

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILE 8672
1750 SCOMM 69: HOUSE LIABILITY INSURANCE TASK FORCE, 1989-1990

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Alaska State Legislature

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SENATE ADVISORY COUNCIL

MEMORANDUM

TO: SENATOR FRED ZHAROFF
FROM: ELIZABETH J. HICKERSON *EJH*
SUBJECT: MEDICAL MALPRACTICE AWARDS
DATE: APRIL 24, 1985

MAY 01 1985

In response to your request for information regarding medical malpractice awards, Rob Nauheim provided your office a memorandum on the general issues involved on this matter. I have been tracking three recent California Supreme Court decisions on the California 1975 Medical Injury Compensation Reform Act. Information on these cases has been difficult to obtain, and I apologize for the delay. The following is a summary of the California act and the recent court decisions.

MEDICAL INJURY COMPENSATION REFORM ACT OF 1975 (MICRA)

In May 1975, the Governor of the State of California convened the Legislature in an extraordinary session to consider measures aimed at remedying the rapid increase in medical malpractice insurance premiums. In response, the Legislature enacted the Medical Injury Compensation Reform Act of 1975 (Stats. 1975, Second Ex. Sess. 1975-1976, chs. 1, 2, pp. 3949-4007). This is a lengthy statute which:

1. attempted to reduce the incidence and severity of medical malpractice injuries by strengthening governmental oversight of the education, licensing and discipline of physicians and health care providers;
2. sought to curtail unwarranted insurance premium increases by authorizing alternative insurance coverage programs and by establishing new procedures to review substantial rate increases; and,
3. attempted to reduce the cost and increase the efficiency of medical malpractice litigation by revising a number of legal rules applicable to such litigation.

Following the adoption of the MICRA, three law suits were filed challenging the constitutionality of the act. By a slim majority, the court upheld the statutes in all three

cases. It is unclear at this time whether or not the cases will be appealed to the U. S. Supreme Court. It may be years before an answer to the constitutionality of the California act is finally decided.

AMERICAN BANK AND TRUST COMPANY v. COMMUNITY HOSPITAL OF LOS GATOS-SARATOGA, INC. (July 9, 1984)

This case involves a constitutional challenge to one provision of MICRA affecting medical malpractice lawsuits (section 667.7 of the Code of Civil Procedure). This section provides that when a plaintiff in a medical malpractice case has sustained "future damages" of \$50,000 or more, compensation for those future damages is to be paid periodically over the course of time the plaintiff incurs the losses, rather than in a lump sum payment at the time of judgement.

Plaintiff brought suit against the hospital for damages caused by severe burns that she suffered as a result of overheated water when she fainted or fell in a shower stall on the eve of her scheduled operation. The plaintiff died while this appeal was pending and the American Bank and Trust Company, special administrator of her estate, was substituted as plaintiff in this action. Plaintiff attacked this provision on the grounds that it violated the state and federal constitutional guarantees of due process, equal protection and the right to jury trial.

The court in a 4-3 decision held that the provision was not unconstitutional since it was rationally related to legitimate state interest of reducing cost of medical malpractice insurance; the statute could be construed to require a jury to designate a portion of its verdict that is intended to compensate a plaintiff for future damages; and the statute is not void for vagueness, ambiguity, and unworkability.

The Dissent stated in part:

Today's majority opinion ignores the lessons of history. This is not the first time that tort victims have, in the face of a "crisis," been deprived of their constitutional rights. In the late 1920's and 1930's, many states, including California, enacted panic legislation restricting the right of automobile guest passengers to obtain relief from negligently inflicted harm. It was not until 1973 that this court recognized this constitutional violation and invalidated the automobile guest statute as applied to negligently injured guests. With today's majority opinion, it appears that once again years will pass and many victims of negligence will undergo injury without adequate relief before their constitutional rights will

be recognized and respected. The periodic payment provision of the Medical Injury Compensation Reform Act violates the constitutional guarantees of trial by jury and equal protection of the law.

American Bank and Trust Company v. Community Hospital of Los Gatos-Saratoga, Inc., (1984) 204 Cal.Rptr. 671, 689-690.

BARME v WOOD (November 8, 1984)

This case involves a constitutional challenge to another provision of MICRA, which provides that no source of collateral benefits introduced shall recover any amount against the plaintiff nor shall it be subrogated to the rights of a plaintiff against a defendant. The purpose of this section has generally been viewed as an attempt to eliminate the so-called "double recovery" obtained by plaintiffs who have their medical expenses paid by their own health insurance and still obtain damages for such expenses from defendant tortfeasors.

The plaintiff, Barme, a police officer employed by the City of Huntington Beach, suffered a heart attack while on duty. He underwent open heart surgery at St. Francis Hospital, during which he sustained brain damage. The plaintiff brought action against the hospital and staff alleging that the brain damage was caused by their negligence. The City of Huntington Beach, a self-insured workers' compensation carrier, intervened seeking to recover from defendants the expenses it had incurred, and was continuing to incur in providing workers' compensation benefits to Barme. The lower court denied the City's complaint in intervention. The City appealed, challenging that the due process clause prohibits the Legislature from arbitrarily eliminating this right and maintains that this provision is arbitrary because it bears no rational relation to a legitimate public purpose, and it shifts some of the cost of medical malpractice from negligent health care providers to innocent employers or insurers.

The Supreme Court of California in a 4-2 decision held that the statute, which precludes a "collateral source" that has provided medical expenses or other benefits to a medical malpractice plaintiff from reimbursement of those expenses from medical malpractice defendant, does not violate due process or equal protection. This decision was based on the conclusion that the provision reduces the potential liability of defendants and that the Legislature could rationally conclude that this would lead to lower malpractice insurance premiums.

The Dissent stated in part:

In American Bank & Trust Co. v. Community Hospital
(1984) 36 Cal.3d 359, 204 Cal. Rptr. 671, 683 P.2d.
670, a slim majority of this court approved the
shifting of a substantial part of the burden of damages
from the tortfeasor to the innocent victim. The
purported reason was the desire to reduce premiums for
medical insurance and by that means to lower medical
and hospital costs. In my dissent in that case I
pointed out how vain that purpose had then proved to
be. The passage of time has further vindicated my
view. In the nine years since adoption of the
so-called Medical Injury Compensation Reform Act of
1975, medical and hospital costs have continued to rise
astronomically. The only "reform" had been to
magnanimously bestow on health providers a generous
insulation from much of the responsibility for their
more egregious negligence.

Now the majority compound their error by permitting yet
another shift of the burdens of malpractice, this time
from medical malpractice defendant to the plaintiff's
employer or workers' compensation carrier. Why the
plaintiff's employer or compensation carrier should
bear any of the responsibility for the defendant's
malpractice defies rational explanation. Once again
the only purpose suggested by the majority is a
hoped-for reduction in medical malpractice insurance
premiums. That the result will be an increase in
workers' compensation insurance premiums appears to be
ignored. As between the two, which should logically
shoulder the burden: the carrier of the tortfeasor or
the carrier of the innocent employer? The answer is
obvious.

Barme v. Wood (1984) 689 P.2d 446, 451.

ROA v. MICRA MEDICAL GROUP, INC. (February 7, 1985)

This final case involves a provision of the MICRA which
limits the amount of fees an attorney may obtain in a
medical malpractice action when he or she represents a party
on a contingency fee basis. This provision places the
following limits on contingency fees:

- 40% of the first \$50,000 recovered,
- 33 ¹/₃ % of the next \$50,000 recovered,
- 25% of the next \$100,000, and
- 10% of any amount exceeding \$200,000.

Plaintiffs challenged the provision on the grounds that it was a violation of due process, equal protection and separation of powers.

The California Supreme Court in a 4-3 decision held that the provision was constitutional. This was based on the determination that due process was not violated because the statute does not impermissibly infringe on the right of medical malpractice victims to retain counsel in malpractice actions, but limits the compensation that an attorney may obtain when he/she represents an injured party under a contingency fee arrangement. With regard to the equal protection claim, it held that the Legislature did not act arbitrarily in selectively imposing the statute's attorney fee limits only in medical malpractice action because of the rational relationship to the objectives of MICRA, which was enacted to reduce the high cost of malpractice insurance premiums. The court held that separation of powers was not violated because the appropriateness of attorney fees is not a matter committed solely to the judicial branch.

The Dissent stated in part:

In effect, section 6146 prohibits severely injured victims of medical negligence from paying the general market rate for legal service, while permitting defendants to pay whatever is necessary to obtain high quality representation.

Out of practical necessity, virtually all plaintiffs use contingent fee arrangements in medical malpractice cases. In fact, for clients of limited means "the contingent fee arrangement offers the only realistic hope of establishing a legal claim."

Section 6146 imposes heavy burdens on the ability of severely injured plaintiffs to obtain adequate legal representation. It sets forth a sliding scale of fee limits--the greater the recovery, the lower the allowable percentage. The effect of this approach is to impose drastically low limits on fees in precisely those cases which require a large recovery to make the plaintiff economically whole.

Roa v. Lodi Medical Group, Inc., (1985) 37 Cal.3d 920, 934-935.

ATTACHMENTS

California Code:

<240.5 (Action against health care provider)
<667.7 (Action against health care provider; periodic payments of future damages)
<1714.8 (Liability of health care provider)
<6146 (Limitations; periodic payments)

California Cases:

American Bank and Trust Company v. Community Hospital of Los Gatos-Saratoga, Inc.

Barme v. Wood

Roa v. Lodi Medical Group, Inc.

Articles:

The Limitation on Recovery in Medical Negligence Cases in Virginia, University of Richmond Law Review

Validity and Construction of State Statutory Provisions Relating to Limitations on Amount of Recovery in Medical Malpractice Claim and Submission of Such Claim to Pretrial Panel

Validity of Statute Establishing Contingent Fee Scale for Attorneys Representing Parties in Medical Malpractice Actions

California Fee Cap Draws Protests, National Law Journal

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SENATE ADVISORY COUNCIL

MEMORANDUM

TO: Senator Fred Zharoff
FROM: Rob Nauheim *Rob Nauheim*
DATE: March 28, 1985
RE: Additional medical malpractice information.

Please find enclosed a copy of a publication from the American Medical Association which we recently received. The comments in this article seem to concur with the findings of the interim report which our office prepared for you.

The review of the situation in Indiana seems particularly interesting in light of the relatively low malpractice insurance rates in that state (see attached chart). The success of the awards cap statute in Indiana may be more closely related to a local perspective in the courts than to a unique statutory approach. However, a closer look at the Indiana statute might be warranted.

I hope you will find this information useful.

Please call if you should have additional questions.

RCN
enclosures:

*From "Professional Liability in the '80s" Report 2
American Medical Association, Nov. 1984*

lenges to address in the next five years, but I don't think we are going to be blown away by the problem. Physicians must realize that they can't be passive participants—they must take a strong stand and get out and do some work if any legislative reforms are to be enacted. Physicians must participate actively in those physician-company functions that require their involvement.

Dion - Some people have suggested that the insurance industry is incapable of dealing with the current professional liability problem effectively. Is federal intervention needed?

Sweetland - Maybe some assistance to the states in their efforts to reform their own laws might be helpful, but I don't think that the government has a satisfactory solution to the professional liability insurance problem.

Morse - I agree. Federal proposals to date are very vague and haven't been studied appropriately. Furthermore, the professional liability problem is a product of 50 different social, legal and economic climates in the states. I'm not sure that uniform, across-the-board federal legislation is the answer.

Phillips - The insurance industry has not failed and the medical profession has not failed to deal with the professional liability problem. We are working with a flawed system. We are trying to deliver a product to compensate patients for things that happened to them through a system that puts only 20% to 25% of the money generated into the hands of the victim. In many cases, a true victim gets nothing, and in others, a claimant able to win the sympathy of the court gets a great deal of money when there was no physician liability. If we need federal intervention, it is to restrain the whole litigious atmosphere in this nation today.

Professional Liability Tort Reform

After the professional liability crisis reached its peak in 1975, physicians and other health care providers and institutions took several steps to solve the problem. One of the most important of these steps was an aggressive campaign to reform state laws affecting medical professional liability lawsuits. The goal was to change state laws governing tort litigation in two general ways: first, to make it harder for plaintiffs to bring groundless lawsuits, and second, to limit the impact of the costs of successful suits on defendants, insurers, and the medical profession as a whole.

In one sense, the campaign for tort law reforms was immensely successful. Every state in the union, except West Virginia, enacted some reform proposals. Some states, including those with the most serious professional liability problems—such as New York, California, Florida, and Illinois—enacted comprehensive packages of legislation over the vigorous and well-organized opposition of plaintiffs' trial lawyers.

But in another sense, the campaign appears to have failed.

The expected reduction in the number and severity of professional liability suits against physicians and hospitals never happened. In the past two or three years the situation has become worse than it was before. More professional liability claims are filed now and jury verdicts against physicians are higher on the average.

According to American Medical Association figures, before 1978 an average of 3.3 professional liability claims were filed for every 100 physicians. From 1978 through 1983, an average of 8 professional liability claims were filed for every 100 physicians. For physician-

owned companies in 1983 the average frequency was 20.3 claims for every 100 physicians. In those cases that go to trial and result in an unfavorable jury verdict, the size of the damages awarded has skyrocketed and the number of million-plus awards has increased each year (See Report 1-Special AMA Task Force on Professional Liability and Insurance.)

Are tort reforms effective?

An obvious conclusion that the wave of tort reform legislation in the 1970s was a failure may well turn out to be partly or wholly inaccurate. First, without the reforms enacted, the situation might be far worse than with the reforms in place. Second, the publicity generated by the first professional liability crisis may have made the public and the legal profession more aware of the vulnerability of the medical profession to successful lawsuits.

Thus, the impact of the wave of tort reforms of the late 1970s on medical liability costs is unclear. Yet it is undeniable that these reforms have not had the effect that their supporters hoped, or at least not yet. This has been true for at least two reasons.

First, some of the reform measures have not been as effective in reducing litigation volume or severity as hoped. Some measures passed during the crisis were poorly thought out, and either had no effect at all on medical liability costs, or in a few cases had an opposite effect. For example, recovery of costs legislation designed to reduce suits without merit by requiring losers to pay costs, including attorney's fees, has

increased outlays for awards in some states

Second, many of the potentially most effective reforms have been successfully challenged on constitutional grounds in the courts. With the exception—thus far—of contractual binding arbitration, every single major tort reform measure has been found unconstitutional by at least one state supreme court. In many states, lower courts have reached conflicting conclusions about the same statutes, and plaintiffs and defendants in many states are still awaiting higher court determinations on the validity of important provisions. Because it often takes several years for a liability case to wind its way from the trial courts through at least one intermediate appeal stage, and finally to the supreme court in the state, many tort reforms passed by state legislatures in the mid-1970s have been subject to supreme court scrutiny only in the last two to four years.

Of course, the view expressed by plaintiffs' lawyers is that physicians and hospitals are guilty of professional negligence far more often than even the latest flood of litigation indicates. These lawyers generally believe that while the tort reforms of the 1970s make their work somewhat more difficult, and treat some injured patients harshly, the tort law changes have no effect on "good" medical liability cases, either in terms of chances of success or in size of eventual settlement or verdict awards.

Whether that view is accurate or not, it does appear that some plaintiffs' attorneys are becoming more proficient at winning bigger settlements or verdicts for their medical liability clients. In recent years, many courts have taken a broader view of what constitutes adequate compensation for an injured plaintiff. The traditional goal of "making the plaintiff whole" has expanded from

merely paying for medical expenses and lost wages to include lifelong compensation for rehabilitation, counseling, physical or occupational therapy and training, and lifestyle changes.

Vulnerability to constitutional challenge

The single greatest legal weakness of nearly all reform measures that have been found unconstitutional is that they apply only to medical liability cases, and no other kind of lawsuit. Plaintiffs are thus able to argue that the laws violate their constitutional rights to "equal protection of the laws." Both state and federal constitutions contain the equal protection provisions, which guarantee that no class of persons can be treated differently from the rest of the population unless there is a very good reason for doing so. When an equal protection claim arises in a case, the court first decides if there is in fact an unequal impact on one class of people. If so, then the court decides whether the unequal burden on the complaining party is justified or outweighed by the reasons given for the different legal treatment.

In the case of medical liability tort reforms, plaintiffs argue that equal protection guarantees are violated because certain measures make it harder for them to file and win a lawsuit, or limit the damages recoverable, while plaintiffs in other kinds of lawsuits faced no such barriers. The courts must determine whether the reasons for that unequal treatment of one class of people (medical liability plaintiffs) compared to other similarly situated classes (other kinds of tort plaintiffs) justify the distinction.

