

Capping Non-Economic Damages: Is It Really What the Doctor Ordered? Predicting the Effect of Federal Tort Reform by Examining the Impact of Tort Reform at the State Level

“Legislators must immediately put on hold all proposals involving non-economic damage caps [in medical malpractice cases] 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.”¹

I. INTRODUCTION

Few would disagree with doctors who claim that the high cost of medical malpractice insurance premiums is unsustainable.² The disagreement among legislators and those in the medical community, however, revolves around the cause of the high medical malpractice insurance premiums.³ Many Republicans, insurance companies, and members of the medical community point to frivolous lawsuits and increasing jury awards for plaintiffs as the cause of doctors’ exorbitant premiums.⁴ One proposed solution caps non-economic damages plaintiffs may receive for pain and suffering in medical malpractice cases.⁵ This proposed remedy to the medical malpractice crisis is embodied

1. MARTIN D. WEISS ET AL., MEDICAL MALPRACTICE CAPS - THE IMPACT OF NON-ECONOMIC DAMAGE CAPS ON PHYSICIAN PREMIUMS, CLAIMS PAYOUT LEVELS, AND AVAILABILITY OF COVERAGE, 4 (2003) [hereinafter WEISS RATINGS REP.] at <http://www.weissratings.com/malpractice.asp>.

2. See *infra* Part II, History, § A (describing history of high insurance premiums).

3. See *infra* text accompanying notes 4-9 (explaining debate over whether high jury awards or other factors cause of high premiums).

4. American Medical Association, MEDICAL LIABILITY REFORM—NOW!, 1,2 [hereinafter AMA, LIABILITY REFORM] (noting increasing trend in jury awards in medical malpractice cases), at <http://www.ama-assn.org/ama1/pub/upload/mm/-1/mlmowjune142005.pdf> (last visited Jan. 31, 2006). Republican Representative Jim Greenwood from Pennsylvania has been a House leader who supports the Health Act. *Id.*; see also Peter Eisler et al., *Hype Outpaces Facts in Malpractice Debate*, USA TODAY, Mar. 5, 2003, at 1 (noting President Bush, doctors, and insurance companies claim frivolous lawsuits cause doctors high premiums), available at http://www.usatoday.com/news/nation/2003-03-04-malpractice-cover_x.htm.

5. See Eisler, *supra* note 4, at 1 (discussing caps as one solution to medical malpractice crisis). Another solution, proposed by the group “Sorry Works,” has already been implemented in community health clinics that

within the Help, Efficient, Accessible, Low-Cost, Timely Health Care (HEALTH) Act of 2004.⁶ In May 2004, the Republican led House of Representatives passed the HEALTH Act, a bill that caps plaintiffs' non-economic damages at \$250,000.⁷

In contrast, the American Association of Trial Lawyers, as well as many Democrats and consumer watch groups, claim that lawsuits and high damage awards are not to blame for doctors' increasing insurance premiums.⁸ These groups point instead to other factors, such as the cyclical nature of the insurance industry and the losses insurance companies have incurred in the stock market, as the cause for rising medical malpractice insurance premiums.⁹

Each side has strong evidence to support their respective contentions.¹⁰ Proponents of the HEALTH Act point to the fact that doctors' insurance

receive federal funding. *Analysis: Sides Seek Compromise on Medical Malpractice Awards* (NPR radio broadcast, Mar. 15, 2005) [hereinafter *Compromise on Medical Malpractice*]. The plan proposes that a patient injured by alleged medical malpractice may make a proposal for what he expects in damages. *Id.* In turn, the health care provider also proposes an offer, and a neutral third party notifies both sides only if their offers are comparable. *Id.* Otherwise, the patient may proceed to litigation. *Id.*

6. Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2004, H.R. 4280, 108th Cong. (2004). The bill states that:

Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

Id. at § 2(a)(1). The HEALTH Act 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.

Id. at § 9(15); see also Adam D. Glassman, *The Imposition of Federal Caps in Medical Malpractice Liability Actions: Will They Cure the Current Crisis in Health Care?*, 37 AKRON L. REV. 417, 419 (2004) (noting HEALTH Act will force caps on states previously reluctant to pass such legislation).

7. See H.R. 4280, § 4(b) 108th Cong. (2004) (capping non-economic damages at \$250,000). Despite the number of parties the plaintiff brings into the action, or how many claims the plaintiff brings, the plaintiff's non-economic damages are still limited to \$250,000. *Id.* The House of Representatives has passed this bill eight times since 1995. *Analysis: Politics of Tort Reform* (NPR radio broadcast, Jan. 5, 2005). The legislation has stumbled, however, from a lack of support in the Senate. *Id.*

8. See The Foundation For Taxpayer and Consumer Rights, *HOW INSURANCE REFORM LOWERED DOCTORS' MEDICAL MALPRACTICE RATES IN CALIFORNIA AND HOW MALPRACTICE CAPS FAILED*, 2 (2003) [hereinafter FOUND. FOR TAXPAYER AND CONSUMER RIGHTS REP.] (reporting capping non-economic damages fails to lower physician's premiums), at www.consumerwatchdog.org/malpractice/rp/1008.pdf; see also Glassman, *supra* note 6, at 419 (noting many Democrats, consumer watch groups, and American Trial Lawyer Association oppose capping damages).

9. WEISS RATINGS REP., *supra* note 1, at 9 (observing factors other than high-jury verdicts cause high medical malpractice insurance premiums).

10. See *supra* notes 1-4 (discussing arguments supporting both sides of medical malpractice debate).

premiums in California, which was one of the first states to place caps on non-economic damages, consistently remain below the national average.¹¹ Critics of capping non-economic damages, however, point to the fact that only .9% of the 5,500 medical malpractice cases adjudicated in 2002 resulted in plaintiffs' verdicts.¹² This further bolsters the argument of those who criticize capping damages: that outrageous jury awards are not the cause of doctors' astronomical medical malpractice insurance premiums.¹³

This Note analyzes the likely effectiveness of the proposed Federal HEALTH Act by examining the effect that caps on non-economic damages at the state level have had on doctors practicing in California, Indiana, and Montana. These states are compared with Illinois and Connecticut, states listed as "crisis states" by the American Medical Association (AMA). The legislatures in these "crisis states" either have not yet capped non-economic damages or recently passed such legislation. Other proposed solutions to the medical malpractice crisis, such as insurance reform, will be discussed and analyzed. This Note concludes that there is currently insufficient data to warrant capping non-economic damages in medical malpractice cases and points to other possible solutions to rising premiums that would not sacrifice the justice owed to plaintiffs of medical malpractice.

II. HISTORY

A. How the Medical Malpractice Insurance Industry Operates

Medical malpractice insurance has become a prerequisite to the practice of medicine.¹⁴ Usually, insurance companies that offer medical malpractice insurance are operated or owned by physicians.¹⁵ The most common form of

11. See Scott Finn, *California Caps or Proposition 103? Lawyers, Doctors Debate What Really Brought Malpractice Insurance Rates Down*, CHARLESTON GAZETTE, Jan. 19, 2003, at *1 (pointing to lower premiums in California when compared to other states), available at <http://www.consumerwatchdog.org/malpractice/nw/?postID=1903>.

12. Christopher H. Schmitt, *A Medical Mistake*, U.S. NEWS & WORLD REP., June 30, 2003, at 24 (pointing to small percentage of plaintiffs who succeed in medical malpractice cases). In addition to the small percentage of plaintiffs who are successful on their claims, two thirds of plaintiffs' medical malpractice claims are dismissed before going to a jury. *Id.*; see also Dr. William P. Gunnar, *Is There An Acceptable Answer to Rising Medical Malpractice Premiums?*, 13 ANNALS HEALTH L. 465, 477 (2004) (stating plaintiffs in medical malpractice cases have twenty percent chance of winning verdict).

13. See *supra* note 12 and accompanying text (discussing small percentage of successful medical malpractice cases).

14. See U.S. GEN. ACCOUNTING OFFICE, Pub. No. GAO-03-702, Report to Congressional Requesters, MEDICAL MALPRACTICE INSURANCE—MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES, 6 (2003) [hereinafter GAO REP. 2003] (stating almost all health care providers purchase medical malpractice insurance), available at <http://www.gao.gov/new.items/d03702.pdf>.

