in states where non-economic damage caps are enacted, greater economic damages are awarded in order to compensate for smaller non-economic damages.[139]

### C. The Constitutionality and Impact of Punitive Damages

Many critics also suggest that punitive damage reform may have little or no affect at all on medical malpractice insurance.[140] Some states simply do not recognize punitive damages, while others do not insure against punitive damages.[141] Medical malpractice cases make up a much smaller proportion of punitive awards than liability, fraud, and intentional tort cases.[142] Furthermore, punitive awards in medical malpractice cases are very seldom awarded and are often reduced on appeal.[143] The tension surrounding punitive damage caps lies between the fact that punitive damages have not met their legislative intent in lowering medical malpractice premiums, and in the more broader view of the Supreme Court that punitive damages need to be controlled.

Statistical research shows that where punitive damage caps are imposed, insurance companies experience lower payouts and

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[136] *Id.* at 392 (defining premiums in the study as rate of payment per physician).

[137] Zeiler, *supra* note 1, at 391-92.

[138] Sharkey, *supra* note 2, at 464, 469 (comparing the experience of states that have enacted non-economic damage caps and those that have not).

[139] *Id.* at 469.

[140] Viscusi, *supra* note 109, at 19.

[141] *Id.*

[142] *Id.*

[143] *Id.*

increase in profits, at the expense of lower medical malpractice premiums.[144] Viscusi and Born found that in states where punitive damage reform was enacted, insurance companies at the 50th, 75th, and 90th percentiles of the distribution of losses experienced significantly fewer losses.[145] They also found that in states where punitive damages reform or overall tort reform was enacted, insurance companies experienced an overall increase in profits.[146] In theory, the decrease in payouts should have resulted in smaller barriers to entry, lead to increased competition from other insurance companies, and lower the medical malpractice premiums for doctors.[147] Contrary to that theory, punitive damages only helped the insurance companies.

While it may seem that the punitive damage caps have not met their legislative intent to lower health care costs, and should therefore be deemed unconstitutional, recent Supreme Court rulings, including that of *State Farm Mutual Automobile Insurance Company v. Campbell* suggest that punitive damages, unlike non-economic damages, should not be treated as a matter of fact for the jury.[148] In fact, the Court in *State Farm* reiterated as it did in previous cases that "to the extent an award is grossly excessive, it furthers no legitimate purpose and constitutes an arbitrary deprivation of property."[149] As a result, courts already engage in "exacting" review of punitive damages to ensure they are not grossly excessive.[150] In light of this broader view punitive damage caps may be valid.

### D. Constitutionality of the Damage Caps Imposed in the HEALTH Act.

Despite the debated causal relationship between non-economic damage caps in medical malpractice cases, and their desired result of lowering medical malpractice premiums for doctors

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[144] *Id.* at 34.

[145] Viscusi, *supra* note 109, at 34.

[146] *Id.* at 38.

[147] *Id.*

[148] Paul Decamp, *Beyond State Farm: Due Process Constraints on NonEconomic Compensatory Damages,* 27 HARV. J.L. & PUB. POL'Y 231, 290 (2003).

[149] *Id.* at 287.

[150] *Id.* at 290.

and health care costs consumers, some find the caps to be constitutional. According to some courts, the jury maintains its function as finder of fact and assessor of damages because economic damages can still be collected without limitation.[151] Without notice of the limitation on damages, the jury subjectively calculates non-economic damages by assessing a price on the pain and suffering of the victim.[152] Courts apply the limitation on non-economic damages only after the jury had completed its duty of fact finding and assessing damages.[153] The two roles supplement each other and do not infringe on the other's duty.[154] Because juries will not know about the limitation on non-economic damages until after they assess all damages, their assessment should be unbiased. Unless the jury's assessment is greater than the maximum, the cap will not be implemented.

In some state courts, non-economic damage caps have been upheld on equal protection grounds on the premise that the limit worked towards a public policy interest.[155] The cap is seen to control increases in health care costs by reducing liability of the medical provider, reducing malpractice insurance premiums, and maintaining affordable health care in state.[156]

Uncertainty raised by statistical studies regarding the lowering of medical malpractice insurance raises doubt as to whether the damage caps invoked under the HEALTH Act will work towards a public policy interest.[157] The uncertainty also raises questions of accessibility and affordability of health care to consumers if the caps are enacted. For the most severely injured victims, economic damages may not offer equal protection because the pain and suffering endured is likely valued much higher than the $250,000 non-economic damage cap of the HEALTH Act. As the *Moore* court

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[151] Crocca, *supra* note 46, at § 5(a).

[152] *Id.*

[153] *Id.*

[154] *Id.*

[155] *Id.* at § 3(a), Zdrojewski v. Murphy, 657 N.W.2d 721, 739 (Mich. 2002).