It is not an easy formula to apply, and it is virtually impossible to predict how courts will treat such claims.

Courts may apply different standards of review. One level of review presumes that the law in question is a valid one, as long as there is any rational and proper explanation for it. A stricter level of review makes no such presumption, but instead examines the statute, its legislative history, and its current impact, to determine what its actual purpose is and whether that purpose could be achieved with a less harsh law. This latter level of scrutiny is usually applied when the person raising the issue can show that a "fundamental right" of all citizens is affected. Fundamental rights usually involve issues such as freedom of speech, freedom of assembly, and racial discrimination. Courts generally do not classify medicolegal issues as fundamental rights. The tort reform provisions have been challenged because they are special legislation; that is, legislation enacted solely to benefit physicians. This analysis is similar to the equal protection arguments.

The kinds of tort reforms most susceptible to equal protection challenges have been limitations or "caps" on liability (when the amount of money a victorious plaintiff can collect is limited) and mandatory pretrial screening panels for medical liability claims.

In tort reform challenges, the concept of free and equal access to the courts is considered by some courts to be a very important right, almost to the level of a "fundamental right." But even in those situations, different courts may reach different results. For example, both the Indiana and New Hampshire supreme court applied the stricter standard to their states' respective liability reform acts; Indiana's court upheld its entire act, while New Hampshire's struck down its entire act.

In some cases, the imposition of mandatory pretrial screening panel review, or other kinds of reforms,

have been invalidated because they were determined by the courts to violate plaintiffs' right to due process of law, or the right to a jury trial of civil claims; both rights are protected under both state and federal constitutions.

In a few cases, laws have been invalidated, or so modified by the courts as to eliminate their effectiveness, for reasons having nothing to do with unconstitutional rights. For example, many attempts to modify statutes of limitation have been blunted by court decisions on the basis of traditional common-law interpretations. The most unusual invalidation occurred in North Dakota. That state's supreme court invalidated all of the state's new medical malpractice act, primarily on equal protection grounds (much as the New Hampshire court did), but also ruled that the legislature's attempt to modify rules of evidence was beyond its authority in the first place. The high court said that matters of pleading and evidence were court rules, and only the supreme court had the authority under the state constitution to determine such rules.

It is important to note that in a few states tort reforms have been invalidated only because they were part of a comprehensive package of statutory changes. Most such statutes contain a "severability clause," which provides that if any section is struck down, the others will remain in force. However, in New Hampshire and North Dakota, for example, high courts invalidated entire medical liability reform acts despite such clauses, under the reasoning that the measures were so interrelated that it was impossible for any part of the law to stand if one part were unconstitutional. Parts of Pennsylvania's comprehensive act received similar treatment.

Some of the tort reform measures that have survived constitutional

challenges have done little to control the medical liability crisis. For example, a widely adopted reform—in at least 20 states—was the imposition of limitations on contingency fees for lawyers who win medical liability cases. Where the fee regulation generally fixed limits on the percentage of awards that plaintiffs' attorneys could claim as fees, the ultimate effect on the size of awards is probably very limited, if any. Indeed, where strict limits on fee percentages were enacted, there may have been a tendency on the part of plaintiffs' lawyers to push for higher verdicts and settlements to maximize their own fees.

Similarly, pretrial screening panels, while considered successful in many states, have been regarded as ineffective and even counterproductive in other states, in deterring the filing of frivolous claims or in making medical liability litigation quicker and more efficient. One reason for this could be the reluctance of plaintiffs' lawyers to use them.

However, other tort reforms have proved to be very effective in achieving the ultimate goal of the whole campaign: reduction of total costs of medical liability litigation. The Rand Corp.'s Institute for Civil Justice rates limitations on "caps" on awards and changes in the collateral source rule as the most effective law changes in terms of reducing the size of jury verdict and settlements. Also, changes in the laws that permit courts to order periodic payments of damages rather than lump-sum payments have been viewed as substantially reducing costs for insurance companies. A Pennsylvania study has estimated potential saving to be between 7% and 14% while a New York study suggests that potential savings might be approximately 5%. Where these reforms have passed constitutional muster, they appear to have played an important role in keeping the cost of medical liability

litigation at a more reasonable level, though not necessarily affecting the number of claims filed.

Tort reforms: a closer look

The single most popular tort reform measure, in terms of the number of states which have adopted it, is a shortening of the statute of limitations for filing medical liability claims; 41 states have modified their statutes of limitation for such cases in recent years. Other popular tort reforms include elimination of "ad damnum" clauses in complaints (statements which specify, sometimes in inflated terms, the amount of money sought in damages), approved in 32 states, and the institution of pretrial screening panels for medical liability claims in 30 states.

The tort reforms most vulnerable to invalidation on constitutional grounds have been those placing limits on liability and pretrial screening panels.

While approximately 20 different categories of tort reform measures have been enacted in the United States with wide variations within those categories—six of these reforms have been most strongly recommended and most widely adopted:

(1) Pretrial screening panels.

This reform was strongly recommended by the secretary of HEW's Malpractice Commission in 1973 as the primary method for speeding resolution of medical liability claims and eliminating non-meritorious suits. Many states adopted varying forms of the model system, which requires review of all medical liability claims by a panel composed of physicians, lawyers, and laypersons. The panel is not required to follow formal rules of evidence. After a pan-

el's decision is given, either party can proceed to a jury trial. Usually, a panel's conclusions can be introduced as evidence at trial.

A critical factor is whether review by the panel is mandatory or voluntary. Where it is mandatory, the plan may be declared an unconstitutional bar to free access to the courts or an impermissible limitation on the right to trial before a jury, as was the case in Missouri and Illinois. In Missouri, mandatory pretrial screening was struck down as an equal protection violation, since medical liability plaintiffs were required to go through a prerequisite before going to court not required of other tort plaintiffs.

Another important issue is whether the pretrial panel is considered to be "judicial" or not—that is, whether the panel's conclusions determine liability or whether they serve as a form of expert evidence that can be relied on later by a trial court. Illinois' pretrial panel plan was struck down as being an unconstitutional usurpation of judicial power because the panels rendered judgments on liability and damages. In Nebraska, the state supreme court said that state's screening system was constitutional since its role was merely to provide evidence to the trial court.

Where pretrial screening is voluntary, it is likely to pass constitutional muster—but according to a 1980 study by a George Washington University health policy group, voluntary panels must be mandatory to achieve the desired goal of speedy disposition of claims. The report of the Intergovernmental Health Policy Project said, "In the six states with voluntary screening panels they either have been under-utilized or are completely inactive." In Arkansas, the voluntary system is essentially inactive; in New Jersey, an under-utilized voluntary system was changed to a compulsory system, resulting in an almost

immediate drop in the number of liability claims filed.

Another potential problem with pretrial screening lies in its administration. While systems in some states work efficiently and quickly, other states' systems have resulted in long delays and other problems. In Florida, for example, a pretrial screening system was originally upheld by the state supreme court in 1976. Four years later, the same court struck down the panels as "arbitrary and capricious," and violative of due process rights because more than half of all cases did not get panel hearings before expiration of the statutory time limit. The screening statute was constitutional as written, but unconstitutional in the way it operated, the court declared.

Variations exist in both structure and operation of panels and these variations have determined the success or failure of the provision when it was challenged in many state courts. Pretrial panels were originally adopted in 30 states, and have been upheld by 10 state supreme courts, struck down by four, and repealed or permitted to expire by four state legislatures.

(2) **Collateral source rule.** This rule of evidence prevents a jury from learning that a plaintiff has been compensated from another source, such as health insurance or worker's compensation, for the injury. This rule often results in a windfall for plaintiffs with insurance, since they recover twice for the same injury: although in some cases the insurer has a right of subrogation against any judgment—that is, the right to get its money back. So far, 19 states have changed the collateral source rule in an effort to reduce this potential double recovery. The changes have been upheld in four states, struck down in three, and allowed to expire in one.

Two general kinds of changes have been made. The first, adopted

originally in nine states, eliminated the collateral source rule and gave either the judge or the jury discretion to consider a plaintiff's other sources of compensation in determining damages. The second kind of change, enacted in ten states, left the rule in place, but required a mandatory offset of the amount of other compensation against the award of damages. That is, the amount of any insurance benefits received by the successful claimant must be deducted from the judgment awarded by the jury.

The mandatory offset of collateral benefits against damage awards is considered by the Rand Corporation's Institute for Civil Justice to be one of the two tort reforms with the greatest impact on the size of awards (a ceiling or "cap" on awards is the other). The Institute reports that in states where a mandatory collateral offset is imposed, the severity of awards drops by 50%, on average, within two years' time.

A Kansas statute permitted evidence of insurance or other compensation, but not of "gratuitous" compensation, such as money from a family member. A federal court declared in 1981 that the distinction did not have a reasonable relationship to the law's stated purpose, and was therefore unconstitutional.

Collateral source rule changes have generally survived court tests, but how the changes are applied can cause problems.

(3) **Attorney fee regulation.** Some form of limitation or control of attorneys' fees has been adopted in 23 states, although these include a wide variety of approaches. The most common general approach is to require court review of proposed attorneys' fees in medical liability cases to determine whether they are "reasonable," but there are several variations within that category.

Several states provide that the lawyer in a medical liability suit must pa-

the winner's "reasonable" attorney fees and costs, if the loser did not appear to have a reasonable chance of winning. The theory is that the attorneys and plaintiffs will more carefully screen cases with such a provision in place.

The other general approach is to set fixed limits on the percentage of

an award that a successful attorney may claim as a fee. Most commonly a sliding scale ensures that as the amount of an award increases, the attorney's share of it decreases. For example, in Delaware, the claimant's attorney's fee may not exceed 35% of the first \$100,000, 25% of the next \$100,000, and 10% of the balance

over \$200,000. Four states place fixed ceilings on fees, declaring that any fee exceeding from 33% to 40% of an award is presumed unreasonable and not enforceable.

Generally, limitations on attorney fees have been upheld by the courts. Only in New Hampshire has attorney fee regulation itself been declared

Florida

Florida's tort reform experience has been tumultuous. The state legislature in the mid-1970s approved a broad range of medical liability reforms, including attorney fee regulations, changes in the collateral source rule, establishment of a patient compensation fund and medical screening panels, periodic payment provisions, and changes in statutes of limitations, among others.

Most of these provisions remain in effect, despite vigorous opposition from Florida's 2,600-member trial lawyers' organization both in the legislature and the courts. Existing and proposed liability reforms remain in constant jeopardy as the result of what some physicians term "open warfare" between the medical profession and trial lawyers.

In 1980, the Florida Supreme Court declared the state's pretrial screening panels to be unconstitutional, since they were "arbitrary and capricious" in their operation. Four years earlier, the same court had upheld the reform. However, since that time the panel system had become bogged down, and fewer than half of all medical liability claims received hearings before panels before expiration of a statutory 10-month deadline. Thus, the statute was

constitutional as written, but unconstitutional in its operation and effect, the court said.

A year later, the high court upheld the constitutionality of changes in the collateral source rule that mandated offsetting of any court-awarded damages by the amount of other compensation received by the successful plaintiff. The provision did not violate equal protection guarantees, the court said; the professional liability crisis affecting health care in the state justified the limitation.

A constitutional attack on the state's patient compensation fund in 1981 came from an unexpected source: 57 hospitals in the Miami area objected to a special \$10.7 million extra assessment against hospitals to pay claims against the fund. A lower court held the compensation fund unconstitutional—as an improper delegation of legislative power—in early 1983. But the state supreme court reversed in June, 1983, holding that the law setting up the fund provided the state insurance department with sufficient guidelines to carry out the legislature's intent. Even so, the PCF, overwhelmed by costly claims, has stopped writing new business.

After Florida's panel system was struck down, Florida's legislature passed a unique attorney fee law, requiring that in all medical liability cases, the loser, whether

plaintiff or defendant, must pay the winner's "reasonable" attorney's fees. (In some recent Florida cases, the fees ran into the millions.) Fees may not be assessed, however, against poor or insolvent parties. The measure is designed to encourage continual negotiation and reevaluation before trial of the merits of each case. The law has not been tested before the state supreme court.

Florida physicians attempted to bypass the legislature and place a general tort reform referendum on the ballot in 1984. The referendum could have required mandatory summary judgment (a decision by the judge on legal issues when no material facts were in dispute), abolished joint and several liability (when there are multiple defendants, each one can be liable for the entire amount if the other can't pay), and limited non-economic damages, such as pain and suffering and mental anguish, to \$100,000.

The referendum was challenged in court by Florida trial lawyers because, according to Florida law, a referendum may only raise one issue and the challenged referendum contained three. The Florida supreme court upheld this challenge on October 3, 1984. Florida physicians have not ruled out legislative proposals or another referendum attempt in 1986.

constitutionally invalid: the state supreme court ruled that the state's sliding-scale fee limit interfered with the freedom of contract between plaintiffs and lawyers, and unfairly made medical liability cases unattractive to lawyers.

Whether such limitations have had any effect on the number and severity of medical liability claims is problematic. Some experts suggest that limiting an attorney's percentage of a liability award only encourages plaintiffs' attorneys to seek even larger awards. Although the contingency fee system has been the subject of acrimonious criticism by physicians, the HEW Medical Malpractice Commission in 1973 found, and lawyers have argued, that the contingency fee arrangement operates as an effective screening device against groundless liability suits—since the lawyer who loses collects nothing. In its survey the Commission found that plaintiffs' lawyers believed that medical liability cases were the most difficult of all personal injury suits. The prospect of spending a great deal of time pursuing a suit that would ultimately be lost caused medical liability attorneys to reject 88% of all prospective plaintiffs. Since that study was done, however, physician-owned insurance companies have observed that plaintiffs' lawyers have become more proficient in developing and pressing professional liability cases.

Therefore, limiting attorneys' fees may not reduce the number or severity of suits; however, it may lead to a more equitable allocation of awards among plaintiffs and their attorneys.

(4) Statute of limitation changes. Statutes of limitation are fixed limits on the length of time following an injury that a person has to file a lawsuit. Every state has a statute of limitations applicable to all tort actions. Some states enacted laws shortening or clarifying these statutes for medical liability claims.

This provision is the most common tort reform, adopted in 40 states. In addition, 23 of these states have modified statutes of limitation claims by minors. Claims by minors have been cited by professional liability insurers as a serious problem in setting premium rates. The primary purpose of these statutes is to require that a claim be asserted when the pertinent evidence and witnesses are available. It is generally accepted that the specter of a lawsuit should not continue for an indefinite time. The shorter statute of limitations makes writing professional liability insurance policies more actuarially predictable.

At issue is the potential "long tail" on such claims. In the past, the time period started running once the patient actually discovered the injury; for minors, the statute started running once the child reached the age of majority. But in recent years, state legislatures began changing the laws to require that claims had to be brought, for example, within two years of the injury, or within two years of the point at which the injury should have been discovered with reasonable diligence. Other state laws require that an action must be filed within a specified number of years after the injury occurred or should have been discovered, but impose a maximum time period within which the action must be brought. For minors, the usual change is to start the regular statutory time after the child reaches a certain age. For example, when a state had adopted a two-year statute of limitations, the law might provide that if a child under the age of six incurs injuries, the child has until the eighth birthday to file suit.

In general, efforts to shorten the statute of limitations have withstood court scrutiny. However, in three states the courts have struck down special rules for minors, stating that the limitations for children arbitrarily

denied their right to seek redress for injuries. Further, even where statutes have not been declared unconstitutional, courts in many states have construed the statutes to mean that the "discovery rule" (when the statute only begins running after the patient has discovered the injury) still applies, either across the board or at least in regard to "foreign body" claims—such as when a sponge is left in the patient after surgery.

A change in the statute of limitations may limit the open-endedness of professional liability suits while still allowing claimants a right to redress for injuries.

(5) Limitations on liability. These limitations, adopted in 17 states, take two forms: one places a limit on certain kinds of damages and one places a fixed cap on a physician's liability. The former generally limits the amount a jury can award for "non-economic damages," which usually means a limit on damages for pain and suffering. No limit is placed on what can be awarded for actual monetary losses because of medical expenses or lost wages, nor are amounts available for punitive damages limited, though punitive damages are rare and awarded only where the defendant's conduct was grossly negligent or reckless. A common belief is that pain and suffering damages are the primary source of inflated awards, and these statutes attempt to control such awards by imposing a limit of, for example, \$250,000 in California.