15. *Id.* at 6 (finding 60% of private practice physicians in U.S. covered by physician-owned or physician-operated insurance companies). Physicians may choose to obtain coverage through other insurance providers such as commercial insurance companies and state-run insurance programs, or physicians may choose to self-

coverage offered by medical malpractice insurance providers is called “claims made coverage.”¹⁶ This type of insurance policy covers physicians from all claims that patients report against them during the year in which the physicians’ policy is in effect.¹⁷ The premiums that physicians pay each year serve as protection from possible claims they may incur in that year.¹⁸ To avoid raising premiums, the insurance company invests premium dollars with the objective that the investment income will supplement the company’s costs.¹⁹ The premiums physicians pay for an insurance policy is the consideration for the insurers’ promise to financially cover any claims against those physicians, up to a certain prescribed amount and within the specified time frame set forth in the policy.²⁰

insure. *Id.*

16. *Id.* at 5-6 (stating insurers changed to “claims-made” coverage in the ‘70s and ‘80s). Insurers previously sold “occurrence based” policies, which covered claims that were triggered by events occurring during the year, although the claim may not have been reported in that year. See GAO REP. 2003, *supra* note 14, at 5. The change to “claims-made” coverage was made in order to improve the accuracy of insurers’ predictions of its losses each year. *Id.*

17. GAO REP. 2003, *supra* note 14, at 6-7 (noting majority of policies provide “claims-made” coverage and over-all decline in occurrence coverage). In contrast to “claims-made” coverage, which provides coverage for all claims made against a physician during the year regardless of when the alleged medical malpractice occurred, occurrence coverage provides physicians with protection against all claims triggered by events that occurred during the year the policy was in effect. *Id.* at 7.

18. See GAO REP. 2003, *supra* note 14, at 7 (stating premium is consideration for protection against malpractice claims).

19. GAO REP. 2003, *supra* note 14, at 7 (explaining investing premium dollars helps reduce premium rates). An insurers’ investment returns are factored into the insurance company’s profits. Christina O. Jackiw, *The Current Medical Liability Insurance Crisis: An Overview of the Problem, Its Catalysts and Solutions*, 13 ANNALS HEALTH L. 505, 512 (2004) (identifying link between high investment returns and low premiums). This means, however, that losses on investment returns necessarily require a corresponding increase in premiums. *Id.* A weakened stock market or lower interest rates can result in declining investment returns. *Id.*

20. GAO REP. 2003, *supra* note 14, at 7 (noting premium payments as quid pro quo for agreement to pay any future claims). In addition to the insurers’ agreement to pay for claims up to a specified amount, insurance companies also investigate and, when appropriate, provide physicians with legal representation. U.S. Gen. Acct. Off. (GAO), Pub. No. GAO/HEHS-00-5, Report to Congressional Requesters, MEDICAL MALPRACTICE EFFECTS OF VARYING LAWS IN THE DISTRICT OF COLUMBIA, MARYLAND, AND VIRGINIA, 4 (1999) available at <http://www.gao.gov/new.items/he00005.pdf>. Because of the limited number of medical malpractice insurance providers and the need for malpractice insurance, physicians are at the mercy of insurance companies and are unable to negotiate the cost of their premiums or shop around for lower rates. See Gunnar, *supra* note 12, at 471 (noting premiums “non-negotiable”); see also *Causes of the Med. Liab. Ins. Crisis: Hearing Before the S. Comm. on S. Appropriations Subcommittee on Labor, Health and Human Serv., Edu., and Related Agencies*, 108th Cong. at *2 (2003) (statement of James Hurley, Chairperson, Medical Malpractice Subcommittee American Academy of Actuaries) (pointing out decreased number of insurers providing medical malpractice insurance), available at 2003 WL 1197993. The United States Department of Health and Human Services stated in a 2002 report that physicians spent \$6.3 billion in 2001 on medical malpractice insurance coverage. U.S. DEPT. OF HEALTH AND HUMAN SERVICES, CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM, 6 (2002), available at <http://aspe.hhs.gov/daltcp/reports/litrefm.pdf> [hereinafter U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP.]. The \$6.3 billion figure does not account for the added strain on the nation’s health care costs resulting from the practice of defensive medicine, where doctors are driven to prescribe tests and treatments primarily because of the fear of suit, not because the physician believes the intervention or test is medically necessary. *Id.* at 6. *But see* Gunnar, *supra* note 12, at 476 (citing Harvard study revealing doctors’ perception

Part of the difficulty in determining the cause of the nation's medical malpractice crisis is due to the unpredictable factors affecting insurance premiums.²¹ Every year, insurance companies decide the premium rate by predicting how much money they will pay on claims and how much money will come from investment returns.²² Insurance companies must speculatively predict their losses from each claim, before each claim is resolved.²³ This prediction is complicated by the length of time that typically lapses before a medical malpractice case is resolved.²⁴ Consequently, the determination of premium rates for any given year is both difficult and conjectural.²⁵ Unfortunately, physicians have repeatedly experienced the hardships associated with exorbitant medical malpractice insurance premiums.²⁶

These high premiums are due to the widely acknowledged cyclical nature of the insurance industry.²⁷ The insurance industry cycle is measured by "hard" and "soft" markets.²⁸ A soft market is typified by lower premium rates that are relatively stable, and stiff competition between insurance companies all vying for physicians' premium payments.²⁹ In contrast, hard markets are marked by swift rises in premiums and fewer insurance options for physicians because of cutbacks in available coverage and a reduction of the number of insurance

of risk of being sued three times actual risk).

21. GAO REP. 2003, *supra* note 14, at 7 (listing factors insurance companies consider when determining premium rates).

22. GAO REP. 2003, *supra* note 14, at 7. A for-profit insurance provider must also consider whether the premium rate decided upon will provide a surplus or profit. *Id.*

23. GAO REP. 2003, *supra* note 14, at 7 (noting insurers must predict what they will have to pay on each claim).

24. GAO REP. 2003, *supra* note 14, at 8 n.17 (stating five year average for verdicts in medical malpractice claims). Furthermore, it is not unusual for some claims to hang in limbo for eight to ten years before a verdict is reached. *Id.* at 8.

25. *See* GAO REP. 2003, *supra* note 14, at 7-8 (pointing out unpredictable nature of "anticipated losses on claims" dictating premiums).

26. *Ins. Indus. Reg.: Hearing Before the S. Comm. on S. Com., Science and Transp.*, 108th Cong. (2003) (statement of Douglas Heller, Senior Consumer Advocate, Foundation for Taxpayer and Consumer Rights) [hereinafter *Cong. Testimony of Douglas Heller*] (discussing insurance cycle and three previous insurance crises), at 2003 WL 6827836. Douglas Heller, of the Foundation for Taxpayer and Consumer Rights, stated in his congressional testimony that the insurance crises in the mid-70s, mid-80s and early 2000s were linked to a slowing economy whereby insurance companies incurred losses on their investment returns. *Id.* at *8.

27. *See id.* at *8 (describing insurance cycle with "hard" and "soft" insurance markets); *see also* GAO REP. 2003, *supra* note 14, at 33 (discussing effect of premium rates on insurance cycle). *See generally* Mitchell J. Nathanson, *It's the Economy (and Combined Ratio), Stupid: Examining the Medical Malpractice Litigation Crisis Myth and the Factors Critical to Reform*, 108 PENN ST. L. REV. 1077 (2004) (noting insurance market cycles linked to stock market).

28. GAO REP. 2003, *supra* note 14, at 33 (explaining hard markets equated with high premiums and soft markets equated with lower premiums).

