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NON-ECONOMIC DAMAGES CAPS: PANACEA OR INEFFECTIVE BITTER PILL

Robert Feinberg, Esquire
Michael Yates, Esquire
Snell & Wilmer LLP, Phoenix, Arizona

Distress over the rising cost of medical malpractice insurance premiums has risen to a fever pitch across the nation. The American Medical Association labels twenty-one states as "in crisis," a designation it gives to states with high medical insurance premiums.[1] One of the most popular suggested solutions involves imposing ceilings on non-economic damages for medical malpractice claims. The idea that non-economic damage caps will reduce the cost of liability premiums has been the source of a fierce debate.

This article examines the effect of legislative caps on non-economic damages, and explores the relationship, if any, between caps and insurance rates.

I. What States Currently Have Damage Caps?

Currently, more than half of the states have non-economic damage caps, and the majority have imposed some type of restriction on tort recovery. Non-economic damage caps vary in make-up, with each state designating its own maximum dollar recovery and procedural restrictions. California was the first state to cap non-economic damages in 1975, and the $250,000 ceiling imposed in 1975 remains in effect today. In Illinois, non-

economic damages are limited to $500,000 against a physician and $1 million against a hospital. Missouri caps its non-economic recovery at $350,000 maximum, regardless of the number of defendants or occurrences. Texas—a state in which non-economic caps were deemed unconstitutional until a few years ago recently lowered its maximum non-economic cap from $750,000 to $250,000 in any single case, against any number of defendant physicians.[2]

II. Why Would We Want Caps On Non-Economic Damages?

Medical liability insurance has been on the rise. Many believe that increases in liability insurance premiums are linked to increased jury awards. Non-economic damages caps are offered as a means to control jury awards, which will in turn trickle down to decrease insurance premiums. On the other hand, opponents of damage caps argue that caps on non-economic damages simply do not have a significant impact on medical liability insurance premiums and disproportionately harm vulnerable populations of society.

III. The Local Effect of High Insurance Premiums

The flight of physicians from certain areas of the country due to high malpractice premiums is a serious problem. Proponents of non-economic damage caps argue that restrictions on non-economic awards are necessary to preserve access to medical care across the country. For example, the trauma center at the University of Nevada Medical Center closed for ten days in 2003 because of a physician “strike” over increased malpractice premiums. In Pennsylvania, forty physicians reportedly left the state or stopped practicing altogether, citing high insurance premiums. In New Jersey, 65% of hospitals surveyed reported physicians were leaving because of increased premiums.[3]

Many of these physicians are relocating in states with lower malpractice premiums.[4]

In August of 2003, the U.S. General Accounting Office (GAO) published a report detailing its findings concerning the impact of rising insurance premium costs on healthcare accessibility.[5] The report found that access to certain high-risk medical services, such as general surgery and OB/GYN services, had been restricted in certain states. As an example, the study identified a large group of emergency room surgeons in Florida who took leaves of absence after the state failed to implement tort reform legislation. In turn, orthopedic and cardiovascular doctors took leaves of absence in order to avoid the risks associated with practicing without available emergency room surgeons in the event of complications. The resulting shortage created a substantial reduction in emergency room on-call surgical coverage at most acute care hospitals in the city.[6]

GAO also found that access problems tended to be more pronounced in rural locations. For example, the lack of OB/GYN practitioners in rural Mississippi forced some pregnant women to commute sixty-five miles to the nearest obstetrics ward. Women in rural areas of Pennsylvania faced an additional thirty to fifty mile commute to deliver.[7]

Not all observers agree with the GAO's report. Some observers point out that the total number of physicians in practice is actually increasing. The Journal of the American Medical Association indicates the supply of professionally active doctors throughout the United States increased from 497,140 in 1985 to 709,168 in 2001.[8] Other studies suggest that the likelihood of an individual physician having a claim paid out on his behalf has diminished over the past few years.[9] Although payouts increased

3.8% annually between 1991 and 2003, these studies conclude that the rising number of physicians has outpaced the number of malpractice claims paid during the same time frame.[10]

The balance of the research appears to indicate that while the total number of physicians has increased, the availability of certain high-risk services such as general surgery, OB/GYN, and neurosurgery has been reduced as a result of higher malpractice premiums in certain areas. Non-economic damage caps may help stop or reverse the flight of physicians from states with high premiums to states with lower malpractice premiums, especially in these high-risk practice areas.