The second kind of limit on liability involves a fixed cap on awards against physicians. These caps are usually tied to a patient compensation fund, under which amounts over the statutory cap—usually \$100,000 to \$300,000—are paid out of a state-operated fund in which all physicians may participate. A total of 10 states have both a patient compensation fund and a statutory limit on physician liability. Where there is

a patient compensation fund the cap on physician liability is not always absolute. For example, a physician (or physician's insurer) is liable up to the cap amount, \$200,000; the patient compensation fund is liable for any amount of a judgment which exceeds \$200,000 but does not exceed \$600,000. The remainder of an award larger than \$600,000 must be paid by the physician. A few states, however, such as Illinois and Indiana, place an absolute limit on physician liability; regardless of the circumstances, no award for medical liability may be greater than \$500,000.

A 1982 Rand Institute for Civil Justice report found that states with caps had an average drop of 19% in the severity of awards within two years of enactment. Liability limits generally have been extremely vulnerable to constitutional challenges. In the 17 states where liability limits were enacted, five state supreme courts have declared the limits to be invalid because they arbitrarily limited the rights of injured plaintiffs to recover for their injuries; Kentucky's provision was held to be part of an unconstitutional scheme.

Where caps on awards remain, they are still vulnerable to attack. For example, in Maryland, a governor's commission on medical liability rejected limits on liability as a solution to professional liability insurance cost problems; such limits were regarded as placing the burden of cost control on a small number of the most seriously injured plaintiffs.

Caps on awards may be one of the most effective tort reforms in reducing their size.

(6) Periodic payment of damages. Seventeen states have passed statutes which require or permit courts to award damage payments periodically, rather than in a lump sum. Under these statutes, courts specify that losing defendants must pay medical expenses as they

Indiana

Indiana's medical malpractice act was the first comprehensive medical liability tort reform package in the nation when it went into effect in 1975. The act established pretrial medical review panels, shortened the statute of limitations, limited physicians' liability to \$100,000 per claim, established a patient's compensation fund to pay the balance of awards over \$100,000 but not more than \$400,000, and limited attorney's fees to 15% of any award from the compensation fund. It did not include changes in the collateral source rule, in evidence or procedural law, or provision for periodic payment.

The act was held constitutional by the Indiana Supreme Court in 1980 in *Johnson v. St. Vincent Hospital*. The plaintiff had challenged several aspects of the act on equal protection grounds. The court agreed that the law's interference with trial by jury, right of recovery, and freedom of contract for medical liability plaintiffs was sufficient to trigger close scrutiny of the act's purposes and effects in relation to the state constitution.

It was unusual for such a strict test to be applied on behalf of medical liability plaintiffs. The stricter standard required that the separate treatment for medical in-

jury plaintiffs must be reasonable not arbitrary, and rest on some ground of difference having a fair and substantial relation to the object of the legislation, and all similarly situated persons must be treated alike.

The court ruled that the legislature's purpose, to prevent a loss of health care services in the state because of the crisis in insurance cost and availability, justified the law. The act's provisions were a reasonable and non-arbitrary manner of addressing the problem. The court dealt specifically with challenges to the attorney fee controls and medical review panels, finding each to be a valid and reasonable limitation on plaintiffs' rights.

Indiana's experience is widely regarded as a success story, since the act has worked well and all potential constitutional challenges to it seem to have been decisively dealt with in the *Johnson* case. Two constitutional challenges to the patient's compensation fund thus far have been rejected by state appellate courts. Although there has been some criticism that the fund system and review panels have produced larger awards than expected, insurance premiums in the state have remained moderate, despite a steady increase in the number of claims filed.

are incurred, rather than speculating on the total future costs and awarding a lump sum. Criticism of lump-sum awards has been that where a plaintiff dies earlier than predicted, the heirs may receive a windfall from the portion of the award based on future damages, or the plaintiff may squander funds needed for future expenses.

The biggest battle over periodic

payment legislation has occurred in California, where the state supreme court first declared the provision unconstitutional, and then a year later, in June, 1984, on rehearing the same case, declared the law valid. California law requires that compensation for future damages awards of \$50,000 or more is to be paid in periodic payments. Plaintiffs argued that the law was an un-

TORT REFORM PROVISIONS

	Alabama	Alaska	Arizona	Arkansas	California	Colorado	Connecticut	Delaware	Florida	Georgia	Hawaii	Idaho	Illinois	Indiana	Iowa	Kansas	Kentucky	Louisiana	Maine	Maryland	Massachusetts	Michigan
Ad Damnum	1	1	1	1	1	1	1	1	1	1	1	1	1	1	2	1	1	1	2	1	1	1
Arbitration	1	1			1					1			1					1	5			2
Attorney Fees			1		1	1		1	1		1	5		2	1	1					1	1
Awarding Costs						1			1				1			1						2
Collateral Source		1	2		1			1	2			5	1		2	1						
Expert Witness								1	1			2						1				1
Limits on Liability					1							5	3	2			4	1				
Patient Compensation Fund						6			2		1		1	2		1	3	2				
Periodic Payment	1	1		1	2			1	1				1			1				1		1
Pre-Trial Screening Panel		1	2	1			1	1	3		1	1	3	2		1		2	1	1	2	
Res Ipsa Loquitur		1			1			1	1				1									
Statute of Limitations	2		1		1	2		1	1	1	1		2	2	1	2	1	1	1	1	1	1
Special Statute of Limitations for Minors	2		1		1	1		1							2	1		1		1	1	
Standards of Care	1	2	1	1				1	1			1						1				1

EXPLANATION OF CHART

1. Provision exists
2. Provision found constitutional by highest state court
3. Provision found unconstitutional by highest state court
4. Provision not severable from an act found unconstitutional by highest state court, although provision not specifically reviewed by the court
5. Provision has been repealed or has sunset
6. Provision exists but not in effect

constitutional violation of equal protection and due process, thus an impermissible limitation on their right to redress for injuries. The NORCAL Mutual Insurance Company, a Northern California physician-owned insurance company, states that the periodic payment provision of the state's liability reform act has saved the company about \$2 million.

Therefore, periodic payment provisions may lessen professional

liability costs because insurers can fund them at a substantially lower cost than a lump sum payment and savings can be passed to providers in the form of lower professional liability premiums or at reduced rates that may translate into lower fees for the patient.

Other tort reform measures have focused primarily on the procedural or evidentiary structure of trials, with little noticeable effect. For example,

12 states have abolished the res ipsa loquitur doctrine, which permits a plaintiff to argue that under certain circumstances specific injuries are presumptively the result of negligence on the part of the physician or hospital; the defendant must prove that negligence did not occur. However, abolishment of this doctrine does not appear to have had a measurable impact on the number or severity of liability awards against

Minnesota	Mississippi	Missouri	Montana	Nebraska	Nevada	New Hampshire	New Jersey	New Mexico	New York	North Carolina	North Dakota	Ohio	Oklahoma	Oregon	Pennsylvania	Rhode Island	South Carolina	South Dakota	Tennessee	Texas	Utah	Vermont	Virginia	Washington	West Virginia	Wisconsin	Wyoming
1	1			1		4		1	1	1		1	1				1		1	1	1	1		1		1	
				2		3	1		1			5	1		1	1	4	5		1			1	1		1	1
				1		4										1	5										
				2		3			1		3	1				3	1		1	1				1			
					1	3						2	1						1				1				
→				2		3		1			3	1		1			1	1		1			1			1	
				2			1		1	1	4				1	1		1								1	1
						3	1				4				1			1						1		2	
		3	2	2	5	1	2	1	1		5	2				3	5		5					1		2	
					1	4					3		1			1			1	1							
1	1	1	1	1	1	1	3		1	1	1	1	1	1	1		1	1	1	2	1	2			1	1	
		1	1				3		1	1	1		3				5		1		3	1				1	1
					1	1	4				1	4		1	1					1			1	1	2		

This chart does not include all of the court rules that affect these provisions.

Data source: AMA Division of Legislative Activities, Department of State Legislation.

physicians. Similarly, changes in the requirements for approval of expert witnesses or in the standard of care required for physicians defending themselves against negligence actions have been approved in many states, but with little apparent effect.

Moreover, where these changes in evidentiary or procedural law are limited to cases involving medical liability, they are vulnerable to constitutional attacks. Such tort law

changes are widely regarded by the legal profession as "special interest" legislation that is not likely to survive. As University of Pennsylvania law professor Arnold J. Rosoff said in testimony to Congress in July, 1984, such "doctors' legislation" is one-sided and unfair, since it is intended "simply to make it harder for aggrieved patients to sue and recover for their injuries."

In general, the tort reform legisla-

tion of the middle and late 1970s has survived in some states but has been and remains vulnerable to attack in other states. Some laws are not likely to face constitutional tests for some years. In addition, trial lawyers are beginning to organize and mount aggressive attacks on some of the earlier reforms; already, 12 states have repealed or let expire some of the reforms of the previous decades, at least partly as a result of trial lawyers' lobbying.

Tort reform legislation that applies to all types of torts may be more likely to survive a constitutional challenge. However, the national awareness of the need to contain health care costs and the unique nature of medical services, such as reliance upon sophisticated new technology and the fact that every patient is different, makes a strong argument for reform that specifically applies to the medical profession.

New Hampshire

In 1977, the New Hampshire legislature approved one of the most comprehensive professional liability reform packages in the nation, including limits on liability, periodic payment provisions, attorney fee regulations, abolition of the collateral source rule, and changes in rules regarding statutes of limitation, expert witnesses, *ad damnum* clauses, *res ipsa loquitur*, and awarding of costs.

In 1980, the New Hampshire Supreme Court invalidated the entire act in *Carson v. Maurer*. The consolidated appeal challenged several sections of the act on equal protection grounds. The court determined that the right to sue and recover for injuries was not a "fundamental right" under the constitution, but was important enough that the same standard of review should be applied to the statute in question. That is, was the statutory classification (medical liability claims versus other kinds of cases) reasonable, not arbitrary, and actually based upon a difference having a "fair and substantial" relation to the purpose of the legislation? The court stated that law must be set up so that all similarly situated persons are treated equally. This standard was the one applied by the Indiana supreme court in the *St. Vincent* case.

The court then declared each challenged section of the statute to be unconstitutional. Attorney

fee limits, abolition of the collateral source rule, expert witness qualifications, limitations on non-economic damages, periodic payment of damages, and changes in the statute of limitations were all unconstitutional, primarily because they were unfair burdens on medical liability plaintiffs.

All other sections of the act were also declared invalid, despite the presence of a "severability clause." The court reasoned that the legislature had intended to create an entirely new and separate comprehensive system of recovery for medical liability claims. Therefore, the valid provisions of the act could not be separated from the invalid provisions, and the entire act was declared unconstitutional. Included in the provisions declared valid but struck down were abolition of the *ad damnum* clause, reforms in the standard of care rule, evidentiary changes, and provisions awarding costs to defendants in frivolous cases.

The effect of the decision was devastating. Fortunately for New Hampshire physicians, the state has not been a hotbed of liability lawsuits and juries are regarded as conservative. According to Jury Verdict Research, Inc., the state is one of only four (the others are Maine, Idaho, and South Dakota) that has not yet had a medical liability verdict of \$1 million or more.

TORT REFORM GLOSSARY

Ad damnum clauses - The *ad damnum* clause is that part of a plaintiff's initial pleadings which states the amount of monetary damages and other relief requested by the plaintiff in a court action. Most of the legislation on this subject provides for the elimination of the *ad damnum* clause altogether. Legislation also often provides that the defendant be apprised of the precise amount sought by the plaintiff through the normal course of pre-trial discovery.

Arbitration - Arbitration statutes relate to voluntary procedures whereby patients and health care providers may enter into written agreements for the submission of any medical liability claims to binding arbitration. This procedure is an alternative to and in lieu of trial by jury. This procedure provides for limited judicial review of the arbitration decision.

Medical liability claims can currently be arbitrated in at least 30 states under the general arbitration statutes in those states. The chart only lists those states with arbitration legislation specifically for medical liability claims.

Most of the medical liability arbitration statutes provide that written arbitration agreements may cover present and future medical injury claims. All of the statutes generally provide that a person's right to treatment shall not be prejudiced in any way by the decision whether or not to enter into an agreement for arbitration of medical liability claims. In other words, the agreement must truly be voluntary to be binding. Also, most statutes which permit arbitration agreements to cover future medical injury claims provide for a certain period of time, either following execution of the contract or provision of the services, in which the patient may reject the arbitration agreement.

Attorney fee regulation - The most common arrangement for payment of plaintiff attorney fees in medical liability cases is the "contingent fee." Under this type of arrangement the attorney receives as his fee an agreed upon percentage (commonly 30% to 50%) of any final award or settlement made to the plaintiff.

Legislation enacted during the last few years regulating attorney fees in medical liability cases has taken several different approaches: a sliding scale for the plaintiff attorney fees in terms of a percentage of the award; court review of the proposed fees or approval of what it considers to be a "reasonable fee"; or limiting attorneys' fees to a certain percentage of the amounts recovered by the plaintiff.

Awarding costs, expenses and fees. - A few states have provisions designed to deter the pursuit of frivolous medical injury claims. These statutes generally provide that where one party to the action has been found to have acted frivolously in bringing the suit, the party may be found liable for payment of the other party's reasonable attorney and expert witness fees and court costs. These provisions differ from the usual civil trial situation in which payment for attorney fees and expert witness fees are normally paid by the party who incurs them.

Collateral source provisions. - The collateral source rule is a rule of evidence that prohibits the introduction into evidence at trial of any indication that a patient has been compensated or reimbursed for the injury from any source other than the defendant.

Legislation modifying the collateral source rule has taken several approaches: permitting consideration of compensation or payments received from some or all collateral sources; requiring the mandatory offset against any award in the amount of some or all collateral source payments received by the plaintiff; or allowing the defendant to introduce evidence of the plaintiff's compensation from collateral sources. The jury is instructed to make a mandatory reduction of the award for economic loss by a sum equal to the difference between the total benefits received and the total amount paid by the plaintiff to secure such benefits.

Expert witness. - Expert witnesses are required to explain many of the complex and difficult issues in a medical negligence case. Legislation affects the qualifications and use of expert witnesses.

Limits on liability. - Some states have enacted legislation that limits the liability of defendants in medical liability lawsuits. These statutes limit liability in one of several ways: limiting recovery of a particular type of damages; placing an absolute cap on the amount of damages recoverable; or placing an absolute cap on physician liability under a patient compensation fund.

Patient compensation fund. - A patient compensation fund is a governmentally operated mechanism established to pay that portion of any judgment or settlement against a health care provider in excess of a statutorily designated amount. A fund may pay the remainder of the award or it may have a statutory maximum (e.g. one million dollars).

Patient compensation funds are generally funded through an annual surcharge assessed against health care providers, with such surcharge often being a specified percentage of the provider's annual insurance premium. Patient compensation funds are also known as "excess recovery funds."

Periodic payments. - In most states, unless otherwise agreed on by the parties or mandated by the court, judgments can only be lump-sum awards. Under a periodic payments system, the payments are made over the actual lifetime of the plaintiff or for the actual period of disability.

Pre-trial screening panels. - Pre-trial screening panels are prerequisites to trial. Procedures for panels usually require a mandatory pre-trial hearing to be conducted by a panel comprised of members as mandated by statute. In some states the pre-trial hearing is voluntary. The composition of the panel and its scope of inquiry vary greatly from state to state.

All statutes establishing pre-trial screening procedures provide that the panel's decision is not binding on the parties and that it does not preclude a plaintiff from initiating a lawsuit. Although some states permit the decision of the panel to be introduced into evidence in a subsequent lawsuit, the panel's decision is not binding upon a judge or jury.

Res ipsa loquitur. - *Res ipsa loquitur* ("the thing speaks for itself") is a common law doctrine which applies when a plaintiff can demonstrate that the injury occurred while the instrumentality causing the injury was under the exclusive control of the defendant and which, if operated in a non-negligent fashion, does not normally cause injury. In recent years, a number of state courts have expanded the application of *res ipsa loquitur*, and increased the effect of its applicability from that of a mere inference to that of a presumption, which if not rebutted, will allow the jury to reach no finding other than liability.

Legislation enacted in several states has codified the doctrine in regard to medical liability cases by delineating those circumstances when the doctrine may be applied, such as when a foreign object has been left in a body or the patient has suffered radiation burns. However, these statutes have sought to make it clear that the mere fact of injury is not sufficient to invoke the doctrine.

Standard of care. - The standard of care in a medical negligence action is that level of care to which a health care provider is held accountable to a patient, and is based upon the prevailing level of care practiced within locality (community, state, or national).