29. GAO REP. 2003, *supra* note 14, at 33; *see also* *Cong. Testimony of Douglas Heller*, *supra* note 26, at *8 (describing characteristics of soft and hard markets). Heller stated in his congressional testimony that when insurance companies experience excellent returns on their investments, they drastically reduce their premiums and take greater risks by insuring physicians that they would not otherwise insure. *Id.* Insurance companies take these measures to obtain more premium dollars to use for investment purposes. *Id.*

companies in the market.³⁰

Proponents of tort reform blame “frivolous” lawsuits and radically high jury awards as the chief culprits of spiraling medical malpractice insurance premiums.³¹ The problem, however, is that this theory has little statistical support.³² Medical errors result in the death of approximately 44,000-98,000 Americans each year, yet only 1.53% of patients harmed by physician negligence file medical malpractice claims.³³ Furthermore, the majority of patients who bring medical malpractice claims are unsuccessful in obtaining a judgment in their favor. Specifically, only 1.2% to 1.9% of plaintiffs in

30. GAO REP. 2003, *supra* note 14, at 33 (describing period from 1998 to present as hard market); *see also Cong. Testimony of Douglas Heller, supra* note 26, at 8 (stating hard markets sparked by diminished investment income for insurance companies); WEISS RATINGS REP., *supra* note 1, at 9 (explaining cycle of hard and soft markets in insurance industry). A hard market also occurred in the mid-1970s and in the mid-1980s. GAO REP. 2003, *supra* note 14, at 33.

31. Eisler et al., *supra* note 4, at 1 (noting “frivolous lawsuits and runaway jury awards” often cited as causes of malpractice insurance crisis). In its report, the U.S. General Accounting Office noted that the increasing litigiousness of the population is one possible factor contributing to insurance companies’ increased losses. GAO REP. 2003, *supra* note 14, at 24.

32. *See* U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 8 (noting small percentage of claims filed and plaintiffs’ poor chances of recovering on claim). In addition to the small percentage of medical malpractice claims filed by plaintiffs, the median jury award for plaintiffs in medical malpractice cases has remained flat from 1999 to 2002. Press Release, Jury Verdict Research (Mar. 20, 2003) (reporting median jury awards in medical malpractice cases), http://www.juryverdictresearch.com/Press_Room/Press_releases/Verdict_study/verdict_study2.html. Between 1999 and 2002, fifty-two percent of plaintiffs’ awards in medical malpractice cases were \$1 million or more. *Id.* *But see* U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 12 (identifying rise in premiums for physicians from 2000 to 2001). Despite the fact that plaintiffs’ verdicts did not increase from 1999 to 2002, physicians still experienced a rise in premiums during that time. *Id.*

33. Jackiw, *supra* note 19, at 510 (citing 2000 report claiming thousands of Americans die every year from medical errors). In 1997, medical error was listed as one of the top ten causes of death in the United States. *Id.* These figures, however, do not account for patients who are injured by medical errors but survive. *Id.* at 511; *see also* U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 8 (stating small percent of victims of medical malpractice ever file claim). A study by the Physician Insurers Association provides further support for these statistics. Gunnar, *supra* note 12, at 477 (citing study finding only .9% of plaintiffs in malpractice cases successfully obtained jury verdict). Though frivolous lawsuits are often blamed for the high cost of health care, an injured patient only has a 20% chance of succeeding on a medical malpractice claim. *Id.*; *supra* note 4 and accompanying text (discussing how “frivolous lawsuits” are often blamed as culprit of malpractice crisis). *But see* U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 7 (noting high cost of defending medical malpractice claim even if physician prevails). *Compare* U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 8 (stating it costs approximately \$24,669 to defend medical malpractice claim), *with* AMA, LIABILITY REFORM, *supra* note 4, at 3 (stating it costs approximately \$87,720 to defend medical malpractice claim). In the few cases where a judgment is rendered for the plaintiff, the largest portion of the judgment is for non-economic damages. U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 8. *But see* GAO REP. 2003, *supra* note 14, at 23 (stating inability to distinguish between economic and non-economic damages regarding insurers’ losses). In fact, “no comprehensive source of information exists on the breakdown of [an insurer’s] losses between economic damages . . . and non-economic damages.” GAO REP. 2003, *supra* note 14, at 23. Remarkably, information regarding the total amounts insurers pay for a single judgment against a physician in a medical malpractice case has not been recorded. GAO REP. 2003, *supra* note 14, at 23. There is also a lack of information that allows insurers’ losses to be broken down between settlement payments and jury verdicts for plaintiffs in medical malpractice cases. GAO REP. 2003, *supra* note 14, at 23.

medical malpractice cases obtain a favorable verdict on their claim.³⁴

Physicians are also burdened by the fact that the medical malpractice industry provides no deductions on insurance premiums for records untainted with malpractice claims.³⁵ Rather, the losses an insurer incurs from large payments on medical malpractice claims are shared among all its insured physicians.³⁶ In fact, five percent of physicians who pay medical malpractice premiums were responsible for one-third of all the money insurers paid out for medical malpractice claims from September 1990 to March 2003.³⁷

B. California as the Model for the HEALTH Act

The effect of tort reform in California—one of the first states to pass this kind of legislation—adds further confusion to the medical malpractice debate.³⁸ In 1975, due to skyrocketing insurance premiums, California enacted the Medical Injury Compensation Reform Act (MICRA).³⁹ Though MICRA ensured plaintiffs would be fully compensated for all economic losses such as lost wages, MICRA capped non-economic damages at \$250,000.⁴⁰ MICRA's effect on physicians' insurance premiums is significant because the proposed federal HEALTH Act is modeled after MICRA.⁴¹ Proponents of the HEALTH Act state that MICRA alleviated California's health care crisis by stabilizing physicians' insurance premiums, which continue to remain well below the national average.⁴²

34. U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 8 (stating small percentage of plaintiffs file medical malpractice claims).

35. Daniel Eisenberg et al., *The Doctor Won't See You Now*, TIME, June 9, 2003, at 46 (noting "conscientious" physicians paying price for "incompetents" driving up premiums).

36. *Id.* at 46 (stating small percentage of physicians responsible for large percentage of insurers' losses).

37. *Id.* (finding competent physicians bear burden of negligent physicians).

38. See Finn, *supra* note 11, at *1 (discussing debate over whether caps or insurance reform lowered premiums in California).

39. CAL. CIV. CODE § 3333.2 (West 2004); see also FOUND. FOR TAXPAYER AND CONSUMER RIGHTS REP., *supra* note 8, at 2 (stating MICRA passed in 1975 and capped non-economic damages at \$250,000); *Med. Liab. Issues: Hr'g Before the Comm. on House Energy and Commerce Subcomm. on Health*, 108th Cong. 42-51 (2003) (statement of Fred Hiestand, CEO and General Counsel, Californians Allied for Patient Protection (CAPP)) [hereinafter *Cong. Testimony of Fred Hiestand*] (noting in 1974 insurance companies in California announced premiums would rise 400%).

40. See *Cong. Testimony of Fred Hiestand*, *supra* note 39, at 46. MICRA also provided for arbitration of medical malpractice claims and implemented a sliding-scale contingency fee so that attorneys would collect smaller fees as the award grew. *Id.* In addition, MICRA eliminated the "collateral source rule," which allowed plaintiffs to collect all of the damages from one defendant, regardless of fault. FOUND. FOR TAXPAYER AND CONSUMER RIGHTS REP., *supra* note 8, at 2.

41. Gunnar, *supra* note 12, at 492 (noting MICRA provided model for HEALTH Act). Just like MICRA, the HEALTH Act would cap non-economic damages at \$250,000. *Id.* The HEALTH Act would also impose a three-year statute of limitations on medical malpractice claims, eliminate joint and several liability, and allow defendants to reveal to juries payments plaintiffs have received from other sources. *Id.*

42. *Cong. Testimony of Fred Hiestand*, *supra* note 39, at 46 (stating physicians' premiums in California well below rate of national average). Physicians in California have experienced a rate increase in their premiums of 168% since 1975. *Id.* In contrast, physicians across the country have experienced a premium rate

Critics of MICRA and the HEALTH Act, however, argue that MICRA did little to alleviate physicians' insurance premiums, pointing to the spike in insurance rates that occurred in California during the mid-1980s.⁴³ Critics of capping non-economic damages attribute the lower premiums doctors pay in California to insurance reform, not tort reform.⁴⁴ Democrats and consumer rights groups who oppose federal legislation that would cap non-economic damages argue that physicians experienced a reprieve in the cost of their insurance premiums when California passed Proposition 103, which imposed stringent regulations on the insurance industry.⁴⁵ The most significant portions of Proposition 103 mandated a twenty percent reduction in medical malpractice insurers' premiums and froze premium rates for one year.⁴⁶ Whether MICRA or Proposition 103 are responsible for the relatively stable insurance climate in California remains a disputed issue at the center of the tort-reform debate.⁴⁷

C. Survey of Two "Crisis" States

1. Illinois

The AMA categorizes Illinois as a "state in crisis" because of the astronomical premiums doctors pay for medical malpractice insurance.⁴⁸ The AMA states that from 2002 to 2003, OB-GYNs in Illinois each paid \$103,000-\$140,000 in medical malpractice insurance premiums.⁴⁹ In 2001, the

increase of 420% since 1975. *Id.*

43. See FOUND. FOR TAXPAYER AND CONSUMER RIGHTS REP., *supra* note 8, at 2 (indicating insurance premiums still rose in California after MICRA); see also *Cong. Testimony of Douglas Heller, supra* note 26, at *3 (noting resurgence of high premiums in California in 1988 sparked Proposition 103).