IV. Are Insurance Premiums Related to Payouts of Non-Economic Damages?

Physicians are understandably concerned about the dramatic rise in malpractice insurance premiums. Premiums have increased over the past several years, with increases for some practitioners reaching as high as 75%.[11] The underlying cause of these increases has been difficult to pinpoint. The sheer number of variables affecting rates, including the extent of state regulation, the level of competition among insurers, interest rates, and income returns, renders any attempt to determine the impact of non-economic damage caps on premiums nearly impossible. The lack of evidence establishing a relationship between damage caps and lower malpractice premiums remains one of the most controversial aspects of tort reform.

For example, some recent national studies concluded that while premiums have continued to rise, physician claim payments, the total number of suits, and the frequency of large awards have remained fairly constant in the past five years.[12] The Kaiser Family Foundation found that both the number of claims per doctor and total

dollar amount of claims have decreased.[13] Other evidence, however, indicates that states with non-economic damage caps had lower growth in malpractice premium rates and claim payments. GAO, for example, found that states with non-economic damage caps of $250,000 averaged premium increases of about 10%, compared to a 29% rate of growth in states without such caps.[14]

The insurance industry itself has also been targeted as a potential cause for rising premiums. Some allege that increases in liability premiums are due not to high claim payouts, but rather to insurance companies' efforts to compensate for documented losses in the bond market between 1998 and 2001.[15] Reports from the Center for Justice & Democracy indicated that by Spring 2005, insurance premiums had begun to stabilize both in states with non-economic caps and those without.[16]

Further, malpractice insurers may not necessarily base their premiums on damage payouts. Notably, a national medical liability insurer explained that it planned to raise its premiums an additional 19% in Texas despite the fact that Texas had approved non-economic damage caps only six months earlier. The provider justified the premium increase by explaining that savings due to the new damage cap would only account for a small percentage of its payouts—a total savings, it revealed, of only 1%.[17]

In sum, studies that conclude that non-economic caps result in the reduction in insurance premiums have yet to determine the extent of the impact due to the large number of variables affecting premium rates. This lack of evidence lends support to critics of tort reform who allege that damage caps will only benefit insurance companies, not lower healthcare costs.

V. Are Damage Awards Lower in States With Caps?

A potential benefit of non-economic damage caps is a reduction of high non-economic damage awards. GAO found that average per capita payments for claims against physicians were lower in states with non-economic caps ($10 on average) than in states without caps ($17 on average).[18] The study also found that the average growth in per capita claims grew more slowly in states with non-economic damage caps (5% to 6% a year) than in states without caps (10% a year).[19]

On the other hand, a recent study published in the New York University Law Review analyzed jury verdicts in twenty-two states. The study concluded that damage awards were relatively similar in states with non-economic damage caps and states without caps.[20] The study concluded that jurors may have a basic sense of the total amount of damages that a plaintiff should receive, and therefore no matter how damages are labeled, jurors may subconsciously incorporate all potential forms of damages to reach a certain monetary amount they feel is appropriate.[21]

Further, the consistency of damage awards in states with and without damage caps could be the result of increased selectiveness of attorneys in choosing their clients. For instance, attorneys may be choosing to bring suit on behalf of only those victims with high incomes who can produce high economic damage awards. If this is the case, the legal system may be leaving certain vulnerable populations without representation.[22]

VI. Do Non-Economic Caps Hurt Vulnerable Populations?

Many view damage caps as a deterrent against greedy patients flooding the courts with frivolous lawsuits. Capping non-economic damages may serve to reduce

frivolous suits, but it also risks curbing meritorious suits with potentially discriminatory effects. Specifically, non-economic damage caps may reduce compensation to women, children, and the elderly.[23] Non-economic damages provide awards where a person's injury cannot be directly translated to out-of-pocket loss. These damages have traditionally been the primary method of recovery for non-working plaintiffs including children, retirees, and homemakers.

By way of example, in a state with a $250,000 non-economic damages cap, a full-time homemaker would be eligible for actual medical costs and a maximum of $250,000 for non-economic damages. This is true regardless of the seriousness of the injury or how negligent the acts of the medical provider. Similarly, a baby who is permanently brain-damaged as a result of medical negligence would be compensated for only the cost of medical expenses and, at a maximum, $250,000.