Statute of limitations. - A statute of limitations is a law that bars a cause of action after the expiration of a specified time period. In many states the statute of limitations for medical liability actions begins to run only upon discovery of the injury. Injuries may be discovered several years after the treatment was provided, so the time period for filing an action may be uncertain. Some states have sought to eliminate the "long tail" by placing an absolute maximum time period within which medical liability suits may be brought. An exception to the time period is provided in some of these statutes where foreign objects are left in the body, or where the health care provider has fraudulently concealed the fact of injury.

Most state statutes of limitations provide that if an injury is incurred by a minor, the statute is tolled (i.e., stops running) on the minor's cause of action until he reaches the age of majority. Changes in the statute of limitations for a minor's actions usually provide that the statute will begin running prior to the age of majority.

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1984 Report on physician/owned medical society created liability insurance companies

Company	Insureds	Limits	Coverage	Premium range	Average premium
Alabama	2,850	\$1M/1M; 5M/5M	CM* O	\$1,159-13,555/466-3,080 1,237-14,729	\$ 4,900
Arizona	3,010	1M/1M; 5M/5M	CM*	3,064-22,252/1,308-8,328	8,500
MIEC, CA	2,900	1M/3M	CM*	4,996-31,648/994-6,294	6,500
NORCAL, CA	5,600	1M/3M; 2M/4M	CM*	2,604-28,520/872-7,116	NA
SCPIE, CA	7,331	1M/3M; 5M/5M	CM*	3,404-29,184/1,288-10,496	6,700
Colorado	2,200	1M/1M; 5M/5M	O	1,200-14,000	5,000
D.C.	1,100	1M/3M; 10M/10M	CM*/O	1,563-26,185/513-11,385/ 1,666-26,382	7,300
Florida	4,360	500/1M; 1.5M	CM*	4,363-42,348/781-7,582	7,700
Georgia	2,400	1M/1M; 5M/5M	CM*	1,147-25,307/380-9,895	5,800
Illinois	7,966	1M/3M; 5M/5M	O	3,944-42,700	9,400
Indiana	430	100/300	O	630-5,048	1,200
Kentucky	1,723	1M/1M; 5.2M/5.6M	CM*/O	1,592-12,196/533-3,631/ 1,691-12,982	3,300
Louisiana	2,000	1M/1M; 5M/5M	O	1,841-15,284	4,500
Maine	895	1M/3M; 5M/7M	CM*	2,858-25,305/752-6,659	5,600
Maryland	2,900	1M/3M; 5M/7M	CM*/O	656-12,400/200-6,200 1,562-19,690	6,000
Michigan	4,585	1M/1M	O	3,935-44,669	5,100
Minnesota	2,203	1M/3M; 4M/7M	CM*	939-13,688/311-4,013	4,700
Mississippi	2,050	1M/1M; 5M/5M	CM*/O	1,501-17,011/461-5,222/ 2,011-22,795	5,000
Missouri	1,254	1M/2M; 2M/3M	O	2,153-21,535	4,291
New Jersey	6,850	1M/3M; 5M/7M	O	3,373-24,272	6,700
New Mexico	1,500	100/300	O	956-6,197	3,250
New York	15,830	1M/3M	O	4,541-63,311	12,500
N. Carolina	3,805	1M/1M; 5M/5M	CM*	1,600-17,129/556-7,330	2,600
Ohio	4,541	1.1M/1.3M 5M excess	O	2,047-17,944	4,080
Oklahoma	3,603	1M/1M; 5M/5M	O	922-5,234	2,903
Pennsylvania	6,200	200/600	CM*/O	2,304-19,351/648-5,443/ 2,400-20,158	4,700
Tennessee	4,830	1M/3M; 10M/12M	CM*	1,933-16,436/649-4,456	4,740
Texas	3,200	1M/2M; 2M/3M	O	1,200-16,500	4,000
Utah	1,325	1M/3M; 5M/7M	O	910-13,674	3,600
Washington	1,803	1M/3M; 5M/7M	RO**	1st 891-7,148 2nd 2,005-16,083 3rd 2,785-22,339	2,800

CM—Claims Made O—Occurrence
 *First year claims made range
 **Report occurrence

Premium range based on \$1 million coverage except when maximum available is less. Maximum limits available are indicated also. Average premiums are estimated. Financial data based on 1983 year end statements.

Data source: AMACO

Alaska State Legislature

Advisory Council Members
Senator Bennett, Chairman
Senator Kerttula
Senator Abood
Senator Sackett



Pouch V
State Capitol
Juneau, Alaska 99811
Phone: (907) 465-3114

SENATE ADVISORY COUNCIL

MEMORANDUM

TO: Senator Fred Zharoff
FROM: Rob Nauheim, Researcher
DATE: March 1, 1985 *Rcn*
RE: Medical Malpractice Awards Cap, Other Alternatives

You have requested that the Senate Advisory Council research the feasibility of a statute which would place a cap on the amount of a monetary award in medical malpractice cases. You also indicated that you are interested in other potential alternatives to an awards cap statute which might help to solve some of the problems to which the article in the Bristol Bay Times, January 15, 1985, alluded.

Since the problem of increasing medical malpractice insurance rates and the associated costs born by the health care provider and ultimately the patient, is a complicated financial and legal problem, an in-depth report has not been prepared. In the interest of providing a prompt response to your request, an interim report has been prepared which should serve to touch upon the most important aspects of this matter.

In order to provide a more meaningful response to your request, it seems appropriate to outline the major components of the medical malpractice insurance crisis. In this manner, potential solutions can be better evaluated in terms of their effectiveness.

During the early and mid 1970s, medical malpractice insurance rates increased dramatically. As a result, many physicians found that they could not afford malpractice insurance or they simply chose not to purchase it. In addition, many insurance companies terminated their malpractice insurance operations because of uncertain risk and potential future losses. Not only did malpractice insurance become more expensive, it also occasionally became unavailable.

While the direct cause of rate increases and insurance unavailability was related to an ever increasing number of malpractice claims and higher awards, an evolution of basic social and legal thought has provided the impetus. In addressing the Alaska Bodily Injury Reparations Advisory Committee in 1979 (BIRAC), Professor William Cohen of Stanford University asserted,

"Twentieth Century law has moved steadily in the direction of modifying or eliminating the limitations upon the defendant's liability -- eliminating immunities and defenses, establishing full duties of care, lowering standards of proof, and allowing juries more latitude for decision."

Other more specific causes include 1) the changing doctor-patient relationship, 2) the legal rights explosion, 3) the impact of the media, 4) the increased proficiency of trial lawyers, and 5) the belief that insurance companies have an unlimited source of funds (Keene 1976).

By 1975 and 1976, many state legislatures were addressing the difficult problems posed by skyrocketing insurance rates and the resultant prospect of increasing medical costs born by the patient. In an effort to reduce the costs of medical malpractice insurance, a variety of measures were passed in state legislatures. The following list identifies some of the kinds of statutory approaches which were adopted in the mid and late 1970s.

Elimination of "Ad Damnum" Clauses

This kind of legislation eliminates the "ad damnum" inclusion of dollar amounts in malpractice suits. The amount of award is determined by the jury and cannot be specified in the suit.

Limits on Attorneys' Fees

Various approaches have been used which limit a portion of the incentive to obtain large settlements by reducing the contingency fee percentage of attorneys as the amount of the award increases.

Liability Limits

- a) limits on the liability of the physician or insurer
- b) limits on the amount of an award for noneconomic loss
- c) limits on the total amount recoverable for any injury or death

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Compensation Funds

Some states have established patient compensation funds in order to supplement awards to successful plaintiffs when the award exceeds the statutory maximum liability of the defendant or of the defendant's insurer.

Elimination of "No Collateral Source" Rules

This kind of statute requires the reduction of award by an amount equal to the amount of certain insurance benefits received by the plaintiff.

Counterclaims Against Frivolous Cases

The assignment of court costs to unsuccessful plaintiffs, punitive damages to plaintiffs/attorneys whose case is determined to have no action and is frivolously filed, is a method of reducing the number of court cases.

Arbitration

These are provisions which call for mandatory or voluntary binding arbitration in order to reduce court costs and the time spent in litigation.

Pre-Trial Screening Panels

Statutes of this type require the use of expert panels which determine if a case has merit and should proceed to trial.

Statutes of Limitation

Statutes of limitation usually limit the period of time after the discovery of the alleged act of malpractice in which cases would be heard.

In Alaska, where insurance availability was perhaps a more serious problem than the escalating costs of premiums, the Medical Indemnity Corporation of Alaska was established by an act of the state legislature in 1976 in order to provide health-care providers with adequate insurance against liability for medical negligence. The act also calls for the use of a pre-trial expert advisory panel in order to review the merits of the case. Additional provisions prohibit "ad damnum" clauses, allow for the reduction of an award by the amount equal to certain insurance benefits received by the plaintiff, and outline conditions by which arbitration might proceed (A.S.09.55.530-560).

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Since it is apparent that the problems associated with malpractice insurance have again become acute, it seems reasonable to suggest that the remedies as provided in legislation heretofore have not been sufficient.

According to John George, Director of the Division of Insurance, Department of Commerce and Economic Development, there are four reasons for the current high rates for medical malpractice insurance in Alaska.

1. The number of malpractice awards has increased substantially in recent years.
2. The dollar amount of individual awards is up.
3. The investment climate which insurance companies enjoyed in the late 1970s and early 1980s has changed. During this period of time, insurance company losses which outstripped revenue from premium payments could be partially offset by high earnings on reserves. Since interest rates are now significantly lower than in the late 1970s and early 1980s, earnings on reserves are much lower.
4. Insurance companies are finding it increasingly difficult to make realistic projections of actuarial risk. Some companies are leaving the market. Recently, the Medical Indemnity Corporation of Alaska (MICA) has had difficulty in securing adequate reinsurers. Reinsuring is a method by which insurance companies spread the risk of loss.

The net result of the above factors and other less important factors is that malpractice insurance rates are up substantially. The insurance premium increase for 1985 is approximately 90% for physicians as a group (MICA).

AWARDS CAPS

In a report from the Governor's Medical Malpractice Insurance Commission, 1975, the Commission rejected arbitrary limits on awards. The rationale can be summarized by the following:

1. The amount of potential reduction of an insurance company's exposure to loss is speculative at best.
2. There was concern that arbitrary limits might serve as a minimum target for potential recovery rather than a maximum.
3. The Commission recognized that certain cases involving serious injury might not be adequately compensated.

The feasibility of legislation which would have the effect of establishing a maximum allowable award is complicated by the constitutional questions involved. The constitutional issues raised in cases wherein a state's award cap statute has been challenged usually relate to 1) equal protection and 2) due process arguments. According to Richards (1982), at least eight of the eleven states which, at that time, had statutes limiting the total amount of damages recoverable in malpractice suits, had been challenged on constitutional grounds. While it appears that the courts have failed to reach a consensus on the matter, the benefit of reduced actuarial risk has not been achieved because of the prospect of unfavorable rulings in the future.

Nevertheless, some states have passed legislation which placed a cap on malpractice awards. Indiana has a statute which limits the total amount of damages recoverable for any injury or death of a patient to \$500,000. The statute also limits the liability of the health care provider to \$100,000 (I.C. 16-9.5-2-2). The constitutionality of this statute was upheld in 1979 and 1980. However, other states have seen their awards cap legislation struck down.

In the BIRAC report to the Governor in 1979, the committee failed to approve any recommendation regarding liability limits or awards caps. However, Arnt Van Hippel, M.D., and Michael Armstrong, M.D., stated in a minority report on professional malpractice of the BIRAC report,

"There seems little merit or justice in any protocol that values death or injury differently depending on the offending agent (airplane or scalpel) or on the popularity or wealth of the party found liable. It seems evident that there must be a recovery limit for death/personal injury from any cause beyond which additional recovery or even unfulfilled liability becomes socially counterproductive due to the rising expectations and legal costs."

A view which contrasts that of many doctors is perhaps best summarized by the past president of the Association of Trial Lawyers, Robert E. Cartwright (1976).

"We have felt that if one person wrongs another that he should have to pay, regardless of whether he is a doctor, lawyer, engineer or private citizen. The reason for this is twofold:

1. The victim who is injured by the wrongful actions of another should be entitled to recover the full amount of his damages, and,

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2. There is a strong therapeutic and prophylactic effect in holding wrongdoers responsible for their actions--the so-called deterrent effect of tort law."

Thus, the problem seems to be associated with certain incompatibilities of the insurance and tort law systems. The feasibility of any statute which would place a cap on the amount of damages recoverable in a malpractice suit seems to be predicated upon a clear consensus from the courts which weighs the rights of the individual to recover damages against the externalization of the costs of recovery on society as a whole.

At this time, our office is awaiting the arrival of information pertaining to the current status of awards cap statutes from other states. In addition, I will compare the malpractice rates of those states which have withstood constitutional challenges with rates from states where no such statute exists. Though there may not necessarily be a statistically meaningful cause-effect relationship, some comparison might help to identify differences in successful approaches. We will continue to build a resource file on this subject and I will send you additional background material as it comes in.

If you should have any questions regarding this matter, please do not hesitate to call.

RN/rcn
enclosures:

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NOV 01 1985
FBI - MEMPHIS

November 1984

LIMITS ON LIABILITY

Some states have enacted legislation which functions as a limit on physician liability in medical injury lawsuits. These statutes may limit liability by: 1) limiting recovery of a particular type of damages; 2) placing an absolute cap on the amount of damages recoverable; or 3) placing an absolute cap on physician liability under a patient compensation fund. In some instances two types of limits on liability may be present. For example, New Mexico law places a limit on all damages except punitive damages and medical care, and also limits physicians' personal liability under the patient compensation fund. Nebraska and Indiana limit physician liability and place an absolute cap on the amount of damages which may be recovered.

Statutes which limit recovery of a particular type of damages most often limit recovery of noneconomic or general damages while permitting unlimited recovery for damages related to medical care. The California statute provides that in no action for injury against a health care provider, based on professional negligence, shall the amount of damages for noneconomic losses exceed \$250,000. South Dakota law provides that the total general damages which may be awarded shall not exceed the sum of \$500,000 but, "no limitation is placed on the amount of special damages which may be awarded." In Texas, the limit on civil liability for damages of a physician or health care provider is an amount not to exceed \$500,000, however, this limit does not apply to damages awarded on a health care liability claim for the expenses of necessary medical, hospital and custodial care received before judgment or required in the future for treatment of the injury.

A few states place an absolute limit on the amount of damages recoverable. This absolute limit may be found in connection with a patient compensation fund, as mentioned above in Indiana and Nebraska, or as a "stand alone" provision as found in Virginia. The Virginia provision states that in any verdict returned against a health care provider in an action for professional negligence, the total amount recoverable for any injury to or death of a patient shall not exceed one million dollars. Illinois and Idaho had similar provisions for absolute limits on recovery, although the statutory maximums were less than Virginia's cap on awards.

The liability of a physician also may be limited under a patient compensation fund. Wisconsin law provides that if a health care provider has met the requirements of the state patient compensation fund, then the health care provider is liable for medical negligence for no more than \$200,000 per claim and \$600,000 per year or the maximum limit for which the provider is insured, whichever is higher. Oregon's patient compensation fund statute provides that the liability of a physician arising out of a claim for damages due to professional negligence shall be limited to any sum payable under the terms of the physician's professional liability insurance policy and the fund.

Note that some patient compensation fund statutes set a maximum on fund liability. In states with such fund maximums, the health care provider remains liable for any portion of a judgment or settlement above the fund maximum, unless there also is an overall cap on awards corresponding with the fund maximum or a limit on physician liability.