[156] Crocca, *supra* note 46, at § 3(a); *Zdrojewski*, 657 N.W.2d at 739, *See infra* Part II.B (discussing cases addressing the constitutionality of caps on non-economic damages).

[157] *See* Crocca, *supra* note 46, at § 3(a) (using the holding of *Zdrojewski* to show that a statute meets equal protection if it serves a legitimate government interest); *Zdrojewski*, 657 N.W.2d at 739.

stated, the "statute operates to the advantage not only of negligent heath care providers over other tortfeasors, but of those providers who are *most irresponsible.*"[158]

The lack of equal protection may be even truer for states that do not impose punitive damages, such as Illinois. While the HEALTH Act also caps punitive damages, it does not impose them in states that do not already recognize such damages in medical malpractice cases.[159] In states where no punitive damages are imposed, the non-economic damage cap will further skew compensation to favor those who are relatively less deserving of the maximum $250,000 non-economic damage cap. Indeed, the most severely injured victim may receive the same maximum $250,000 non-economic damages as a victim who is less severely injured despite the greater severity of the injury.

### E. Alternative Solutions

The lack of clarity of a significant relationship between damage caps and medical malpractice premium levels suggests that an alternative solution may be more effective. One such solution is stronger regulation of the insurance industry.[160] Insurance regulation reform has successfully prevented large rate increases in California since 1988.[161] Similarly, one component of Illinois' recently passed SB 475 permits the state in select instances to deny increases in medical malpractice rate increases.[162] Accordingly, coalitions and organizations such as the Americans for Insurance Reform recommended a number of ways to better regulate the insurance industry. The recommendations include: undertaking a review of rate levels to determine if rates are excessive, initiating an investigation into anti-competitive behavior, calling a rate hearing if an insurer files a rate request in excess of current inflation, beginning a careful

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[158] Moore v. Mobile Infirmary Ass'n, 592 So. 2d 156, 169 (Ala. 1991) (emphasis added).

[159] H.R. 534 § 7(a), 109th Cong. (2005).

[160] Boehm, *supra* note 13, at 368.

[161] *Id.* at 369, Californians Allied for Patient Protection, *California's Medical Injury Compensation Reform Act*, *available at* http://www.micra.org/MICRAprovisions.pdf (last visited Oct. 11, 2005) (summarizing California's Medical Injury Compensation Reform Act limiting non-economic damages to $250,000, attorneys' contingency fees, and the statute of limitations on injury claims).

[162] Ill. S.B. 475, Pub. L. No. 94-0677 (effective Aug. 25, 2005).

analysis as to what led to this most recent cycle or period of increases in medical malpractice premiums and the state insurance commissioner's department's role in it by allowing rates to fluctuate between excessive and inadequate, and alerting the legislature to the end of the hard market and advise them that there is no need to rush into legislative fixes.[163]

Another alternative to the proposed damage caps is to have managed care providers disclose to their current and prospective enrollees the terms of their contracts with physicians.[164] Since patients operate under imperfect information when assessing whether their injury was truly caused by negligent behavior on the part of the physician, the disclosure of contract terms would lower the barrier of imperfect information.[165] If patients know the type of fee for service arrangement between managed care organizations and the physician, they will have a better idea of whether they were provided with more or less expensive treatment.[166] This information could potentially resolve some of the uncertainty surrounding malpractice when a patient decides whether or not to pursue costly litigation.[167] The downside to disclosure is that trade secrets of competing managing care organizations would be revealed, which could lead to less innovative contracts for physicians in the future.[168]

Additionally, in 2003, the American Medical Association endorsed the concept of state legislation for a "health court" system.[169] The proposal included pretrial screening panels typically consisting of three physicians and a lawyer that would make factual determinations as to whether the provider's acts or omissions caused the patient's injury and whether the patient shared equal or greater blame for any negligence.[170] The conclusions by the panel would be admissible in a later trial before a health court.[171] In response to

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[163] Boehm, *supra* note 13, at 368; Californians Allied for Patient Protection, *supra* note 161.

[164] Zeiler, *supra* note 1, at 394.

[165] *Id.* at 395.

[166] *Id.*

[167] *Id.*

[168] *Id.* at 397.

[169] John Gibeaut, *The Med-Mal Divide*, 91 A.B.A. J. 39, 41 (Mar. 2005).