Those who support caps argue that the tort system has always taken income and income potential into consideration, and that the right to collect damages must be balanced against the interest in providing affordable healthcare to the general public. For example, when the Texas legislature approved a $250,000 non-economic damage cap, 128 Texas counties did not have a pediatrician and 154 Texas counties did not have local access to OB/GYN services.[24]

Damage caps may possibly result in injustices and limitations on recovery to vulnerable populations. While some believe that the right to collect an unlimited award must be curtailed in favor of expanding access to healthcare, others believe that it is unfair to shift the burden onto vulnerable segments of the population; namely, women, children, and the elderly.

VII. National Caps – Are They Coming?

President George W. Bush continues to encourage tort reform including caps on non-economic damages. Although this topic has received increased attention in recent years, it is not a new issue. In every Congress since 1995, the House has passed a bill to limit non-economic damage caps for medical malpractice suits. Each time, the Senate has rejected it.[25] Whether President Bush will be successful where others have failed remains to be seen, but the increased attention surrounding this issue, culminating in greater pressure on lawmakers, may act as a catalyst for establishing national damage caps. The constitutionality of such a cap is in question, but challenges at the state level suggest the caps will face at least some scrutiny.

Many of the states that now have non-economic damage caps have either faced constitutional challenges or have previously held caps unconstitutional. In Ohio, non-economic damage caps were ruled unconstitutional as a violation of due process in 1991.[26] The law was reworded and passed again, and was again held unconstitutional in 1999 by the Ohio Supreme Court based upon the fact that the law imposed the cost of the intended benefit to the general public (lower healthcare costs) upon a class consisting of those most severely injured by tortious conduct.[27]

In Wisconsin, the state supreme court ruled that the state's pain and suffering caps, in place for more than a decade, violated the equal protection clause of the state constitution by discriminating against severely injured patients while preserving recourse for a less-injured class of patients. The case involved a baby who was injured during delivery. A jury awarded the child $700,000 in non-economic damages, which was reduced to the state limit of $410,322. On appeal, the state supreme court

overruled the decision, stating, “if the legislature’s objective was to ensure that Wisconsin people injured as a result of medical malpractice are compensated fairly, no rational basis exists for treating the most seriously injured patients of medical malpractice less favorably than those less seriously injured.”[28]

New Hampshire, Illinois, Minnesota, and Oregon courts have also found non-economic damages caps to be unconstitutional.[29]

VIII. Is Some Litigation a Good Thing?

Medical providers have an interest in keeping costs down while patients have an interest in improving medical care and remedying past wrongs. Sometimes these interests are achievable primarily through financial incentives. According to some, medical providers will tolerate the cost of negligence until it becomes less expensive to improve quality of care than to pay increased claims and costs.[30]

For example, anesthesia used to be a field where high rates of injury occurred. In the past, anesthesiologists elected not to routinely use patient monitors to supervise misintubations because the machinery was deemed too expensive even though it was commonly understood that it would prevent injury.[31] Only after lawsuits made it *more* expensive *not* to use the technology did its use become routine. Similarly, computerized physician order entry systems and patient records often are not used due to the expense. Some believe that providers will implement these policies and procedures only when they are forced to bear the cost of *not* improving patient safety.[32]

On the other hand, supporters of caps believe that the high cost of jury awards, settlements, legal fees, and the practice of defensive medicine have rendered healthcare unaffordable for millions of ordinary Americans. The tension between

implementing new and expensive technology to improve safety on one hand and reducing costs in order to provide more affordable healthcare to more Americans on the other highlights a fundamental problem underlying the tort reform debate.

IX. Where Do We Go From Here?

The relationship between rising insurance premiums and non-economic damage awards continues to be a controversial issue. In examining how to reduce healthcare costs, lawmakers and their constituents should carefully examine both the positive and negative aspects of non-economic damage caps. While evidence suggests that non-economic caps help control malpractice premiums and jury awards, it is also possible that caps will disproportionately harm society's most vulnerable populations. The debate between those demanding lower healthcare costs through tort reform on one hand and those demanding full compensation for injured patients on the other will no doubt continue throughout the duration of this new healthcare crisis.