States which have enacted some form of limitation on liability in medical injury actions are:

- | | |
|-------------------------|--------------------|
| 1. California | 10. North Dakota* |
| 2. Idaho* (sunset 6/81) | 11. Ohio |
| 3. Illinois* | 12. Oregon |
| 4. Indiana* | 13. South Carolina |
| 5. Kentucky* | 14. South Dakota |
| 6. Louisiana | 15. Texas |
| 7. Nebraska* | 16. Virginia |
| 8. New Hampshire* | 17. Wisconsin |
| 9. New Mexico | |

Court Decisions: Limits on Liability

Idaho

In Jones v. State Board of Medicine, an Idaho trial court found unconstitutional the state's Hospital-Medical Liability Act using a reasonable relationship standard of review. The act included a provision which set a ceiling on recoverable damages for actions against physicians and hospitals of \$150,000 per claim and \$300,000 per occurrence. On appeal, the Idaho Supreme Court stated that for purposes of an equal protection claim, the standard of review should be a "means-focus" or "means scrutiny" test. Under this intermediate standard of review, in order for a statute to be found constitutional, it must be shown that the legislative means used substantially further some specifically identifiable legislative end. The supreme court stated that it was unable to substantively rule on the case based on the facts before it. The case was remanded to the trial court with directions to apply the "means scrutiny" test. On remand, the trial court found that the limits on recovery did not substantially affect the availability of a liability market for physicians and hospitals at reasonable expense or the continued availability of health care facilities. As a result, the trial court held that the legislation did not meet the means scrutiny equal protection test and so was unconstitutional. [555 P.2d 399 (Idaho 1976); Case No. 55527, No. 55586 Fourth Judicial District]

Illinois

In Wright v. Central Du Page Hospital Association, a decision striking down several parts of the Illinois medical liability law, the Illinois Supreme Court held that the provision limiting recovery in medical injury actions to \$500,000 was arbitrary and constituted a special law in violation of the state constitution. The court noted that other statutes, such as the state dramshop act, limit recovery where

there originally had not been a common law cause of action for damages. The court also distinguished the medical injury limit on awards from the state workers' compensation act, stating that the workers' compensation act provides a quid pro quo in that the employer assumes a new liability without fault but is relieved of the prospect of a large damage judgment while the employee, whose monetary recovery is limited, is awarded compensation without regard to the employer's negligence. The court found that the medical liability limit on recovery abolished no common law defenses, nor did it purport either to alter the essential elements of a cause of action for medical injury or lessen the burden of proof. Furthermore, the very seriously injured patient might be unable to recover all the medical expenses incurred because of the recovery limitation, in which event he would recover nothing for any other loss suffered. The court stated that although it did not find or even imply that under no circumstances may the legislature abolish a common law cause of action without a concomitant quid pro quo, the court had consistently held that to the extent that recovery is permitted or denied on an arbitrary basis, a special privilege had been granted in violation of the state constitution. [347 N.E.2d 736 (Ill. 1976)]

Indiana

In Johnson v. St. Vincent Hospital, the Supreme Court of Indiana addressed the constitutionality of the Indiana Medical Malpractice Act. The court stated that in considering the constitutional challenges, the act was to be accorded every reasonable presumption supporting its validity and the burden was on the party challenging it to show unconstitutionality. Before the court would declare a statute repugnant to the federal and state constitutions, any fatal constitutional defects had to be clearly apparent. The court held that the Indiana Medical Malpractice Act did not violate the federal and state constitutions.

The court reviewed a provision of the act which limits total recovery of a patient to \$500,000 and limits the liability of any health care provider to \$100,000. The limit on total recovery was challenged as violative of the due process and equal protection guarantees of the fourteenth amendment of the federal constitution.

In reviewing the claim of unconstitutionality under the due process clause, the court found that the limitation on recovery was a natural consequent of the establishment of an insurance type program (the state patient compensation fund). The limitation, the court stated, provides a factor for calculating premiums and charges to the insured so that the insurance operation remains sound and the funds collected are sufficient to meet the obligations incurred. The court also stated that it must be accepted that the badly injured plaintiff who may require constant care will not recover full damages. It was impressed, however, with the large amount which is recoverable and the probability of fully compensating a large proportion of injured patients. The court noted that the badly injured patients would have little or no chance of recovering large sums of money if an environment developed in Indiana in which private or public liability insurance were unavailable or unused -- a development the act was intended to prevent. The court also attributed some relevance to the fact that after suit and recovery against a health care

provider is completed, there continues to be a lifetime dependency upon other health care providers for treatment of illness due to the prior negligence, as well as for new and unrelated illnesses. Thus, to the extent that the limitation on 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. Also, there was evidence in the record that the act with its limit on recovery was achieving its intended goal. As a result, the court held that the limit on patient recoveries was not arbitrary or irrational, but rather furthers the public purpose of the act in a manner consistent with due process of law guaranteed by the state and federal constitutions.

The limit on recoveries was also challenged on equal protection grounds. The court found that while the statute does impose a special burden on those persons with medical injury damages in excess of \$500,000, the statute was consistent with the provisions of the state constitution which prohibit special privilege legislation and consistent with the equal protection guarantees of the fourteenth amendment.

The standard of review used for equal protection analysis was that the classification not be arbitrary or unreasonable and that a "fair and substantial relationship exist between the classification and the purpose of the legislation creating it." The court found that there was good reason to believe that the interests of patients in ultimately transforming valid claims into money is furthered by the availability to the health care industry of some risk spreading mechanism at reasonable cost. Evidence was presented for constitutional purposes that part of the private insurance industry had ceased to make professional liability insurance available to some health care providers in the state. The court found that curtailment very important as a reality that the legislature was responding to in creating the state patient compensation fund. The court found that the legislature reasonably could have considered a set limitation upon recoveries to be an essential part of any operable plan to spread the risk of loss to participating health care providers and to regulate the cost to them, and thereby meet the danger it perceived to the public welfare. The classifications of health care providers and injured patients were held to be composite parts of the limitation itself and likewise justified.

The Indiana court distinguished its decision from the Illinois Supreme Court decision in Wright v. Central Du Page Hospital Association, stating that unlike that court, the Indiana court found a rational justification for the difference in treatment accorded various groups within the rationality of the legislative program to protect vital societal interests. [404 N.E.2d 585 (Ind. 1980)]

Kentucky

In McGuffey v. Hall, the Kentucky Supreme Court reviewed the constitutionality of several provisions of the act establishing the Kentucky Patients' Compensation Fund. The act created the fund as an agency within the state department of insurance and provided: that every physician and hospital be a member of the fund; that every member of the fund carry professional liability insurance with minimum coverage of \$100,000 per occurrence and \$300,000 annual aggregate (or must be

similarly self-insured); that each member of the fund pay an annual assessment; that financial resources of the fund were to be used for payment of judgments and settlements in excess of the basic insurance coverage; and that a claimant could collect from the fund that portion of a judgment or settlement which exceeded \$100,000 and if the fund became exhausted, such claims were to be paid out of the general fund of the Commonwealth. Moneys drawn from the general fund were to be repaid with interest by the fund at the earliest practicable time. The court found that the provision regarding recourse to the state general fund violated that state constitution's prohibition against commitment of future general revenues without a vote of the people and the state constitution's prohibition against the state loaning or giving its credit to any person or corporation for any purpose. The court also held that the provision for compulsory professional liability insurance was not shown to be a justified exercise of police power and so was in violation of the state constitution. The court found that those provisions held unconstitutional were so essential to the patient compensation fund statute that the remaining sections of that statute, including the limit on physician liability, could not stand without them. As a result, the patient compensation fund statute was held invalid in its entirety. [537 S.W.2d 401 (Ky. 1977)]

Nebraska

In Prendergast v. Nelson, the Nebraska Supreme Court considered and upheld the constitutionality of the state Hospital-Medical Liability Act. The act includes provision for the establishment of the Excess Liability Fund (patient compensation fund) under which physician liability is limited to \$100,000 per occurrence and \$300,000 annual aggregate liability. The act also places a \$500,000 overall limit on recovery (one million dollar limit after 12/31/84). The court held that the legislature, consistent with the dictates of the state and federal constitutions, may pass a law which seeks to distinguish between different types of tort actions. The legislature's ability to do this is conditioned upon the distinctions being reasonable and grounded upon real differences inherent in those tort actions.

The ceiling on judgments was challenged as a special privilege for health care providers and an undue restriction on the seriously injured patient. The court indicated that it must be remembered that the Excess Liability Fund procedure is an elective one, (a patient may elect not to come under the terms of the Hospital-Medical Liability Act prior to treatment). It went on to note that under an election, the act guarantees the prevailing claimant an assured fund of \$500,000 for the payment of any medical injury claim, while under the common law remedy a claimant has no such guarantee. If a health care provider had been unable to acquire medical liability insurance, the likelihood of collecting a substantial judgment would be quite remote. The court also noted that under the act, the claimant is assured of a procedure which will provide him access to an impartial medical review panel to determine whether the health care provider met the applicable standard of care and in return the claimant by his election agrees to the \$500,000 ceiling.

The court held that there was no merit to the argument that if a common law right is taken away something must be given in return. Nevertheless, the act was found to provide quid pro quo in that the claimant receives assurance of collectibility and the benefit of the opinion of a panel of experts.

The court also found that the classifications under the act rest on public policy reasons and a substantial difference between medical care providers and other tortfeasors. The court would only find constitutional safeguards had been offended if the classification rested on grounds wholly irrelevant to the achievement of the state's objective. The legislature is presumed to have acted within its constitutional power despite the fact that in practice its laws may result in some inequality. The court stated that it would not set aside a statutory discrimination if any facts reasonably existed to justify it. The court held that a legitimate legislative objective was being furthered by the act and the classification was proper. The court found of paramount importance the fact that the enactment was, and appeared to the court to be, in the public interest. [256 N.W.2d 657 (Neb. 1977)]

New Hampshire

In Carson v. Maurer, several aspects of the New Hampshire medical liability statute were challenged. The state supreme court in Carson found that the right to recover for personal injuries is not a "fundamental right" but is nevertheless an important substantive right. It concluded that the rights involved were sufficiently important to require that the restrictions imposed on those rights be subjected to a more rigorous judicial scrutiny than allowed under the rational basis test. The court applied the "substantial relationship" test in reviewing the statute, i.e., the statutory classifications must be reasonable, not arbitrary and must rest upon some ground of difference having a "fair and substantial" relation to the object of the legislation in order to satisfy state equal protection guarantees. (The U.S. Supreme Court has restricted use of the "substantial relationship test" in federal constitutional cases to classifications based upon gender and illegitimacy.)

The provision limiting liability in the New Hampshire statute provided that "compensation for noneconomic losses shall in no event exceed the sum of \$250,000." The court noted that the purpose of this section was to stabilize insurance risks and reduce medical liability insurance rates by providing that insurers would not have to pay out damages for "pain and suffering" in excess of the stated amount. The plaintiffs in Carson challenged this provision as a denial of equal protection of law, in that it created an arbitrary damage limitation and thereby precluded only the most seriously injured from receiving full compensation for their injuries. The court agreed with plaintiffs' argument, finding that the necessary relationship between the legislative goal of rate reduction and the means chosen to attain that goal was weak because paid-out damage awards constitute only a small part of total insurance premium costs and because all individuals suffer noneconomic damages in excess of \$250,000.

The court also found that the limit on recovery distinguishes not only between medical injury claimants and other tort claimants but also between medically injured claimants with noneconomic losses which exceed \$250,000 and those with less egregious noneconomic losses. It held that it was unfair and unreasonable to impose the burden of supporting the medical care industry solely upon those persons who are most severely injured and therefore most in need of compensation. The limit on noneconomic damages was found to deny medical liability plaintiffs the equal protection of law guaranteed by the state constitution. [424 A.2d 825 (N.H. 1980)]

North Dakota

The North Dakota Supreme Court found that state's Medical Malpractice Act unconstitutional in Arneson v. Olson. The court, in considering the constitutionality of provisions of the act, applied a test similar to the substantive due process standard of scrutiny. This test requires that there be a "close correspondence between the statutory classification and the legislative goals"; this is a stricter standard of scrutiny than the rational basis test. In examining the act, the court noted that although there need not always be a guid pro quo when a right is limited or withdrawn, any limitation or elimination of a preexisting right may not be arbitrarily imposed.

The act provided that, in conjunction with the Patient Trust Fund (patient compensation fund), a health care provider's liability for all claims of professional negligence was limited to \$300,000 from any one occurrence; \$100,000 to be paid by the health care provider's personal insurance, the remainder of damages to be paid by the fund. The court reviewed the limit on recovery to determine whether the limit was arbitrary and unreasonable and violative of due process, or whether there was a sufficiently close correspondence between statutory classification and legislative goals so as not to violate the equal protection requirements of the state and federal constitutions. The court found that the limit on recovery did not promote the stated legislative purposes of assurance of availability of medical services at reasonable cost, elimination of nonmeritorious claims, and encouragement of physicians to enter into and remain in practice in the state. In addition, the court found no evidence of an availability or cost crisis in the state. As a result, the court held "the drastic limitation on recovery to be a violation of the equal protection clause of the state constitution and the fourteenth amendment of the federal constitution."

The court went on to hold that although some of the provisions of the act individually would not violate due process, the cumulative effect was to violate the right of medical patients in the state to due process of law. It found that the act was arbitrary, unreasonable and discriminatory, and that the methods adopted had no reasonable relation to the attainment of the results desired. As a result, the court found the entire act unconstitutional because the provisions were so connected and dependent upon each other that it could not be presumed that the legislature would have enacted the valid sections without the unconstitutional sections. [270 N.W.2d 125 (N.D. 1978)]

* See Concluding

FEB 22 1985

Statutes Limiting Medical Malpractice Damages

J. KENT RICHARDS*

I.

INTRODUCTION

In some states, the amount of damages recoverable by victims of medical malpractice is limited by statute. These statutes were enacted in the middle 1970s in response to a crisis in the availability and cost of medical malpractice insurance. The crisis, headlined by skyrocketing premiums and the outright withdrawal of many insurance companies from the medical malpractice insurance market,¹ led to the passage of some sort of medical malpractice reform in nearly every state.² These reforms varied widely from state to state but the ultimate goal invariably was to stabilize medical malpractice insurance premiums by controlling damage awards and reducing actuarial uncertainty.³ Toward this end, some states decided to encourage or mandate settlement of medical malpractice lawsuits outside the tort system by instituting medical malpractice litigation

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¹ Waxman, *Spiraling Costs: A Health Care Slide*, 11 TRIAL 23 (May/June 1975); Gibbs, *Medical Malpractice Insurance Crisis*, 80 CASE & COMMENT 5 (July/Aug. 1975). One commentator noted "we are in a medical malpractice panic, and that no one can deny." Hirsh, *Malpractice Crisis: Fact or Fiction*, 80 CASE & COMMENT 3 (July/Aug. 1975). Some state courts have been openly skeptical that there was a medical malpractice insurance crisis in their state, insinuating that the state legislature had panicked when it passed responsive legislation. See note 68 *infra* and accompanying text. In addition, many commentators have suggested that though the crisis was real, its causes were outside the tort system. It has been suggested that poor investment practices by insurers, the "Marcus Welby" syndrome, the high incidence of actual medical malpractice, and the increasing complexity of medicine were root causes of the crisis. See Note *California's Medical Injury Compensation Reform Act: An Equal Protection Challenge*, 52 SO. CAL. L. REV. 829, 849-52 (1979).

² See AMERICAN INSURANCE ASSOCIATION, STATUTES AFFECTING LIABILITY INSURANCE (1981). "There has never been such dramatic and immediate response by the state legislatures to the pressure for any reform such as the reaction of all fifty state assemblies to the demands made by and on behalf of the medical profession in 1975." Fuller, *The Insurance Crisis in Medical Malpractice*, MEDICAL MALPRACTICE 10-1, 10-14 (Illinois Institute for Continuing Legal Education ed. 1975).

³ *Carson v. Maurer*, 120 N.H. 928, 941, 424 A.2d 525, 536 (1980). See Note, *California's Medical Injury Compensation Reform Act: An Equal Protection Challenge*, 52 SO. CAL. L. REV. 829, 846 (1979).

screening panels⁹ and mandatory, though nonbinding, arbitration. Other states chose to modify the tort system by abrogating the collateral benefits rule¹⁰ eliminating the "double recovery" barrier, or limiting the amount of damages recoverable.¹¹ Another popular reform was to limit attorneys' fees in medical malpractice cases through statutory controls on contingency fees.¹² A few states instituted only one or two of these reforms. As a rule, however, most states enacted a hodgepodge of reforms combining several changes within and without the tort system.

Most of these reforms have been controversial.¹³ One of the more interesting and continuing controversies revolves around the constitutionality of statutes putting an absolute limit on the amount of damages that victims of medical malpractice may recover.¹⁴ These statutes limiting the amount recoverable fell into one of three categories. First, some states chose to limit the amount recoverable in a medical malpractice action by simply limiting the liability of medical care providers to a specific dollar amount -- typically \$500,000.¹⁵ A second way in which states limited the amount recoverable in a medical malpractice action was by limiting the medical care provider's liability to a modest amount -- typically \$100,000 -- and establishing some kind of patient compensation fund to pay judgments in excess of the provider's liability. However, many of the patient compensation fund provisions also place a ceiling on the amount that can be paid out of the fund so that it is possible that a judgment could exceed the amount payable

by the provider and the limited pool amount to be placed in the fund, and suffering from the distinction will be in statutes because the determining the con-

These three different common the fact the malpractice may be recovered in the ab- statutes limiting the grounds. At least the limits on the amount actions.¹⁵ At least a tionally challenged the state courts have ality of these laws, been upheld. Thus, s. stabilized insurance cannot be achieved

The purpose of the selective implemen dollars recoverable on equal protection

⁹ E.g., ARIZ. REV. STAT. ANN. §12-567 (1982) upheld against equal protection challenge in *Eastin v. Broomfield*, 116 Ariz. 570, 582-83, 570 P.2d 744, 770-51 (1977).