[170] *Id.*

[171] *Id.*

previous medical malpractice crises in the 1970s and 1980s, at least thirty-four states passed laws creating screening panels.[172] Currently, however, only a half-dozen of mandatory systems that include admissible results remain, while the others were either declared unconstitutional or were repealed by legislature.[173] A potential constitutional problem arises because the model requires the panel to issue a written opinion that would be admissible regarding whether malpractice occurred and who is at fault.[174] The focus of the opinion is very similar to the factual findings that juries have been left to determine, which could violate the Seventh Amendment.[175] In fact, some states have declared the panels unconstitutional. Perhaps a less extreme alternative with a similar purpose as the health court is having a physician certify that an action has merit before the case can be brought against a doctor or a hospital, as is the case in Illinois, under its recently passed legislation.

Finally, proposed legal reforms not limited to medical malpractice tort cases may also be suitable alternatives to non-economic damage caps. One such reform requires courts to better inform jurors of the range of non-economic compensatory damages that prior juries have awarded in factually comparable cases.[176] To the extent that the Seventh Amendment continues to require that the amount of non-economic damages be treated as a fact, juries should be provided with evidence that can permit that to make a reasoned valuation of the harms at issue.[177] Courts should provide juries with a range of awards for injuries that are factually comparable to those harms that the plaintiff claims to have suffered so that juries can make reasoned valuations of the harms at issue.[178]

A related reform requires trial courts to exercise de novo review of the verdict for excessiveness when the jury has returned a verdict that exceeds the range established by comparable cases.[179] Such a standard of review is similar to the Supreme Court's

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[172] *Id.* at 42.

[173] *Id.*

[174] Gibeaut, *supra* note 169.

[175] *Id.*

[176] DeCamp, *supra* note 148, at 292.

[177] *Id.*

[178] *Id.*

[179] *Id.* at 295

recognition in tort cases that the amount of punitive damages, although a factual matter, may be deemed unconstitutionally excessive by the court when the award exceeds what the law will allow, or becomes an "arbitrary deprivation of property."[180] In regard to non-economic compensatory damages, the relevant objective standard should be dictated by the body of factually comparative precedents.[181]

## V. CONSUMER IMPACT

The impact of the proposed non-economic damage caps under the HEALTH Act on health care consumers is uncertain given the preponderance of empirical evidence that non-economic damage caps have no significant effect in driving down health care costs. The impact of the proposed damage cap will be experienced most by severely injured tort victims and not by the hospitals or doctors that the caps seek to impact. Since health care consumers benefit from the spillover effects of lower medical malpractice insurance premiums, the impact on consumers is dependent upon whether physicians will actually pay lower malpractice insurance premiums, which in turns depends on the insurance industry.

However, that is not to discredit the fact that medical malpractice jury verdicts have increased over time in some states, and that non-compensatory damages can constitute a large part of the overall compensation. The 2003 GAO study recognized that since 1999, medical malpractice premium rates have increased significantly for physicians in some specialties in a number of states.[182] Additionally, a 2004 RAND study of 257 medical malpractice cases in California courts between 1995 and 1999 found that non-economic damages constituted forty-two percent of the total aggregate damages awarded before any MICRA deductions.[183] The consequent impact on public interests, especially the availability of insurance and adequate health care at reasonable cost, drives the initiative for reform including that of medical malpractice damage caps.[184] Implicit in imposing non-economic damage caps is that unlike non-economic

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[180] *Id.*

[181] DeCamp, *supra* note 148, at 295.

[182] U.S. Gen. Accountability Office, *supra* note 106.

[183] Sharkey, *supra* note 2, at 404.

[184] *Id.*

damages, economic damages are rational and predictable.[185]

While non-economic damage caps may appear desirable in light of public policy interests, the proposed legislation imposing damage caps will likely have no affect on the vast majority of those injured by medical malpractice because most never bring a claim. In fact, only about one in eight of those injured choose to file a claim, despite the fact that medical malpractice kills an estimated 195,000 hospital patients every year.[186] Furthermore, in Illinois, the rate at which medical malpractice claims are filed has remained stable for the last ten years.[187] Although, the total number of claims filed increased in Illinois, the number of filings per one hundred doctors remained the same once the number of physicians was adjusted for.[188]

The HEALTH Act of 2005 seeks a redundant objective. The disincentive to bring frivolous medical malpractice already exists. Rule 11 sanctions seek to deter frivolous lawsuits. Additionally, tort lawyers typically work on a contingency fee basis, and generally fund many cases themselves.[189] It would not make economic sense to take on a baseless case and invest in litigating it when the probability of prevailing is so small that the expected outcome is smaller than the initial investment.

Moreover, the proposed damage caps will most likely affect access to attorneys for tortiously injured consumers.[190] The expected outcome from a case is often defined as the product of the total amount of damages and the probability that the physician performed medical malpractice, also referred to as the likelihood that the injured victim will prevail.[191] The abolishment of joint and several-liability and enactment of non-economic and punitive damage caps are likely to lower the expected outcome of litigation and result in attorneys litigating fewer medical malpractice claims.