44. See FOUND. FOR TAXPAYER AND CONSUMER RIGHTS REP., *supra* note 8, at 2 (attributing twenty percent decline in California physicians' premiums in three-year time span to insurance reform).

45. FOUND. FOR TAXPAYER AND CONSUMER RIGHTS REP., *supra* note 8, at 2 (attributing reduction in premium rates to Proposition 103). After Proposition 103, "malpractice insurance was subject to the nation's toughest rate regulation system in the country." *Id.* Other significant aspects of Proposition 103 included: (1) rate freeze of premiums for one year; (2) mandatory refunds to policy holders that reached billion dollar figures; (3) authority of insurance commissioner to reject or approve a proposed rate increase; (4) ability of policy holders to challenge proposed rate increases; and (5) elimination of the exemption from state and federal anti-trust laws that the insurance industry previously enjoyed. See CAL. INS. CODE § 1861.01(a) (West 2004) (setting forth provisions of Proposition 103); see also FOUND. FOR TAXPAYER AND CONSUMER RIGHTS REP., *supra* note 8, at 2 (explaining provisions of Proposition 103).

46. See FOUND. FOR TAXPAYER AND CONSUMER RIGHTS REP., *supra* note 8, at 2 (listing significant provisions of Proposition 103).

47. See Finn, *supra* note 11, at *1 (discussing debate surrounding effects of MICRA versus Proposition 103).

48. See American Medical Association, *Medical Liability Crisis Map* [hereinafter AMA, *Crisis Map*] (listing Illinois as "state in crisis"), at <http://www.ama-assn.org/ama/noindex/category/11871.html> (last visited Jan. 8, 2006). According to the AMA, the following are "crisis states": Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Texas, Washington, West Virginia, and Wyoming. *Id.*

49. See American Medical Association, *America's Medical Liability Crisis Backgrounder, Illinois* (Feb. 22, 2006) (placing premium rates in Illinois above \$100,000 per year), at <http://www.ama->

Department of Health and Human Services also reported high insurance premium rates, estimating that OB-GYNs in Illinois paid anywhere from \$72,500-\$110,000 in that year for their insurance premiums.⁵⁰ The AMA contends that caps on non-economic damages would successfully lower doctors' premiums in Illinois because non-economic damages accounted for 91% of the plaintiffs' awards in Illinois medical malpractice cases.⁵¹ This hard insurance market in Illinois has driven many medical malpractice providers out of the state.⁵² Thus, doctors in Illinois have little hope of finding competitive rates among a shrinking pool of insurance providers.⁵³

Currently, the Illinois legislature has not imposed caps on non-economic damages.⁵⁴ It attempted to impose caps on non-economic damages but the Illinois Supreme Court struck down each proposed legislative cap.⁵⁵ Most recently, the Illinois Supreme Court struck down the legislative caps on non-economic damages in the case *Best v. Taylor Machine Works et al.*,⁵⁶ calling the caps "arbitrary."⁵⁷ The court failed to find a rational link between capping non-economic damages and the state's interest in reducing the "systemic costs of the civil justice system."⁵⁸

[assn.org/ama/pub/category/12386.html](http://www.ama-assn.org/ama/pub/category/12386.html).

50. See U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 16 (citing similar but slightly lower premium rates in Illinois than AMA report).

51. See U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 7 (stating non-economic damages account for large proportion of plaintiffs' awards). *But see* GAO REP. 2003, *supra* note 14, at 23 (finding minimal information available distinguishing economic from non-economic damages in settlements and jury verdicts). Statistics from Madison County, Illinois, which has a reputation for overly generous awards to plaintiffs, raise doubts about insurers' claims that the money they have collected in premiums failed to cover the costs of settlements and verdict payments. Christi Parsons, *Verdicts Belie Image in Madison County*, CHICAGO TRIB., Jan. 9, 2005, at C1. Four of the county's 374 medical malpractice cases filed since 1996 have resulted in verdicts for plaintiffs. *Id.* One of the verdicts resulted in a \$1.8 million award for the plaintiff but the aggregate of the other three awards barely equaled \$500,000. *Id.* Such statistics, however, fail to account for the draconian costs of litigation and payments made in settlements. *Id.*

52. Gunnar, *supra* note 12, at 471 (stating number of insurance providers in Illinois shrunk from twenty to six).

53. *Id.* Due to the lack of competition in the insurance market, physicians are "at the mercy" of insurance companies because insurance companies are able to turn physicians away and refuse to provide malpractice insurance coverage. *Id.* This is especially difficult for physicians because carrying medical malpractice insurance is an absolute necessity. *Id.*

54. See American Medical Assoc., *America's Medical Liability Crisis Background—Illinois* (describing premiums and legislation in state of Illinois), at <http://www.ama-assn.org/ama/pub/category/12386.html> (last visited Mar. 22, 2006). Furthermore, Illinois has not abolished joint and several liability. *Id.*

55. *Id.* (describing legislative and judicial approaches to malpractice "crisis"). Illinois has implemented collateral source reform for medical malpractice cases and has limited attorneys' fees so attorneys receive an increasingly smaller percentage over a certain amount of recovery. See American Medical Association, *America's Medical Liability Crisis Background*, (explaining Illinois' current situation) at <http://www.ama-assn.org/ama/pub/category/12386.html> (last visited Feb. 22, 2006).

56. 689 N.E.2d 1057 (Ill. 1997).

57. *Id.* at 1076 (noting illogic in capping non-economic damages merely because of difficulty assessing).

58. *Id.* (finding caps on non-economic damages did not pass rational basis test).

2. Connecticut

Connecticut faces a similar medical malpractice crisis: proposed increases in physician insurance premiums have fueled the state's debate over tort reform.⁵⁹ The solution to the state's medical malpractice problem placed the legislature, which had been reluctant to place caps on non-economic damages, at odds with the then governor, who strongly supported capping non-economic damages.⁶⁰

Similar to those in Illinois, Connecticut physicians have been hit hard with inflated malpractice premiums.⁶¹ One insurer, GE Medical Protective, raised premium rates for OB-GYNs on July 1, 2004, by 93.7%.⁶² As a result, OB-GYNs insured by GE Medical Protective in Connecticut are facing premiums of \$173,000.⁶³

GE Medical Protective was not the only Connecticut insurer to raise doctors' premiums rates in 2004.⁶⁴ Physician-owned Connecticut Medical Insurance Co. announced that it would raise its premiums by an average of 14.6%, taking effect January 1, 2005.⁶⁵ Similarly, ProMutual Group, which insures

59. Diane Levick, *Malpractice Maelstrom Two Major Insurers Seek to Raise Doctors' Rates as Much as 25%*, HARTFORD COURANT, Oct. 2, 2004, at E1 [hereinafter Levick, *Malpractice Maelstrom*] (discussing problem of rising premiums in Connecticut).