¹⁰ E.g., ALASKA STAT. §9.55.535 (Supp. 1981).

¹¹ E.g., R.I. GEN. LAWS §9-19-24 (Supp. 1981).

¹² E.g., MASS. GEN. LAWS ANN. ch. 231, §60C (West Supp. 1980).

¹³ See notes 12-14 *infra*.

¹⁴ E.g., DEL. CODE ANN. tit. 18, § 6565 (Supp. 1980) (Contingent Fees limited to 35% of first \$100,000, 25% of next \$100,000, 10% of balance).

¹⁵ See Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 TEX. L. REV. 759 (1977); Comment, *Recent Medical Malpractice Legislation — A First Checkup*, 50 TEX. L. REV. 655 (1976); Comment, *An Analysis of State Legislative Responses to the Medical Malpractice Crisis*, 1975 DUKEL. J. 1417; Annotation, 80 A.L.R.3d 583 (1977).

¹⁶ In a broad sense the controversy is caused by a conflict between the insurance system and the tort system. The goal of insurance is to protect the assets of policyholders. In contrast, the goal of the tort system is just compensation for victims to be achieved by reaching the assets of tortfeasors.

¹⁷ IDAHO CODE § 39-4204 (1977); ILL. REV. STAT. ch. 70, § 101 (1975) (held unconstitutional in *Wright v. Central DuPage Hospital Assoc.*, 65 Ill. 2d 313, 347 N.E.2d 704 (1976) and repealed by P.A. 51-28, § 18 N.D. CENT. CODE § 26-40.1-11 (1978) (held unconstitutional in *Arneson v. Olson*, 270 N.W.2d 123 (1978); VA CODE § 8.01-581.15 (1977).

¹⁸ IND. CODE ANN. § 1-10-1 (West 1977); N.E. REV. S.

¹⁹ CAL. CIV. CODE § 38 (1979); OHIO REV. CODE trial court in *Grady v. S. LAWS § 21-3-11 (1979).*

²⁰ See notes 12-14 *supra*.

²¹ *Fein v. Permanent Jones v. State Bd. of M. 914 (1977); Wright v. C. Johnson v. St. Vincent N.W.2d 125 (N.D. 1978 Carson v. Maurer, 120 1255 (La. 1978). In additionality of Ohio's dam: N.E.2d 832 (1976). Sim 903 (1976).*

²² This article does malpractice reform le; with limits on recover attack." Note, *California Challenge*, 52 So. 1 to lesser degrees. *Id.*

by the provider and the fund combination.¹⁴ A final way that some states limited the amount that medical malpractice victims can recover was by placing absolute limits such as \$250,000 on the recovery of pain and suffering general damages.¹⁵ For purposes of this discussion no distinction will be made among the three types of damage limitation statutes because the courts have not relied on such distinctions when determining the constitutionality of these laws.

These three different approaches to limiting recoveries have in common the fact that the most seriously injured victims of medical malpractice may be unable to recover as much as they would have recovered in the absence of the limitation. Not surprisingly, these statutes limiting damages have been challenged on constitutional grounds. At least eleven states have passed statutes placing absolute limits on the amount of damages recoverable in medical malpractice actions.¹⁶ At least eight of those eleven statutes have been constitutionally challenged in reported state supreme court cases.¹⁷ However, the state courts have failed to reach any consensus on the constitutionality of these laws. Some have been struck down while others have been upheld. Thus, ironically, the lower actuarial risk and resulting stabilized insurance premiums that the acts were intended to procure cannot be achieved because their constitutionality is still in doubt.

The purpose of this article is to examine the constitutionality of the selective implementation of tort reform by limiting the amount of dollars recoverable in medical malpractice actions.¹⁸ The focus will be on equal protection analysis, which has been the favorite and most

¹⁴ IND. CODE ANN. § 16-9.5-2-2 (Burns Supp. 1981); LA REV. STAT. ANN. § 40:1299.42(B) (West 1977); N.H. REV. STAT. § 44:250 (1978); N.M. STAT. ANN. § 41-5-6 (1978).

¹⁵ CAL. CIV. CODE § 36-33.2 (West Supp. 1979); N.H. REV. STAT. ANN. ch. 507-C:7II (Supp. 1979); OHIO REV. CODE ANN. § 2307.43 (1981) (held violative of equal protection by state trial court in *Graley v. Satayatham*, 74 Ohio Op.2d 316, 343 N.E.2d 832 (1976); S.D. COD. LAWS § 21-3-11 (1979).

¹⁶ See notes 12-14 *supra*.

¹⁷ *Fein v. Permanente Medical Group*, 121 Cal. App. 3d 135, 175 Cal. Rptr. 177 (1981); *Jones v. State Bd. of Medicine*, 97 Idaho 659, 555 P.2d 399 (1976), cert. denied, 431 U.S. 914 (1977); *Wright v. Central DuPage Hosp. Ass'n*, 63 Ill.2d 313, 347 N.E.2d 736 (1976); *Johnson v. St. Vincent Hosp. Inc.*, 424 N.E.2d 585 (Ind. 1980); *Arneson v. Olson*, 270 N.W.2d 125 (N.D. 1978); *Prendergast v. Nelson*, 195 Neb. 97, 256 N.W.2d 657 (1977); *Carson v. Maurer*, 120 N.H. 925, 424 A.2d 825 (1980); *Everett v. Goldman*, 359 So. 2d 1256 (La. 1978). In addition, two reported trial court decisions considered the constitutionality of Ohio's damage limitation law. *Graley v. Satayatham*, 74 Ohio Op.2d 316, 343 N.E.2d 832 (1976); *Simon v. St. Elizabeth Medical Center*, 3 Ohio Op.3d 164, 355 N.E.2d 903 (1976).

¹⁸ This article does not consider the constitutionality of other provisions of medical malpractice reform legislation for two reasons. First, "legislative provisions dealing with limits on recovery have consistently been the most vulnerable to constitutional attack." Note, *California's Medical Injury Compensation Reform Act: An Equal Protection Challenge*, 52 S. CAL. L. REV. 629, 668 (1979). Other reforms have proved vulnerable to lesser degrees. *Id.* Second, the issues and arguments are likely to be very similar

...by these shall in law be treated as recovery of damages. Plaintiffs will be required to prove that the damage limitation is a classification under the federal and state constitutions. If so, the state's decision will be deemed to be a violation of the federal and state constitutions. Next, the good practice process argument that has been advanced in many of the cases will be discussed. Following that, other miscellaneous state constitutional provisions that might be relevant will be mentioned. Finally, there will be a consideration of whether the principles evident in the medical malpractice cases are likely to apply if similar legislation limiting damages in products liability actions is passed.²²

II. EQUAL PROTECTION

The most successful argument for invalidating legislation limiting damages is that the limitation violates equal protection. The courts have discerned a number of classifications in the statutes, including (1) plaintiffs with medical malpractice claims contrasted with plaintiffs bringing other tort actions, and (2) medical malpractice claimants with damages above the statutory limit on recovery contrasted with medical malpractice claimants with damages within the statutory limit.²³ The classifications are both obvious and intentional in each of the statutes limiting medical malpractice damages. Therefore, the real question in these cases is whether the classification chosen by the legislature is a permissible one.

Plaintiffs have usually asserted both federal and state equal protection claims. The federal equal protection arguments have not been a significant factor in the cases. Nevertheless, our equal protection discussion must start with an outline of federal equal protection doctrine because the states have largely drawn on the federal case law for their own doctrine.

When courts consider whether a statute or regulation violates the

regardless of the specific provision challenged. Therefore, although cases ruling on medical malpractice reform provisions other than damage limitations may be important and relevant in specific instances, they generally are not helpful here in presenting the issues that are raised by damage limitation statutes.

²² See notes 23-41 *infra* and accompanying text.

²³ See notes 42-69 *infra* and accompanying text.

²⁴ See notes 70-84 *infra* and accompanying text.

²⁵ See notes 85-88 *infra* and accompanying text.

²⁶ See notes 89-93 *infra* and accompanying text.

²⁷ E.g., *Carson v. Maurer*, 120 N.H. 925, 931, 424 A.2d 525, 530 (1980).

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equal protection clause of the federal constitution, they normally employ a two-tier analysis: if a suspect classification²⁹ or a fundamental interest³⁰ is involved, then the legislation is subjected to the strict scrutiny test. The test is "strict" because, according to the Supreme Court, it has been accurately observed that the strict scrutiny test is "strict" in theory and fatal in fact³¹ because laws subjected to the strict scrutiny test are inevitably struck down.³² In contrast, if suspect classification or fundamental interests are not involved, then the constitutionality of the classification is determined by subjecting the legislation to the rational basis test.³³ The rational basis test asks whether there is a rational relationship between the classification drawn by the statute and the achievement of a legitimate state purpose.³⁴ In application, the rational basis test is characterized by extreme deference to the legislature.³⁵ Thus, economic or social welfare legislation that does not create a suspect classification or infringe on a fundamental interest is inevitably upheld against equal protection attack because the rational basis test is applied.

In recent years, the equal protection doctrine has been in a state of flux

²⁹ See *Developments in the Law — Equal Protection*, 82 HARV. L. REV. 1065 (1969).

³⁰ A suspect class consists of a "discrete and insular minority" that is politically powerless due to circumstances beyond its control. *United States v. Carolene Prods. Co.*, 304 U.S. 144, 153, n.4 (1938). Classifications based on race (*McLaughlin v. Florida*, 379 U.S. 184, 191-92 (1964)), alienage (*Graham v. Richardson*, 403 U.S. 365, 372 (1971)), and nationality (*Korematsu v. United States*, 323 U.S. 214, 216 (1944)) have been found to be suspect.

³¹ Fundamental rights are rights explicitly or implicitly guaranteed by the Constitution. The Supreme Court has found voting (*Dunn v. Blumstein*, 405 U.S. 330, 336 (1972)), travel (*Shapiro v. Thompson*, 394 U.S. 618, 629-30 (1969)) and marriage (*Loving v. Virginia*, 388 U.S. 1, 12 (1967)) to be among the fundamental rights guaranteed by the Constitution.

³² Nowak, *Realigning the Standards of Review Under the Equal Protection Guarantee — Prohibited, Neutral, and Permissive Classifications*, 62 GEO. L.J. 1071, 1074 (1974).

³³ *Id.*

³⁴ Gunther, *The Supreme Court, 1971 Term — Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1, 8 (1972). But see *Korematsu v. United States*, 323 U.S. 214 (1944).

³⁵ Nowak, *Realigning the Standards of Review Under the Equal Protection Guarantee — Prohibited, Neutral, and Permissive Classifications*, 62 GEO. L.J. 1071, 1073 (1974).

³⁶ In *McGowan v. Maryland*, 366 U.S. 420, 425-26, (1961), the Court stated: "The constitutional safeguard [of equal protection] is offended only if the classification rests on grounds wholly irrelevant to the achievement of the state's objective. State legislatures are presumed to have acted within their constitutional power despite the fact that, in practice, their law results in some inequality. A statutory discrimination will not be set aside if any statement of facts may be reasonably conceived to justify it."

³⁷ Comment, *Equal Protection and Due Process: Contrasting Methods of Review Under Fourteenth Amendment Doctrine*, 14 HARV. C.R.-C.L.L. REV. 529, 534-35 (1979).

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equal protection law. In a number of doctrine, the state courts have not hesitated to vary their analysis when applying the equal protection clause. ⁴³ The courts have also varied their analysis from federal constitution equal protection analysis. ⁴⁴ This is of great interest in this discussion because it accounts for the decisions holding that medical malpractice laws violate state equal protection requirements.

State supreme courts have uniformly held that medical malpractice legislation does not create suspect classifications or implicate fundamental interests. ⁴⁵ Accordingly, no state court has applied or discussed applying the strict scrutiny test to equal protection challenges to damage limitation laws.

Rather, the decisive issue in the cases has been the decision whether to apply the rational basis test or an intermediate level of review. Just as the choice between the strict scrutiny and rational basis tests is outcome determinative under traditional equal protection analysis, it appears that the choice between the rational basis test and the intermediate test will predict the result of equal protection challenges to medical malpractice damages limitations statutes. Of eight courts that have discussed the equal protection issue, three applied an intermediate test, ⁴⁶ and four applied the rational basis test. ⁴⁷ In one the standard chosen was unclear. ⁴⁸ Of the three courts that chose intermediate scrutiny, two held the statute unconstitutional ⁴⁹ and one remanded for more information. ⁵⁰ In contrast, no state court that has applied the rational basis test has failed to find the statute in question constitutional. ⁵¹

Because the choice of test is critical to the outcome, it is worthwhile

⁴³ See notes 55-62 *infra* and accompanying text. See generally Brennan, *State Constitutions and the Protection of Individual Rights*, 90 HARV L. REV. 489 (1977).

⁴⁴ E.g., *Fein v. Permanente Medical Group*, 121 Cal. App.3d 135, 175 Cal. Rptr. 177, 184-85 (1981). This has also been true in cases challenging the constitutionality of medical malpractice reforms other than damages limitations. See cases collected at Note, *California's Medical Injury Compensation Reform Act: An Equal Protection Challenge*, 52 SO CAL. L. REV. 829, 861 (1979).

⁴⁵ *Jones v. State Board of Medicine*, 97 Idaho 859, 555 P.2d 399, 407 (1976), cert. denied, 431 U.S. 914 (1977); *Carson v. Maurer*, 120 N.H. 925, 932, 424 A.2d 825, 830-31 (N.H. 1980); *Arneson v. Olson*, 270 N.W.2d 125, 133 (N.D. 1978).

⁴⁶ *Fein v. Permanente Medical Group*, 121 Cal. App.3d 135, 175 Cal. Rptr. 177, 184 (1981); *Johnson v. St. Vincent Hospital, Inc.*, 404 N.E.2d 565, 600 (Ind. 1980); *Everett v. Goldman*, 359 So.2d 1256, 1266 (La. 1978); *Prendergast v. Nelson*, 199 Neb. 97, 113, 256 N.W.2d 657, 668 (1977).

⁴⁷ *Wright v. Central Du Page Hospital Ass'n*, 60 Ill.2d 313, 347 N.E.2d 706 (1976).

⁴⁸ *Carson v. Maurer*, 120 N.H. 925, 424 A.2d 825 (1980); *Arneson v. Olson*, 270 N.W.2d 125 (N.D. 1978).

⁴⁹ *Jones v. State Board of Medicine*, 97 Idaho 859, 555 P.2d 399 (1976), cert. denied, 431 U.S. 914 (1977).

⁵⁰ See list at note 43 *supra*.

⁵¹ See list at note 43 *supra*.

...of the court's "intermediate" factors influence the result is chosen. The traditional equal protection analysis clearly applies the rational basis test to social welfare legislation. Therefore, the courts that have applied the rational basis test to medical malpractice legislation are not inconsistent in their application, by noting that the law in question is social welfare legislation.⁴⁹ Nevertheless, two of the cases have specifically relied on the U.S. Supreme Court decision in *Dandridge v. Williams*⁵⁰ to support their use of the rational basis test. In *Dandridge* the Court considered the validity of a regulation that limited, irrespective of the number of children in the family, the total amount that a family could receive under the Federal Aid to Families with Dependent Children program. Finding the regulation to be economic and social, the Court applied the rational basis test, and upheld the regulation against an equal protection challenge.⁵¹ The Indiana Supreme Court followed *Dandridge* and applied the rational basis test because it found the interest of a medical malpractice victim in recovering an amount greater than the statutory limit to be "not greater than that of the children needing but being denied subsistence level support in *Dandridge*."⁵² Likewise, the Nebraska Supreme Court quoted at length from *Dandridge* before announcing that it would apply the rational basis test.⁵³

It is somewhat difficult to discern why the courts that have applied an intermediate scrutiny test chose to apply an elevated standard of review. Furthermore, several formulations of the intermediate scrutiny standard have been applied. The Idaho Supreme Court applied the "means scrutiny" intermediate standard of review. The test applied was whether "the legislative means substantially furthers some specifically identifiable end."⁵⁴ This intermediate level test, which the court derived from several U.S. Supreme Court cases, had been applied

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⁵¹ *Carson v.*

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⁵⁴ *Arneson v.*

⁵⁵ *Id.*

⁵⁶ *White & N.* 312, 330 (1977).