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[185] *Id.*

[186] Boehm, *supra* note 13, at 358.

[187] Neil Vidmar & Russell M. Robinson II, *Medical Malpractice & the Tort System in Illinois: a Report to the Illinois State Bar Ass'n* , May 2005, at 22-23, *available at* http://www.isba.org/medicalmalpracticestudy.pdf (last visited Oct. 11, 2005).

[188] *Id.*

[189] Boehm, *supra* note 13, at 359.

[190] Zeiler, *supra* note 1, at 389.

[191] *Id.*

For example, take two scenarios, one of a tort victim injured by medical malpractice and another victim injured by a tort other than medical malpractice. Assume that in both cases, the probability of prevailing in court is the same. Also, assume that in both cases the total damages would normally be the same, except that the damages on the medical malpractice case are capped. For attorneys who generally work on a contingency fee basis, there may be a disincentive to pick up cases where the likelihood of prevailing is even smaller because the total amount of damages will be smaller due to both the non-economic and punitive damage caps. This may be especially true in states that currently do not offer punitive damages, such as Illinois. The attorney's stake in the case is reduced by the damage caps and by limitations on attorneys' fees.

As a result, medical malpractice attorneys may choose not to take a case even if the client suffered severe injuries. Estimates of expected damages depend on the anticipated damage award and the probability the patient will prevail.[192] The probability of prevailing depends on the likelihood that the medical provider engaged in noncompliant medical care.[193] Therefore, the greater the likelihood of malpractice, the more likely an injured person will file a claim.[194] However, a rational attorney will file a claim only if expected damages exceed litigation costs. Where enacted damage caps and limits on contingency fees may render a smaller expected outcome, attorneys may turn down more cases because the cost of bringing the case to court may exceed their expected recovery. In essence, the proposed caps create incentives to discriminate against some medical malpractice tort victims with severe injuries.

Furthermore, as long as medical malpractice premiums remain high, which statistical research predicts, doctors will continue to leave rural areas and stop practicing high-risk medicine in such areas. Moreover, even if medical malpractice premiums *do* decrease as a result of the non-economic damage caps, there is no guarantee that Act's goal to curb the shortage of the rural consumers' access to medical care will be resolved.[195] Rural health care shortage is a global problem, including areas where there is no comparable U.S.

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[192] *Id.*

[193] *Id.*

[194] *Id.*

[195] Boehm, *supra* note 13, at 361.

civil justice system in its place.[196] If doctors are leaving rural areas in the United States, some will arguably continue to do so despite stabilization of medical malpractice insurance premiums.

Finally, the reduction in liability exposure by non-economic damage caps sometimes makes it optimal for doctors to "face potential liability for medical malpractice rather than provide costly treatment that complies with the legal standard of care."[197] If damage caps reduce exposure to liability, physicians may be less careful in providing compliant treatment.[198]

## VI. CONCLUSION

Since a causal relationship between non-economic damage caps and medical malpractice insurance levels is at best unclear, the legislative intent of the caps is hard to justify. The evidence is mixed as to whether non-economic damage caps lead to decreased medical malpractice insurance premiums. Some statistical evidence shows that in the past where states have enacted non-economic damage caps in medical malpractice cases, there was no significant impact, positively or negatively, on malpractice insurance premiums once other factors that may affect medical malpractice premiums were taken into consideration.[199] However, other studies conclude that non-economic damage caps significantly impact medical malpractice premiums negatively.

The proposed legislation to cap non-economic damages is unlikely to affect medical malpractice insurance prices or the majority of victims of medical malpractice since they do not file claims. Instead the non-economic damage cap will affect the most severely injured victims who do have cases with merit and make it into court. On the other hand, a crossover effect may occur where higher economic damages are awarded by the jury to compensate for less non-economic damages, in which case overall damage compensation may not be affected.[200]

The question for Congress is whether it is worthwhile to take a gamble on the future rates of medical malpractice premiums,

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[196] *Id.* at 362.

[197] Zeiler, supra, note 1 at 389.

[198] *Id.* at 390.

[199] U.S. Gen. Accountability Office, *supra* note 106, at 48.

[200] Zeiler, *supra* note 1, at 393.

knowing state tort reform history, at the expense of the severely injured medical malpractice victims who will largely endure the effects of caps on non-economic damages. The actual effects of the bill will ultimately determine the constitutionality of the legislation, especially from the perspective of equal protection. Given the potentially large costs to severely injured malpractice victims and the precarious benefit to physicians and health care consumers, Congress should consider the elements of House Bill 534 carefully to ensure that its costs and benefits are as predictable as they think.

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