60. Christopher Keating, *Caps on Verdicts Rejected House Votes Against Limiting 'Pain and Suffering' Awards to Reduce Medical Malpractice Premiums*, THE HARTFORD COURANT, April 27, 2004, at B1 (noting legislature and governor in conflict over placing caps on non-economic damages). On April 26th, 2004, the Connecticut House of Representatives vetoed a proposed bill that imposed a cap of \$350,000 on non-economic damages. *Id.* Legislative progress has been slow, in part, because then-governor John G. Rowland limited his support to bills that would place a cap on non-economic damages, something the legislature was reluctant to do. *Id.*; see also Christopher Keating, *Senate Approves Malpractice Bill No Cap on Damages Makes Rowland Support Uncertain*, HARTFORD COURANT, May 4, 2004, at B1 [hereinafter Keating, *Malpractice Bill*] (pointing to disagreement between Governor and legislature over caps as solution to high premiums). Though Governor Rowland is no longer in office, the current Governor, M. Jodie Rell, acknowledged in her State of the State address on January 5, 2005, that medical malpractice reform is a major priority for the Connecticut legislature. Mark Pazniokas and Christopher Keating, *Bold Challenge Governor Asks Legislature for Major Reforms in Month; State of the State*, HARTFORD COURANT, Jan. 6, 2005, at A1.

61. See Levick, *Malpractice Maelstrom*, *supra* note 59, at E1 (reporting on rising premiums in Connecticut).

62. Diane Levick, *No Longer Able to Deliver Costs Send Some Ob-Gyns Packing*, HARTFORD COURANT, May 2, 2004, at A1 [hereinafter Levick, *OB-GYNs Packing*] (noting proposed rise in GE Medical Protective's premiums). Both trial lawyers and consumer watch groups have challenged this rate increase. Levick, *Malpractice Maelstrom*, *supra* note 59, at E1. The average increase for all physicians insured by GE Medical Protective was 89.6%. *Id.*

63. Levick, *OB-GYNs Packing*, *supra* note 62, at A1 (discussing effect of proposed premium increases of large Connecticut insurer).

64. Levick, *Malpractice Maelstrom*, *supra* note 59, at E1 (pointing to other insurance companies also raising premiums in Connecticut).

65. *Id.* (listing other insurance companies in Connecticut and their corresponding rate increases). But see Keating, *Malpractice Bill*, *supra* note 60, at B1 (noting few specialties primarily affected by high premiums). Despite the insurance hike for OB-GYNs, 50% of physicians covered by Connecticut Medical Insurance Co. paid \$27,000 per year in premiums for medical malpractice insurance. Keating, *Malpractice Bill*, *supra* note 60, at B1.

approximately 3,500 Connecticut physicians, increased its rates by 25% in 2004.⁶⁶

Though some opponents of caps on non-economic damages claim that the “medical malpractice crisis” has been over-blown, the impact of high premiums on Connecticut OB-GYNs has been clear - the number of OB-GYNs practicing in Connecticut is dwindling.⁶⁷ As of January 2004, there were 14.5% fewer OB-GYNS practicing in the state of Connecticut than were practicing in 2002.⁶⁸

D. Survey of States Avoiding a Medical Malpractice Crisis

1. Indiana

In contrast to neighboring Illinois, doctors in Indiana have managed to avoid skyrocketing medical malpractice premiums.⁶⁹ Indiana is only one of six states that the AMA has labeled with the status of “currently okay” in the nation’s medical malpractice crisis.⁷⁰ Proponents of capping damages attribute Indiana’s success to its cap on damages in medical malpractice cases, which the legislature passed in 1990.⁷¹ The cap limits all damages, both economic and

66. Levick, *Malpractice Maelstrom*, *supra* note 59, at E1 (pointing out rise in premium rates of Boston based insurer affecting Connecticut physicians).

67. See Levick, *OB-GYNs Packing*, *supra* note 62, at A1 (noting skepticism of president of Connecticut Trial Lawyers Association and decreased number of OB-GYNS in state).

68. *Id.* Due to high premiums, Women’s Health Connecticut, a Connecticut OB-GYN practice, attempted to levy a \$500 charge for each pregnant patient the practice treated. Diane Levick, *Doctors Threaten New Fee*, HARTFORD COURANT, May 19, 2004, at E1 (reporting physician’s shifting burden of high premiums onto patients). The state Attorney General, however, stated that the charge may be “illegal,” thus putting the planned fee on hold. Marian Gail Brown, *Attorney General Attacks Avon, Conn.—Based Physician Partnership*, CONNECTICUT POST, May 22, 2004, at *1 (discussing Connecticut Attorney General’s concerns over surcharge), available at 2004 WL 59488855.

69. See WEISS RATINGS REP., *supra* note 1, at 16 (stating median premium in Indiana in 2002 equaled \$22,886).

70. See AMA, *Crisis Map*, *supra* note 48. The other states that the AMA evaluated and determined to be “currently okay” are: California, New Mexico, Colorado, Wisconsin, and Louisiana. *Id.*

71. See IND. CODE ANN. § 34-18-14-3 (West 2004). The Indiana Supreme Court upheld the constitutionality of the cap when it was first enacted. *Johnson v. St. Vincent Hosp.*, 404 N.E.2d 585 (Ind. 1980) (finding risk of scarce state resources justified capping damages in medical malpractice cases). The court stated:

It must, however, be accepted that the badly injured plaintiff who may require constant care will not recover full damages, yet at the same time we are impressed with the large amount which is recoverable and its probable ability to fully compensate a large proportion of injured patients. In the same vein, badly injured patients would have little or no chance of recovering large sums of money if the evil the act was intended to prevent were to come about, i.e. that an environment would develop in the State in which private or public malpractice insurance were unavailable or unused . . . Thus to the extent that the limitation upon recovery is successful in preserving the availability of health care services, it does so to the benefit of the entire community including the badly injured plaintiff.

non-economic, to \$1.25 million.⁷²

According to the U.S. Department of Health and Human Services, physicians in Indiana have only seen a fifteen percent increase in their premiums from 2000 to 2001.⁷³ In 2002, the median premium a physician paid in Indiana for medical malpractice insurance was \$22,886.⁷⁴ Under Indiana's law, a health care provider is only liable for \$250,000 for an incident of medical malpractice.⁷⁵ Any award exceeding \$250,000 is satisfied through the state's patients' compensation fund, which is funded by contributions from health care providers.⁷⁶

Supporters of legislation capping non-economic damages often raise concerns that doctors are leaving states with high medical malpractice premiums to practice in states with lower premiums.⁷⁷ Interestingly, despite the state's low premiums, physicians have not flocked to Indiana for reprieve from high premiums in other states.⁷⁸ In fact, Indiana has one of the lowest-per-capita doctor to citizen ratios in the country.⁷⁹

Id. at 599.

72. IND. CODE ANN. § 34-18-14-3(a)(3) (West 2004). The statute's limit of \$1.25 million applies to any injury or death that resulted from medical malpractice that occurred after June 30, 1999. *Id.* For incidents of malpractice that occurred before January 1, 1990, the statute limits damages to \$500,000. *Id.* at 3(a)(1). For all incidents of medical malpractice occurring between December 31, 1989, and July 1, 1999, a plaintiff is limited to \$750,000 in damages. *Id.* at 3(a)(2). Indiana's stringent cap is troubling given the rising cost of economic damages for those patients who suffer severe disability as a result of medical malpractice. See Analysis: Malpractice Lawsuits (NPR radio broadcast, Feb. 1, 2005) (reporting economic cost of injuries rising into multi million dollar figures).

73. U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 12 (comparing states with caps on non-economic damages and states without such caps). The study added the averages of the state's highest premiums for physicians across three specialties: OB-GYNs, Internists, and General Surgeons. *Id.* at 12-13. This same study indicated that these three groups of physicians in Connecticut incurred a rise in their premiums rise by an average of fifty percent. *Id.*

74. WEISS RATINGS REP., *supra* note 1, at 16 (listing median premiums in Indiana in 1991 and 2002).

75. IND. CODE ANN. § 34-18-14-3(b) (West 1999) (establishing limit on damages).

76. IND. CODE ANN. § 34-18-14-3(c) (West 1999) (explaining patients' compensation fund pays for part of judgment). Health care providers support the Indiana Patients Compensation Fund through surcharges. See *Medical Malpractice the Issue: Indiana's Tough System Called into Question*, EVANSVILLE COURIER, April 25, 2004, at A16 [hereinafter *Indiana's Tough System*] (discussing mechanics of Indiana Patients Compensation Fund). Health care providers must pay \$100 into the fund in order to fall within the fund's protective scope. See IOWA MEDICAL SOCIETY, PATIENT COMPENSATION FUNDS WHITE PAPER 1 (2004) [hereinafter IOWA MEDICAL SOCIETY] (explaining how patient compensation fund works) at http://www.iowamedical.org/legis/white_paper_to_gov_for_PCF.pdf. Currently, eleven states have patient compensation funds: Indiana, Florida, Kansas, Louisiana, Nebraska, New Mexico, New York, Pennsylvania, South Carolina, Virginia, and Wisconsin. *Id.* at 1.