⁴⁹ *E.g.*, *Prendergast v. Nelson*, 199 Neb. 97, 114, 256 N.W.2d 657, 668 (1977).

⁵⁰ 397 U.S. 471 (1970)

⁵¹ *Id.* at 485-87.

⁵² *Johnson v. St. Vincent Hospital, Inc.*, 404 N.E.2d 585, 600 (Ind. 1980). The Indiana Supreme Court also relied on *Duke Power Co. v. Carolina Env. Study Group*, 438 U.S. 59 (1978), in which the U.S. Supreme Court applied the rational basis test to determine whether the limit on the nuclear power industry's liability contained in the Price Anderson Act violates equal protection. *Id.* at 83. However, the *Duke Power Co.* case can be distinguished on the ground that Congress has made a commitment to act if damages from a nuclear accident exceed the liability limits of the Price Anderson Act, whereas under medical malpractice damage limitations there is a "strong possibility of damage above the limitation and no legislative commitment beyond the limitation." *Arneson v. Olson*, 270 N.W.2d 125, 135, n.6 (1978).

⁵³ *Prendergast v. Nelson*, 199 Neb. 97, 113, 256 N.W.2d 657, 668 (1977).

⁵⁴ *Jones v. State Board of Medicine*, 97 Idaho 839, 667, 555 P.2d 399, 407 (1976), cert. denied, 431 U.S. 914 (1977).

in prior cases involving "obviously discriminatory classifications." The court clearly held that the discrimination in the Idaho statute between medical malpractice plaintiffs with damages exceeding the state's tort limit and those with damages well below that amount warranted application of the intermediate test.⁵⁷

The New Hampshire Supreme Court derived its intermediate scrutiny standard elsewhere. The court found a right to recover in tort for personal injuries that, although not a fundamental right, was important enough to require heightened scrutiny.⁵⁸ The court labelled its intermediate test a substantial relationship test, under which the statute "must be reasonable, not arbitrary, and must rest upon some ground having a fair and substantial relation to the object of the legislation."⁵⁹ The court acknowledged that the Supreme Court has not extended intermediate scrutiny to economic and social welfare legislation but noted that it had done so on prior occasions and was free to apply its own test in interpreting the equal protection provisions of the New Hampshire Constitution.⁶⁰

The Supreme Court of North Dakota, the final state to apply an intermediate scrutiny test, required a "close correspondence between statutory classification and legislative goal."⁶¹ The only apparent reason that the court applied the intermediate test was because it had applied it in judging the constitutionality of the state's automobile guest statute. That case, said the court, had "many similarities to the present case."⁶²

The surest way to predict which equal protection test a state court will apply may be to examine prior cases determining the constitutionality of that state's automobile guest statute.⁶³ Four of the above states

⁵⁷ *Id.*

⁵⁸ Nevertheless, after extensive discussion, the court did not reach the merits of the issue because there was inadequate information in the record to perform the analysis. Instead the case was remanded. *Id.* at 570, 555 P.2d at 416.

⁵⁹ *Carson v. Maurer*, 120 N.H. 925, 931-32, 424 A.2d 825, 830 (1980).

⁶⁰ *Id.* at 932-33, 424 A.2d at 831.

⁶¹ "We recognize that recently the United States Supreme Court has restricted its application of this substantial relationship test to cases involving classifications based upon gender and illegitimacy. In interpreting our state constitution, however, we are not confined to federal constitutional standards and are free to grant individuals more rights than [sic] the Federal Constitution requires. Indeed, we have applied the 'fair and substantial relation' test not only in scrutinizing gender-based classifications but also in examining economic and social legislation and ordinances which did not involve distinctions based upon gender or illegitimacy." 120 N.H. 925, 932, 424 A.2d 825, 831 (1980) (citations omitted).

⁶² *Arneson v. Olson*, 270 N.W.2d 125, 133 (N.D. 1978).

⁶³ *Id.*

⁶⁴ White & McKenna, *Constitutionality of Recent Malpractice Legislation*, 13 *FORUM* 312, 330 (1977). A table showing the consistency or inconsistency of state court decisions

1977) that it should be used when they discussed which test should be applied. The state applied the same standard to the medical malpractice law as it did to the general statute law.⁶⁷

Under the application of the rational basis test, the courts are generally willing to defer to the legislative judgment, reflected in the statute, that the classification is rationally related to a legitimate state purpose. For instance, in *Fein v. Permanent Medical Group*,⁶⁸ the plaintiff argued that the California statute limiting pain and suffering damages in medical malpractice cases violated equal protection because "the alleged 'crisis' pursuant to which the legislation was enacted was largely fabricated."⁶⁹ The court noted that the plaintiff was asking it to reconsider the legislature's findings, which it refused to do under the rational basis test.⁷⁰

In stark contrast, when the intermediate level test is applied, the courts are willing to scrutinize the basis for the legislative decision to limit damages far more closely. The Idaho Supreme Court was clearly skeptical that any crisis existed in Idaho and remanded for determination of whether malpractice claims had caused increased insurance rates and whether the damage limitation would actually stabilize insurance rates.⁷¹ The New Hampshire Supreme Court was unable to find the necessary relationship between the legislative goal of rate reduction and the damage limitation statute because "paid out damage awards constitute only a small part of total insurance premium costs [and] few individuals suffer non-economic damages in excess of \$250,000."⁷²

Thus, the functional difference between the rational basis test and the intermediate test is the degree to which the legislative judgment reflected in the statute will be examined. The practical difference is that under the rational basis test the statute will surely be found constitutional while the opposite result is likely if the intermediate test

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⁶⁷ *Jones v. State Board of Medicine*, 97 Idaho 859, 567, 555 P.2d 399, 407 (1976), cert. denied, 431 U.S. 914 (1977); *Johnson v. St. Vincent Hospital, Inc.*, 404 N.E. 2d 585, 608 (Ind. 1980); *Prendergast v. Nelson*, 159 Neb. 97, 113, 256 N.W.2d 657, 665 (1977); *Arneson v. Olson*, 270 N.W. 2d 125, 134 (N.D. 1978).

⁶⁸ Cal. App.3d 123, 175 Cal. Rptr. 177 (1981).

⁶⁹ 175 Cal. Rptr. at 183.

⁷⁰ *Id.* at 184-86.

⁷¹ *Jones v. State Board of Medicine*, 97 Idaho 859, 874, 555 P.2d 399, 414 (1976), cert. denied, 431 U.S. 914 (1977).

⁷² *Carson v. Maurer*, 120 N.H. 925, 941, 424 A.2d 825, 836 (1980).

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⁷⁶ *Id.* at 2
⁷⁷ *Id.* at 2
⁷⁸ *Id.* 201-

is applied. At any rate, the crucial issue in such cases remains which standard of review the court chooses to apply.

III. DUE PROCESS—THE *QUID PRO QUO* THEORY Analysis

Plaintiffs have invariably raised due process objections to statutes that limit their right to recover damages in medical malpractice actions. However, even when courts have struck down the statute, they have relied on equal protection, not due process grounds. When the traditional due process issue has been addressed, the test applied by the state courts has been merely whether the statute bore a rational relation to the achievement of governmental objectives.⁷⁰ Judged by this standard, there is no doubt that the statutes are constitutional.

However, a less conventional due process argument has been advanced by plaintiffs in most of the cases. They have argued that the right to recover medical malpractice damages in tort is a property interest that the state legislature cannot deprive them of unless it provides a *quid pro quo* in return.⁷¹ The *quid pro quo* theory originated with *New York Central Railroad Co. v. White*,⁷² which upheld the New York workmen's compensation law against a constitutional challenge. Although the United States Supreme Court clearly indicated in *White* that there is no vested right in common law liability rules allowing tort recovery from negligent employers, the Court implied that due process required a "reasonably just substitute."⁷³ The suggested requirement of a *quid pro quo* was expressly indicated to be dicta,⁷⁴ although the Court pointed out that the workmen's compensation law in question did in fact provide a *quid pro quo*. Workers gave up their common law tort rights in return for a guaranteed recovery while employers gave up their common law defenses in return for a limit on their potential liability.⁷⁵

The basic theory has not developed appreciably in the sixty odd years since it was first expounded in *White*. The Court has stated many

⁷⁰ *E.g.*, *Johnson v. St. Vincent Hospital, Inc.*, 404 N.E.2d 585, 598 (Ind. 1980).

⁷¹ The argument is discussed in detail by Learner, *Restrictive Medical Malpractice Compensation Schemes: A Constitutional "Quid Pro Quo" Analysis to Safeguard Individual Liberties*, 18 HARV. J. ON LEGIS. 143 (1981).

⁷² 243 U.S. 183 (1917).

⁷³ *Id.* at 200-01.

⁷⁴ *Id.* at 201.

⁷⁵ *Id.* 201-02.

times that there is no right to a common law cause of action.⁷⁶ Yet, at the time the *quid pro quo* argument has arisen, the Court has declined to rule on its validity while keeping the theory alive by pointing out how the challenger should prove a *quid pro quo*.

The only state court discussion of the *quid pro quo* argument in relation to a statute limiting medical malpractice recovery that is not clearly dicta is found in *Carson v. Maurer*.⁷⁷ There the New Hampshire Supreme Court was considering an equal protection challenge to a statute limiting pain and suffering damages in medical malpractice actions to \$250,000.⁷⁸ The court indicated that its prior cases upholding a \$50,000 statutory limit on tort recovery for personal injury against municipalities and upholding a statute limiting recovery in wrongful death actions were inapposite because in neither case was there a common law right to recovery. Therefore the legislature could abolish or limit such actions.⁷⁹ Furthermore, the state workmen's compensation law was distinguishable because it provided a *quid pro quo* to injured workers in return for their common law rights.⁸⁰ However, the court did not explicitly conclude that the limitation on pain and suffering damages was unconstitutional because no *quid pro quo* was provided.

Instead, the court held that the statute violated the equal protection clause of the state constitution. The *quid pro quo* analysis was contained within the court's equal protection discussion, following notation of the unfairness of the classification drawn by the law but preceding the court's statement that it was holding the statute violative of equal protection.⁸¹ Thus it is unclear exactly what the court's analysis was. It may simply have confused the due process *quid pro quo* argument with the equal protection issue. It is also possible that the court was saying that under the intermediate scrutiny test that it was applying in the case, a classification might survive scrutiny if a *quid pro quo* were provided to those in the affected class. Although the court's reasoning is unclear, what is fairly certain is that the court

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⁷⁶ "Our cases have clearly established that '[a] person has no property, no vested interest, in any rule of the common law.'" *Duke Power Co. v. Carolina Env. Study Group*, 438 U.S. 59, 85, n.32 (1977) (collecting cases).

⁷⁷ *Duke Power Co. v. Carolina Env. Study Group*, 438 U.S. 59, 86 (1977) (Price-Anderson Act limiting liability of nuclear power industry). See Learner, *Restrictive Medical Malpractice Compensation Schemes: A Constitutional "Quid Pro Quo" Analysis to Safeguard Individual Liberties*, 18 HARV. J. ON LEGIS. 143 (1981).

⁷⁸ 120 N.H. 925, 424 A.2d 825 (1980).

⁷⁹ N.H. REV. STAT. ANN. ch. 507-C:7II (Supp. 1979).

⁸⁰ 120 N.H. at 942-43, 424 A.2d at 837.

⁸¹ *Id.* at 943, 424 A.2d at 837-38.

⁸² *Id.* at 941-43, 424 A.2d at 835-38.

⁸³ *Jones v. Boe*, 431 U.S. 914 (1977).

⁸⁴ See, e.g., *Pre* Prendergast the c
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approved of and applied the *quid pro quo* analysis.

Other state courts that have discussed the *quid pro quo* due process question have either rejected the *quid pro quo* theory, citing Supreme Court cases holding that the legislature is free to limit rights as long as it does not do so arbitrarily.⁸³ However, the majority of the courts generally have acknowledged the argument, expressed reservations about the vitality of the theory, noted that the law in question does provide a *quid pro quo*, and decided the case on other grounds.⁸⁴ Thus, the *quid pro quo* argument in cases challenging damage recovery limitations has been relatively unimportant. As long as the equal protection argument is present, it appears that the *quid pro quo* argument will not be squarely faced.

The *quid pro quo* due process analysis would assume more importance if no equal protection argument were present. That would be the case if a state legislature chose to put a damage recovery limit on all tort actions. When squarely faced with the issue, and in the absence of any further indication of the vitality of the *quid pro quo* theory from the United States Supreme Court, the state courts would likely be reluctant to apply it to challenges based on the due process clause of the federal constitution.

However, the generally favorable dicta found in the state cases suggests that individual states might choose to apply the *quid pro quo* doctrine under the due process clause of their state constitutions. That would lead to a situation similar to the present where some courts have held legislation limiting damages recoverable in tort actions to violate state but not federal equal protection provisions.

IV.

SPECIAL STATE CONSTITUTIONAL PROVISIONS

The vital role that state equal protection clauses have played in determining the constitutionality of medical malpractice damages limitation statutes has already been discussed. Other state constitutional provisions that are more unique to certain states have been argued by plaintiffs as well. For instance, it has been argued that

⁸³ Jones v. Board of Medicine, 97 Idaho 859, 869, 555 P.2d 399, 409 (1976), cert. denied, 431 U.S. 914 (1977).

⁸⁴ See, e.g., Prendergast v. Nelson, 199 Neb. 97, 120-21, 256 N.W.2d 657, 671 (1977). In Prendergast the court rejected the *quid pro quo* argument, noting that the legislature is free to abolish even common law rights. Nevertheless the court thought that the damage limitation statute did provide a *quid pro quo* because it helped make medical malpractice liability insurance available and affordable, thereby assuring that judgments would be collectible. *Id.* at 121, 256 N.W.2d at 671. The notion that a societal *quid pro quo* might be adequate was flatly rejected by the Illinois Supreme Court. Wright v. Central Du Page Hospital Ass'n, 63 Ill.2d 313, 328, 347 N.E. 2d 736, 742 (1976).

damages limitations constitute prohibited special legislation," contravene the right to jury trial, or fail to provide a complete remedy for harm suffered.⁸⁸ The only statute limiting medical malpractice damages that has been struck down on other than equal protection grounds was that of Illinois, which the Illinois Supreme Court held violated the special privilege prohibition of the state Constitution.⁸⁹ With this exception, arguments based on state Constitutional provisions have been generally treated as make weight arguments behind the equal protection analysis.

V.

THE PRODUCTS LIABILITY ANALOGY

The same type of insurance crisis that prompted major medical malpractice reforms in the 1970's appears to be brewing in the products liability area.⁹⁰ Products liability and medical malpractice are similar in that both involve insurance problems—specifically, the cost and availability of insurance.⁹¹ In addition, as in the malpractice insurance case, pressure for reform is likely to come from manufacturers and insurers rather than those who are injured.⁹² No doubt legislatures will be pressed to adopt remedial products liability legislation similar to the previous medical malpractice changes.⁹³ Thus, it would not be surprising if some states placed limits on the amount of damages recoverable in products liability actions.

Despite the similarities between medical malpractice and products liability, there are a number of distinctions that may support treating the two problems differently. The number of medical malpractice claims is significantly smaller than the number of products liability claims and products liability litigation is more expensive than malpractice litigation. Unlike medical malpractice insurance, the problem

in products liability is because of the greater extent of the damage.

Nevertheless, liability plaintiffs' objections to the damage limitation that the lack of tort law reform.

The case law shows that the reasons for the damage limitation are several years old. Although these cases are unsettled, the substantial availability of damage recovery is a tort law cost and availability.

⁸⁸ *Wright v. Central Du Page Hospital Ass'n*, 63 Ill.2d 313, 326, 330, 347 N.E.2d 736, 741, 743 (1976); *Arneson v. Olson*, 270 N.W.2d 125, 136-37 (N.D. 1978).

⁸⁹ *Johnson v. St. Vincent Hospital, Inc.*, 404 N.E.2d 585, 601-02 (Ind. 1980).

⁹⁰ *Id.* at 593.

⁹¹ *Wright v. Central Du Page Hospital Ass'n*, 63 Ill.2d 313, 330, 347 N.E.2d 736, 743 (1976).