About the Authors:

Robert H. Feinberg and Michael Yates are attorneys in the Phoenix law firm of Snell & Wilmer LLP. Mr. Feinberg's broad-based healthcare litigation practice centers on representation of physicians, nurses, other healthcare professionals and hospitals in credentialing and malpractice actions. He is a frequent speaker at medical malpractice and healthcare law seminars and has written manuals about the defense of malpractice cases and hospital corporate liability and institutional negligence. Mr. Feinberg is currently serving his fourth term as Vice Chair of the Healthcare Liability and Litigation Practice Group for American Health Lawyers Association. Michael Yates graduated from the James E. Rodgers College of Law with distinction, Michael J. Yates represents hospitals, physicians and other healthcare providers in medical malpractice litigation matters. Mr. Yates also represents a broad spectrum of other clients in general litigation matters, including commercial contractors and financial institutions.

Endnotes

[1] Vedder, Price, Kaufman & Kammholz, P.C., *Illinois Caps Non-Economic Damages in Medical Malpractice Cases*, Mondaq Business Briefing (Jul. 18, 2005).

[2] If the plaintiff also sues an unaffiliated healthcare facility that facility may potentially be liable for up to an additional $250,000.

[3] Robert H. Feinberg & Robert G. Vaught, *Runaway Malpractice Verdicts: Cause and Effect*, Health Lawyers News, vol. 7 no. 11 (Nov. 2003), *citing* United States Department of Health and Human Services, *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing our Medical Liability System*, July 25, 2002 at pp. 2-4, available at <aspe.hhs.gov/daltcp/reports/litrefm.html>.

[4] Ruth Heitz, *Medical Liability Cap Benefits State*, Wis. State J. June 22, 2005, at A8.

[5] U.S. General Accounting Office 03-836, Medical Malpractice: Implications of Rising Premiums on Access to Health Care at 30, 37 (Aug. 29, 2003), available at http://www.gao.gov.

[6] *Id.*

[7] *Id.*

[8] *Malpractice: Studies Examine Effect of Tort Reform Laws,* American Health Line, June 1, 2005.

[9] *Id.*

[10] *Id.*

[11] Feinberg & Vaught, *supra* note 3.

[12] Bill McKelway, *Doctors Seek Courts for Malpractice Cases*, Richmond Times Dispatch (July 23, 2005).

[13] *Id.*

[14] U.S. General Accounting Office 03-836, *supra* note 5.

[15] *Malpractice: Studies Examine Effect of Tort Reform Laws*, *supra* note 8.

[16] Darshana Patel, *Unequal Justice: the Hidden Gendered Impact of "Tort Reform"; Taking Away Victims' Rights*, Multinational Monitor no. 3-4, vol. 26, p. 22 (March 1, 2005).

[17] Jerome M. Staller, *Statistical Analysis; Medical Malpractice Law & Strategy*, Medical Malpractice Law & Strategy vol. 22, no. 3, p. 1 (January 10, 2005).

[18] U.S. General Accounting Office 03-836, *supra* note 5. .

[19] *Id.*

[20] Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps,* 80 N.Y.U.L. Rev. 391, 472 (May 2005).

[21] *Id. at 431.*

[22] *Id at 488.*

[23] John Council, *Tort Reform King; Joe Nixon Makes No Apologies for H.B. 4,* Texas Lawyer, December 22, 2003, at 18.

[24] *Id.*

[25] Rovner, Julie, *Malpractice Lawsuits*, National Public Radio, *Morning Edition* (February 1, 2005).

[26] Sharkey, *supra* note 23 at 497, *citing* Ohio Rev. Code Ann. 2307.43 (repealed 1997, 2001); *Morris v. Savoy*, N.E.2d 765, 770-71 (Ohio 1991); Ohio Rev. Code Ann. 2307.54 (repealed 2001).

[27] *State ex rel. Ohio Academy of Trial Lawyers v. Sheward*, 715 N.E.2d 1062, 1095 (Ohio 1999).

[28] *Ferdon ex rel. Petrucelli v. Wisconsin Patients Compensation Fund*, 701 N.W.2d 440, 466 (Wis. 2005).

[29] Sharkey, *supra* note 23 at 498-500.

[30] David A. Hyman & Charles Silver, *Speak Not of Error*, *supra.*

[31] *Id.*

[32] *Id.*