77. See generally AMA, LIABILITY REFORM, *supra* note 4 (discussing declining number of physicians due to high premiums).

78. Bryan A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Health Care*, 30 AM. J.L. & MED. 501, 508 (2004) (noting low per-capita number of physicians in Indiana).

79. *Id.*; see also *Indiana's Tough System*, *supra* note 76, at A16 (stating doctor to citizen ratio in Indiana is 108: 100,000). Only twelve states have a lower per-capita doctor ratio. *Indiana's Tough System*, *supra* note 76, at A16.

2. Montana

Though the AMA has not yet ranked it as a “state in crisis,” Montana was upgraded to the status of a “state that may be facing problems.”⁸⁰ If tort reform is the answer to rising premiums, Montana’s potential problems with high premiums are surprising because its legislature placed a \$250,000 cap on non-economic damages in 1997.⁸¹

Though premiums for OB-GYNs in Montana are still lower than the premiums in the “crisis states,” they are increasing.⁸² In 2001, OB-GYNs in Montana paid \$36,000-\$38,600 in premiums for medical malpractice insurance.⁸³ Some consumer groups who oppose capping non-economic damages are troubled, however, not by the median premium payment that physicians pay in Montana but by the percent rise in premium payments over the past ten years.⁸⁴ The median premium payment for a physician in Montana in 1991 was \$18,697.⁸⁵ In 2002, the median payment for medical malpractice insurance premiums rose to \$27,011, which represents a 44.5% increase.⁸⁶ This is significant because, according to the report by Weiss Ratings Inc., states that did not enact caps on non-economic damages saw only a 35.9% rise in physicians’ premiums for the same time period.⁸⁷

80. See AMA, *Crisis Map*, *supra* note 48 (stating Montana is state “showing problem signs”). Other states are similarly experiencing rising premiums, despite having placed caps on non-economic damages. *Id.* The AMA has listed Utah, Hawaii, and Michigan as states “showing problem signs,” despite capping non-economic damages. *Id.* Hawaii placed a \$375,000 cap on non-economic damages in 1976, one year after California. See WEISS RATINGS REP., *supra* note 1, at 16. Utah capped non-economic damages at \$250,000 in 1996 and has seen an 82.1% increase in premiums from 1991-2002. *Id.* Michigan has a \$624,000 cap on non-economic damages, which was enacted in 1993. *Id.* Though on the AMA watch list, according to Weiss Ratings, Inc., Michigan physicians have only seen a 3.5% increase in their premiums from 1991-2002. *Id.*

81. MONT. CODE ANN. § 25-9-411 (West 2004) (capping non-economic damages in medical malpractice claims at \$250,000). Montana is not the only state “showing problem signs,” according to the AMA, despite capping non-economic damages. See AMA, *Crisis Map*, *supra* note 48. The U.S. Department of Health and Human Services Report stated that Utah, Hawaii, and Michigan have all capped non-economic damages, yet the AMA has labeled all of these states as states “showing problem signs” regarding rising premiums. See U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 12-13 (listing states that have capped non-economic damages).

82. See U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 14 (comparing premiums of Montana OB-GYNs to premiums of OB-GYNs in other states); see also WEISS RATINGS REP., *supra* note 1, at 16 (noting rise in premiums in Montana from 1991 to 2002).

83. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 14 (reporting high and low premiums OB-GYNs in Montana pay).

84. See WEISS RATINGS REP., *supra* note 1, at 16 (noting rise in Montana’s premiums from 1991 to 2002).

85. WEISS RATINGS REP., *supra* note 1, at 16.

86. WEISS RATINGS REP., *supra* note 1, at 16. Montana physicians are not the only ones experiencing increasing premiums; hospitals in Montana are also victims of skyrocketing malpractice insurance premiums. See Richard Ecke, *Malpractice Insurance Woes Threaten Doctors*, GREAT FALLS TRIB., June 17, 2003, at 1L (stating Great Falls hospital spent \$1.5 million on malpractice insurance in 2003). Medical malpractice insurance cost the same hospital only \$500,000 in 2001. *Id.* Each year, the hospital’s profit is only \$3-\$4 million dollars. *Id.* Thus, each year the hospital spends almost half of its profits on medical malpractice insurance, preventing the hospital from up-grading equipment. *Id.*

87. WEISS RATINGS REP., *supra* note 1, at 3 (stating greater increase in premiums in states that passed

In addition to capping non-economic damages, Montana also formed the Montana Medical Legal Panel.⁸⁸ This panel, comprised of both physicians and lawyers, is responsible for reviewing all medical malpractice claims before plaintiffs can file their claims in state court.⁸⁹ The state's Medical Legal Panel may partly be responsible for the decreasing number of claims that insurers paid out for Montana physicians.⁹⁰ In fact, insurers paid out on ninety-three claims for Montana physicians in 1999, compared to sixty-nine claims in 2001.⁹¹ Despite the formation of the Medical Legal Panel and the caps on non-economic damages, premiums in Montana have continued to rise, prompting the AMA to place Montana on the list of states that may face future problems.⁹²

E. California: A Closer Look

Because California's MICRA is the model for the proposed HEALTH Act, a closer look at the effect of MICRA on physicians' premiums in California is important.⁹³ The exact effect that MICRA had on physicians' premiums in California, however, has been at the center of the debate between supporters and critics of the HEALTH Act.⁹⁴ Critics of the HEALTH Act argue that not only did MICRA fail to lower physicians' premiums, but in the first twelve years after California enacted the \$250,000 cap on non-economic damages, physicians saw a 450% increase in their premiums.⁹⁵

After 1975, insurers in California initially experienced a decline in their incurred losses.⁹⁶ In 1981, however, insurers' incurred losses began to rise

caps). According to Weiss Ratings, Inc., physicians' premiums increased by an average of 48.2%, but physicians in states without caps saw only a 35.9% average increase in premiums. *Id.*

88. See MONT. CODE ANN. § 27-6-401 (West 2005) (describing creation and function of panel).

89. *Id.* (stating health care providers and members of state bar must sit on Medical Legal Panel). The purpose of the Medical Legal Panel is to:

prevent where possible the filing in court of actions against health care providers and their employees for professional liability in situations where the facts do not permit at least a reasonable inference of malpractice and to make possible the fair and equitable disposition of such claims against health care providers.

MONT. CODE ANN. § 27-6-102 (West 2005). The panel's decision is "without administrative or judicial authority and is not binding upon any party." MONT. CODE ANN. § 27-6-606 (West 2005). Furthermore, if the parties continue to adjudicate the case in court, they may not introduce into evidence the decision or reasoning of the panel at the trial. MONT. CODE ANN. § 27-6-704 (West 2005).

90. See Ecke, *supra* note 86, at 1L (suggesting link between panel and decline of paid claims).

91. *Id.* (citing Montana Medical Legal Panel's 2003 annual report noting decline in claims).

92. See AMA, *Crisis Map*, *supra* note 48 (stating Montana physicians may face problems of rising premiums).

93. See Gunnar, *supra* note 12, at 484-86 (discussing MICRA as model for HEALTH Act).

94. See Finn, *supra* note 11, at *1 (arguing caps in California effectively lowered premiums); Gunnar, *supra* note 12, at 465, 490-91 (discussing rise in physicians' premiums after MICRA enacted).

95. See FOUND. FOR TAXPAYER AND CONSUMER RIGHTS REP., *supra* note 8, at 3 (noting steady rise in premiums after California enacted MICRA).

96. See GAO REP. 2003, *supra* note 14, at 21 (demonstrating rise and fall of insurers incurred losses from

rapidly.⁹⁷ Incurred losses represent what insurers expect to pay for all claims reported in any given year, and therefore are closely linked to the premiums the insurer sets.⁹⁸ Thus, the rise in insurers' incurred losses in California in the early '80s corresponded to the dramatic rise physicians saw in their annual premiums.⁹⁹ In contrast, physicians experienced a decline in their premiums in 1988, immediately following the enactment of Proposition 103, which drastically reformed the insurance industry.¹⁰⁰

III. ANALYSIS

A comparison of Illinois, Connecticut, Indiana, and Montana reveals that physicians' premiums are currently higher in Illinois and Connecticut, states that do not cap non-economic damages.¹⁰¹ According to figures provided by the Department of Health and Human Services, in 2001, OB-GYNs in Illinois paid approximately \$54,000 more in premiums than OB-GYNs practicing in Montana.¹⁰² In 2001, OB-GYNs in Connecticut paid approximately \$17,800 more in premiums than OB-GYNs practicing in Montana.¹⁰³ Based on the proposed increases of insurers covering physicians in Connecticut, this disparity will only increase.¹⁰⁴

1975-2001).

97. GAO REP. 2003, *supra* note 14, at 21.

98. See GAO REP. 2003, *supra* note 14, at 7 (explaining incurred losses comprised of estimates of what insurer will pay on future claim). "Claims against a policyholder are recorded as expenses, or incurred losses, which are equal to the amount paid on those claims as well as the insurer's estimate of future losses on those same claims." *Id.* In contrast to incurred losses, paid losses are the actual dollar amount an insurer paid out in that year on claims against policy holders. See GAO REP. 2003, *supra* note 14, at 16.

99. See GAO REP. 2003, *supra* note 14, at 7 (stating premiums determined by insurers' anticipated incurred losses on claims); see also FOUND. FOR TAXPAYER AND CONSUMER RIGHTS REP., *supra* note 8, at 3 (noting premium increases from 1983 to 1988). Proponents of capping non-economic damages argue that repeated challenges to MICRA in California's judicial system weakened the effect of the statute, thus preventing the statute's cap from lowering premiums. See FOUND. FOR TAXPAYER AND CONSUMER RIGHTS REP., *supra* note 8, at 3. The Foundation For Taxpayer and Consumer Rights Report, however, notes that even after the California Supreme Court upheld MICRA in 1985, premiums continued to rise from 1986 to 1988. *Id.*

100. See FOUND. FOR TAXPAYER AND CONSUMER RIGHTS REP., *supra* note 8, at 3 (stating premiums continued to decrease from 1988 to 1991); see also CAL. INS. CODE § 1861.01 (West 2005) (setting forth the provisions of insurance reform within Proposition 103); *supra* note 45 and accompanying text (explaining provisions of Proposition 103).

101. See U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 16 (comparing premiums and state caps in Montana, Illinois, and Connecticut); WEISS RATINGS REP., *supra* note 1, at 16 (reporting premiums in Indiana).

102. See U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 16. This figure was obtained by first averaging the high and low premium rate for physicians practicing in Montana (\$37,300), and then subtracting this figure from the average premium rate for physicians in the Chicago area of Illinois (\$91,300). See *id.*

103. See U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 16. The average of the high and low premiums reported by the U.S. Department of Health and Human Services for Montana was subtracted from the average premium rate reported for Connecticut physicians, which was \$55,100. See *id.*

104. See *supra* notes 62-65 and accompanying text (discussing dramatic rate increases proposed by insurers covering Connecticut physicians).

Despite these findings and what proponents of the HEALTH Act have argued, a closer look at these states reveals that caps on non-economic damages have failed to cure the “medical liability crisis.”¹⁰⁵ Though high premiums have undoubtedly driven some physicians out of states with intolerable premium rates, lower premiums in Indiana have not attracted a significant number of physicians.¹⁰⁶ Indiana’s experience is especially significant, given its close proximity to Illinois, a state labeled as a “state in crisis” by the AMA.¹⁰⁷ Thus, caps and lower premiums do not necessarily draw physicians into a state, even when that state neighbors a “state in crisis.”¹⁰⁸

More significantly, physicians practicing in Montana, a state that placed a cap on non-economic damages in 1997, are experiencing a significant rise in premiums.¹⁰⁹ The rise in premiums in Montana has prompted the AMA to classify Montana as a state that is “showing problem signs.”¹¹⁰ Further, Montana’s physicians are experiencing a rise in their premiums despite a reduction in the number of medical malpractice claims filed in the state.¹¹¹ Applying the reasoning of those who support the HEALTH Act as the solution to high premiums, insurers covering Montana physicians should experience a reduction in incurred losses, because the state has capped non-economic damages and the number of claims filed in the state has declined.¹¹² Logically,

105. See *supra* note 5 and accompanying text (discussing support for capping non-economic damages solution to rising medical malpractice premiums). But see WEISS RATINGS REP., *supra* note 1, at 16 (discussing rising premiums in states with caps on non-economic damages); AMA, *Crisis Map*, *supra* note 48 (noting states in crisis and showing problems despite caps); *supra* text accompanying notes 80-83 (discussing problem of rising premiums in Montana).

106. See *supra* notes 78-79 and accompanying text (discussing low doctor-patient ratio in Indiana).

107. See AMA, *Crisis Map*, *supra* note 48 (listing Illinois as “state in crisis”).

108. See *supra* text accompanying notes 78-79 and accompanying text (discussing low number of physicians in Indiana despite close proximity to neighboring state “in crisis”); see also U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 1 (stating citizens in states with high premiums may have difficulty finding doctors). In fact, “[i]ncreasingly, Americans are at risk of not being able to find a doctor when they most need one because the doctor has . . . moved to a state with a fairer legal system where insurance can be obtained at a lower price.” U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 1.

109. See Ecke, *supra* note 86, at 1L (discussing rising premiums in Montana despite caps).

110. See AMA, *Crisis Map*, *supra* note 48 (reporting Montana as a state that “showing problem signs”); WEISS RATINGS REP., *supra* note 1, at 16 (citing rise in premiums in Montana).

111. See *supra* notes 90-91 and accompanying text (discussing declining number of claims in Montana reported by Montana Medical Legal Panel).

112. See *supra* note 4 and accompanying text (noting specific groups argue frivolous lawsuits and high jury awards cause of rising premiums); see also *supra* note 98 and accompanying text (explaining incurred losses comprised of amount insurer pays on claim and estimates of future losses). One benefit to insurers of capping non-economic damages is that it eases the speculation involved when predicting the amount they will have to pay on a claim. See GAO REP. 2003, *supra* note 14, at 7. Despite this advantage to insurers, Montana’s premiums have continued to rise. See WEISS RATINGS REP., *supra* note 1, at 16. Though Weiss Ratings, Inc. reported a 44.5% increase in median premium rates in Montana from 1991-2002, Montana did not enact its cap on non-economic damages until 1997. *Id.* This figure is inaccurate because the report fails to break down this 44.5% increase into the percent increase occurring before the state capped non-economic damages and the percent increase occurring after the state capped non-economic damages. *Id.*

a reduction in insurers' incurred losses would seemingly result in a reduction, not an increase, in premium rates.¹¹³ The fact that other states are experiencing rising premiums despite caps on non-economic damages demonstrates that Montana is not an anomaly.¹¹⁴ If states that have enacted statutory caps on non-economic damages are still "showing problem signs," the solution to the problem of rising premiums appears to be more complicated than the proponents of the HEALTH Act believe.¹¹⁵

Another difficulty for proponents of the HEALTH Act, which used MICRA as a model, is that MICRA's effect on premiums in California is unclear.¹¹⁶ Premiums actually rose in California after MICRA was enacted.¹¹⁷ Though court challenges to MICRA could account for some of its ineffectiveness, this explanation is weakened by the fact that premiums in California continued to rise even after the state supreme court upheld MICRA.¹¹⁸ In addition, California's low premiums may be a result of insurance reform, not MICRA.¹¹⁹ At the very least, the effect of insurance reform on premiums in California remains unknown.¹²⁰ Thus, federal legislators should be concerned that the state statute which was used as the inspiration and framework for the HEALTH Act may have failed to reduce malpractice premium rates.¹²¹

In addition to the questionable effect of MICRA in California, legislators are missing an enormous amount of essential information crucial to concluding

113. See WEISS RATINGS REP., *supra* note 1, at 7 (discussing logical link between diminished insurer payout and lower premiums). The Weiss Ratings Report states that caps on non-economic damages have only reduced the amount insurers are paying out on claims and has not resulted in the next logical step, a reduction in physicians' premiums. *Id.*; see also GAO REP. 2003, *supra* note 14, at 6-8 (explaining how insurance industry determines premiums and their link to "anticipated losses on claims").

114. See AMA, *Crisis Map*, *supra* note 48 (listing other states that may be "showing problem signs").

115. See *supra* note 6 (stating HEALTH Act based on civil justice system creating problems in health care system); see also GAO REP. 2003, *supra* note 14, at 43 (concluding medical malpractice claims "primary driver" of increased premiums). *But see* *supra* note 80 (pointing to rising premiums in states with caps on non-economic damages); see also *supra* notes 80, 84, 91, and accompanying text (discussing Montana's rising premiums despite drop in number of claims).

116. See FOUND. FOR TAXPAYER AND CONSUMER RIGHTS REP., *supra* note 8, at 3 (suggesting MICRA ineffective in lowering premiums).

117. FOUND. FOR TAXPAYER AND CONSUMER RIGHTS REP., *supra* note 8, at 3 (pointing to 450% rise in premiums in California after MICRA). In contrast, when California enacted Proposition 103, malpractice premiums in the state fell by twenty percent in three years. *Id.* at 1.

118. FOUND. FOR TAXPAYER AND CONSUMER RIGHTS REP., *supra* note 8, at 3 (stating premiums rose 47% in three years after California Supreme Court upheld cap); see also GAO REP. 2003, *supra* note 14, at 21 (pointing to initial decline then rise in insurers' incurred losses in California after MICRA).

119. See FOUND. FOR TAXPAYER AND CONSUMER RIGHTS REP., *supra* note 8, at 2-3 (attributing California's lower premiums to insurance reform, not MICRA).

120. See GAO REP. 2003, *supra* note 14, at 42 (noting debate about effect of insurance reform on premiums). Though the GAO Report concluded that medical malpractice claims were the primary culprit of high premiums, the Report admitted that "a lack of comprehensive data on losses at the insurance company level" has made it impossible to determine the impact of insurance reform on premium rates. *Id.*

121. See FOUND. FOR TAXPAYER AND CONSUMER RIGHTS REP., *supra* note 8, at 3-4 (explaining impact of insurance reform on physician premiums).

whether caps on non-economic damages do, in fact, lower premiums.¹²² First, the impact of many factors affecting premium rates—other than caps on non-economic damages—are unknown.¹²³ For example, the General Accounting Office (GAO) was unable to measure the impact of insurers' investment returns on premium rates.¹²⁴ Secondly, the information distinguishing non-economic damages from economic damages in settlements, jury verdicts, and insurers' incurred losses is lacking.¹²⁵ Similarly, because complete information on insurers' incurred losses is unavailable, it is impossible to determine the effect of insurance reform on insurers' losses and premium rates.¹²⁶ These unknown variables and factors are imperative to a comprehensive analysis of the medical malpractice crisis and place the HEALTH Act on shaky ground.¹²⁷

Though proponents of the HEALTH Act repeatedly point to “junk and frivolous lawsuits” as the driving factor behind rising premiums, the HEALTH Act does not make it more difficult to file a “frivolous lawsuit.”¹²⁸ Instead, the HEALTH Act simply prevents victims of egregious medical malpractice from recovering more than \$250,000 for non-economic damages.¹²⁹ If the goal is to reduce “junk” lawsuits, Montana demonstrated that claims may be reduced by instituting a medical-legal panel that hears all claims before plaintiffs can file suit in state court.¹³⁰

Because a small percentage of physicians are responsible for a large proportion of insurers' losses on claims, greater regulation within the medical community is necessary.¹³¹ Weeding out incompetent doctors would reduce the cost to insurers' of incompetent physicians and reduce the number of medical errors that result in patient harm.¹³² Unlike capping non-economic

122. See GAO REP. 2003, *supra* note 14, at 4, 23, 42 (admitting information on many factors possibly contributing to problem of rising premiums lacking).

123. See GAO REP. 2003, *supra* note 14, at 4 (noting some factors could not be analyzed due to “lack of comprehensive data”).

124. See GAO REP. 2003, *supra* note 14, at 4 (stating high investment returns may disguise losses and prevent insurers from raising premiums accordingly). The GAO stated that they could not fully analyze the composition and causes of losses at the insurer level due to a lack of comprehensive data. *Id.*

125. See GAO REP. 2003, *supra* note 14, at 23 (noting unavailability of information distinguishing non-economic damages from economic damages).

126. See GAO REP. 2003, *supra* note 14, at 42 (admitting lack of information on insurers' losses prevent analysis of impact of insurance reform).

127. See GAO REP. 2003, *supra* note 14, at 4, 23, 42-43 (discussing lack of information vital to analyzing causes of rising premiums).

128. See *President Uses Dubious Statistics on Costs of Malpractice Lawsuits*, Jan. 29, 2004 at <http://factcheck.org/article.aspx@docID=133.html> (quoting President Bush attributing rising health care costs to “junk” lawsuits); see also *supra* notes 6, 7, and accompanying text (explaining HEALTH Act).

129. See *supra* notes 6, 7, and accompanying text (discussing provisions of HEALTH Act).

130. See Ecke, *supra* note 86, at 1L (citing declining number of claims in Montana). *But see* U.S. DEPT. OF HEALTH AND HUMAN SERVICES REP., *supra* note 20, at 8 (stating very few victims of medical malpractice file claims).

131. See Eisenberg, *supra* note 35, at 46 (stating small percentage of physicians responsible for bulk of insurers' losses).

132. *Cf.* Eisenberg, *supra* note 35, at 46 (implying effectiveness of weeding out physicians responsible for

damages, efforts to remove negligent physicians from the practice of medicine would not penalize victims of medical malpractice.¹³³

IV. CONCLUSION

The debate surrounding tort reform has become so contentious in part because physicians and patients both correctly view themselves as victims in our nation's medical liability crisis. Competent doctors, at the mercy of their insurance providers, are finding that high premiums make it impossible, or at the very least unprofitable, to practice medicine. At the same time, patients who are victims of medical malpractice already face an uphill climb in the judicial system—even without a legislative cap on the damages they may receive for pain and suffering. Thus, the medical liability crisis places physicians and patients at odds with one another, and both groups have a high stake in any federal legislative solution.

Legislative caps on non-economic damages provide an appealing solution to a problem that, like the practice of medicine, is complex and multi-faceted. The HEALTH Act, in its most favorable light, provides a simple solution by placing the blame for rising premiums squarely on the shoulders of victims of medical malpractice. On a cursory review, proponents of tort reform and the HEALTH Act are correct in their assertion that physicians in states that have passed caps on non-economic damages have lower premiums. The problem, however, is the failure of those who support caps on non-economic damages to appreciate the numerous additional factors that drive insurance premiums. Plaintiff awards are only one factor influencing premium rates. The effect of other outside influences on the insurance industry is unknown. The fact that a number of states that passed legislation capping non-economic damages years ago and are still experiencing rising premiums is damaging evidence for supporters of tort reform.

The lack of data supporting the HEALTH Act is even more troubling because the Act imposes such a great burden on victims of medical malpractice. There is no doubt that patients bring frivolous claims against their physicians. These claims, even when dismissed, cost money to defend and place a strain on insurers, physicians, and our health care system. The HEALTH Act, however, will not reduce the number of frivolous claims and will not encourage greater regulation within the medical profession. The HEALTH Act simply penalizes those who have already suffered because they did not receive the competent health care they sought and to which they were entitled. Unfortunately, if Congress passes the HEALTH Act, or another

large percentage of medical errors). *See also supra* note 33 and accompanying text (discussing high number of deaths caused by medical error).

133. *See supra* note 132 and accompanying text (discussing internal regulation as solution to medical errors).

similar piece of legislation that caps non-economic damages, victims of medical malpractice will find they have once again suffered as a result of negligence, only this time it will be at the hands of their legislators.

Cathleen B. Tumulty