⁹² Comment, *Solving the Products Liability Insurance Crisis: A Study of the Rule of Economic Theory in the Legislative Reform Process*, 31 MERCER L. REV. 755, 756-60 (1980). See generally INTERAGENCY TASK FORCE ON PRODUCT LIABILITY, U.S. DEPARTMENT OF COMMERCE 3-7 (1977).

⁹³ INTERAGENCY TASK FORCE ON PRODUCT LIABILITY, U.S. DEPARTMENT OF COMMERCE 436 (1975).

⁹⁴ *Id.* at 419.

⁹⁵ *Id.* at 434.

⁹⁶ *Id.* at 422.

⁹⁷ See *Dagu*, Indiana law a decision upholding challenge.

in products liability insurance is more one of cost than availability because manufacturers can absorb higher costs by raising prices to a greater extent than doctors can.³³ Finally, products liability involves products while malpractice involves services.

Nevertheless, if laws limiting the amount of damages that products liability plaintiffs can recover are passed, the same constitutional objections that have been asserted against medical malpractice damage limitations would surely be raised.³⁴ One may surmise, however, that the lack of consensus on the constitutionality of medical malpractice laws would lead to similar uncertainty in regard to products liability reforms.

VI. CONCLUSION

The cases on the constitutionality of state statutes limiting damages recoverable in medical malpractice actions reveal a variety of reasons for rendering decisions and arriving at conflicting results. Although the number of such statutes passed has slowed in the last several years as the medical malpractice insurance crisis has receded, these cases are of considerable importance. As long as the results are unsettled, the issue will probably continue to be litigated. In addition, substantial premium increases in the future or restrictions on the availability of medical malpractice insurance, for whatever reasons they occur, will likely stimulate the passage of more laws restricting damage recoveries. Finally, similar legislation may be passed in analogous tort areas such as products liability in response to crises in the cost and availability of liability insurance.

³³ *Id.* at 422.

³⁴ See *Dague v. Piper Aircraft Corp.*, 513 F.Supp. 19, 29 (N.D. Ind. 1980) (applying Indiana law and citing Indiana medical malpractice limitation case in support of decision upholding ten year products liability statute of limitations against equal protection challenge).



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

April 3, 1985

MEMORANDUM

TO: Representative Mike Szymanski

FROM: Jonathan Sherwood
Legislative Analyst

RE: Regulation of the Insurance Industry in Alaska
Research Request 85-239

You requested that we provide information on current State efforts to regulate the insurance industry and on the potential need for additional regulatory controls. Title 21 of the Alaska Statutes contains numerous provisions regulating various aspects of the insurance industry in Alaska. The title includes almost 400 pages; it contains general provisions for the insurance regulation and several chapters pertaining to the regulation of specific types of insurance. This memorandum does not provide a comprehensive summary of all insurance regulation; rather, we will discuss the major directions of insurance regulation, particularly those aspects of regulation which extend across types of insurance.

Current Regulation of Insurance in Alaska

In the discussion of Alaska insurance regulation, it is important to distinguish between two distinct classes of insurers, admitted and nonadmitted. The nonadmitted (also called surplus lines) insurer is not subject to the same level of regulation that admitted insurers are; however, surplus lines insurance must be sold through a broker who posts a bond of \$200,000. Surplus lines insurance is generally used as the insurance of last resort, when coverage from admitted carriers cannot be obtained.

Authorized Insurance. To operate as an admitted insurer in Alaska, a business must obtain a certificate of authority from the Division of Insurance. By law, such insurers must meet minimum financial requirements for surplus capital, as specified in AS 21.09.070, and maintain a minimum deposit for the protection of policyholders and creditors.¹

¹Title insurance is exempted from the deposit requirement.

The Division of Insurance also regulates the rates, policies and trade practices of the insurance industry. According to AS 21.39.010, the purpose of rate regulation is:

"to promote the public welfare by regulating insurance rates in order that they will not be excessive, inadequate or unfairly discriminatory, and to authorize and regulate cooperative action among insurers in rate making and in other matter within the scope of this chapter."

Rate regulation does not apply to reinsurance, disability insurance, some types of marine insurance and aircraft insurance.

Under the provisions of AS 21.39.030, insurers must consider past and prospective loss experience, catastrophe hazards, reasonable profit and contingencies, past and prospective expenses, and all other relevant factors in developing their rates. Insurers must include in their rate submission enough information on the basis for the rates to enable the division to determine whether the rates are justified. According to John George, insurers must show that the basis on which they discriminate in their rates is based on reasonable grounds as well.

The Division of Insurance can disapprove rates filed by insurers. However, Mr. George noted that although the division can prohibit an insurer from selling a policy at a given price, it cannot require that a policy be offered at a given price. He further stated that, in the recent past, insurance regulators have tended to allow insurers to set rates which were too low to accumulate adequate funds to meet claims, rather than permitting excessive rates.

Insurers are also required to file their insurance policy or contract forms with the Division of Insurance. Under the provisions of AS 21.42.130, a policy may be disapproved if it:

- 1) is in any respect in violation of or does not comply with this title;
- 2) contains or incorporates by reference, where incorporation is permissible, an inconsistent, ambiguous, or misleading clause, or exception and condition that deceptively affects the risk purported to be assumed in the general coverage of the contract;
- 3) has a title, heading or other indication of its provision that is misleading;
- 4) is printed or otherwise reproduced in a manner that renders a provision of the form substantially illegible; and

Representative Szymanski
April 3, 1985
Page Five

The division has a consumer complaints section and a market surveillance section. Mr. George stated that a considerable amount of the division's effort is directed toward monitoring the finances and claims practices of insurers.

Mr. George noted that under Alaska law, the Director of Insurance has substantial direct authority over insurers. The director has subpoena power, an absolute right to examine insurance records, the authority to force insurers to pay claims, and the power to levy administrative penalties against members of the insurance industry.

The Need for Additional Insurance Regulation

In this section, we discuss briefly the potential for increasing the regulation of the insurance industry in Alaska. To put the regulatory scheme used by Alaska into perspective, we first discuss how regulation of insurance in Alaska compares to regulation in other states.

In the United States, state governments are the primary source of regulation for the insurance industry; the federal government does not regulate insurance. In fact, the insurance industry is exempt from federal antitrust laws. According to Art Chartrand, with the National Association of Insurance Commissioners (NAIC), although there are many specific differences between individual states, the general pattern of insurance regulation tends to be consistent among the states. All states regulate trade practices, policies, rate practices, and the financial stability of insurance companies.²

According to John George, the NAIC is responsible for some of this consistency. With representatives from all fifty states, NAIC develops model laws, coordinates examinations of insurance companies, and generally fosters cooperation among states. NAIC model laws are frequently used by the states as the foundations for their insurance statutes.

Mr. George noted that many of the differences between states result from the individual circumstances of the state's insurance industry. For example, Alaska is recognized as a leader in surplus lines regulation; it is also the state with the greatest proportion of its insurance written by surplus lines insurers. New York has become a leader in crime insurance regulation for similar reasons.

²There are structural differences in the way insurance regulatory agencies are established. Attached is a previous House Research Agency memorandum which compares the structure of the Texas State Board of Insurance to the Alaska Division of Insurance.

Representative Szymanski
April 3, 1985
Page Seven

Apparently, during the period of high interest rates, insurance companies were making a high yield on their investments. In order to increase the scale of their investments to make more money, they began lowering premium rates to attract more capital to invest. However, in the last few years, the return on investments has declined; but rates have not been increased accordingly.

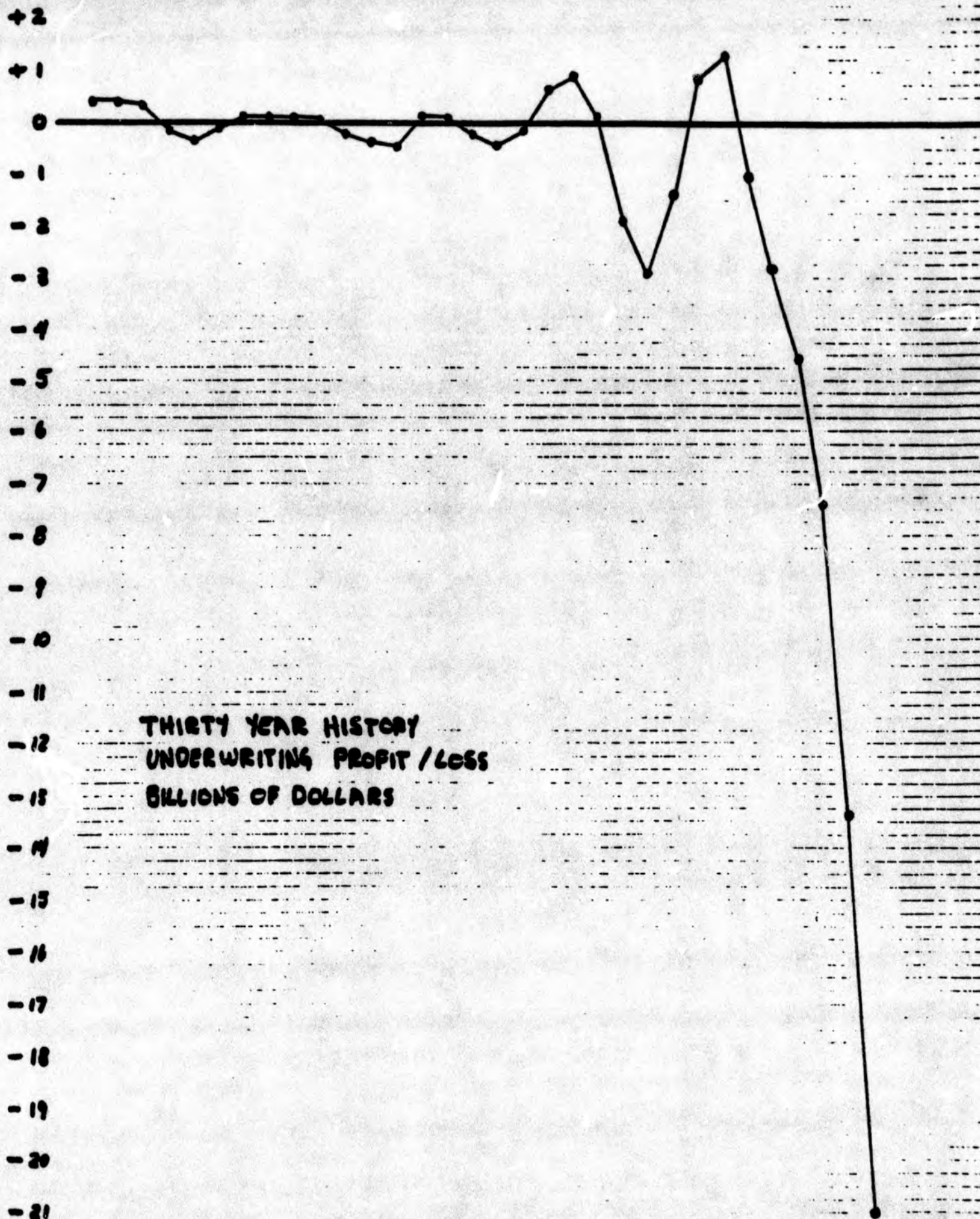
Attachment B shows two tables provided by the Division of Insurance illustrating this phenomenon. According to the first table, underwriting profits and losses have traditionally fluctuated around zero, but never dropping below zero for more than three consecutive years. However, beginning in 1979, underwriting has produced six straight years of increasingly large losses. In 1984, the insurance industry suffered a \$21 billion underwriting loss. The second table shows that through most of this period, underwriting losses were offset by investment income. However, in 1984, the insurance industry suffered a net loss of almost \$4 billion.

The losses suffered by the insurance industry have reduced the cash reserves that companies maintain as protection against underwriting losses. The amount of a company's cash surplus determines the amount of coverage it can sell; insurers can write less insurance when cash reserves decline. Because of underwriting losses, some insurers may currently have more insurance issued than their cash surplus would permit.

According to John George, the Division of Insurance is concerned about the financial conditions of several insurers doing business in Alaska. He noted that when looking at the financial condition of insurers, coverage of high-risk lines such as crab boats or liquor law liability is likely to have a negative impact on his evaluation.

For some lines of insurance, the public does have some protection against insurer insolvency. Under AS 21.80, all companies providing direct insurance except for life, title, surety, disability, credit, mortgage guaranty, and ocean marine insurance, are members of the Alaska Insurance Guaranty Association. If an insurer is declared insolvent, all insurers offering the same line of insurance are assessed a fee in proportion to their share of the line in the state to cover unmet claims obligations and premium refunds. Companies may not be assessed more than two percent of their surplus in any one year. Currently, there is a bill (SB 88) before the Alaska Senate which would create the Alaska Life and Disability Insurance Guaranty Association.

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ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

House of State Capitol
Juneau, Alaska 99811
(907) 465-1991

November 5, 1982

MEMORANDUM

TO: Representative Thelma Buchholdt

FROM: Leonard Steinberg, Research Staff *L. S.*

RE: Insurance Agency Organization
Research Request Number 82-183

You requested information about the organization and effectiveness of state insurance agencies in Alaska and Texas. Specifically, you asked for information about:

- 1) The functions and structure of the Texas State Board of Insurance;
- 2) How the work of the Board of Commissioners differs from the work of their staff;
- 3) How well the Texas State Board of Insurance performs its duties particularly with regard to consumer affairs; and
- 4) How the Alaska Division of Insurance compares with the Texas organization.

Texas State Board of Insurance

Insurance regulation in Texas is handled through the State Board of Insurance. The Board is composed of three full-time commissioners. The Governor, with the advice and consent of the Senate, appoints the commissioners to serve six-year terms staggered every two years. Board members must have at least ten years experience in business, professional, or governmental activities and Texas law prohibits individuals with conflicts of interests from serving on the Board.

The State Board of Insurance (SBI) is responsible for:

- 1) promulgating rates;
- 2) promulgating and adopting administrative regulations;
- 3) hearing appeals from Commissioner's decisions; and
- 4) establishing policies on insurance regulation.

The three-member Board also has general oversight responsibilities for agency performance and the power to hire and fire the Commissioner of Insurance who is the chief of staff. The Commissioner of Insurance is responsible for administering, enforcing, and carrying out the insurance provisions of Texas statutes and regulations.

The Chairman of the three member State Board of Insurance (who is designated by the Governor in odd-numbered years) is also responsible for appointing the State Fire Marshall.

Currently, there are four Deputy Commissioners reporting to the Commissioner each having responsibility for one of the following Divisions:

- 1) Business Practices and Enforcement;
- 2) Financial Monitoring;
- 3) Property Insurance; and
- 4) Casualty Insurance.

Additionally, the managers of the following eight Departments also report directly to the Commissioner:

- 1) Liquidation;
- 2) Statistical and Rate Development;
- 3) Surplus Lines;
- 4) Hearings;
- 5) Legal;
- 6) Support Services;
- 7) Personnel; and
- 8) Data Processing.

The State Board of Insurance has recently proposed two changes which are to be implemented in September 1983. First, in order to improve the efficiency and effectiveness of the way the Board deals with complaints and investigations, it is proposing to create a Legal and Compliance Division. Second, the Board is proposing to increase the number of Deputy Commissioners from four to six but reduce the number of programs and program managers reporting directly to the Commissioner.

Under the new organization, only the following programs, each headed by a Deputy Commissioner, would report to the Commissioner:

- Casualty;
- Property;
- Life;
- Administrative Services;
- Legal and Compliance; and
- Corporate and Financial Affairs.

For FY 1982, the operating budget for the State Board of Insurance was \$17.5 million and the agency employed 651 persons. Though most of the State Board of Insurance's staff is located at the state capitol in Austin, Texas, there are numerous field offices throughout the state. The State Fire Marshal has four field offices to assist in arson investigations and inspect fireworks stands and buildings for fire hazards. The Property Division also has numerous field offices to inspect buildings and assign property insurance ratings.

Claims and Complaints Section

Under the current structure, the Claims and Complaints Section is part of the Business Practices and Enforcement Division. If the proposed reorganization is implemented in September 1983, the Claims and Complaints Section will operate under the Legal and Compliance Division.

The Claims and Complaints Section responds to written inquiries or complaints regarding consumer dissatisfaction with claim benefits, underwriting practices, or questionable business practices. The State Board of Insurance examines and analyzes these complaints, determines what, if any, action should be taken pursuant to the Texas Insurance Code, and if appropriate, compiles information for legal proceedings or other actions determined necessary by the Commissioner.

The State Board of Insurance has found that when violations of policy provisions have been identified, insurance companies usually cooperate and correct claims errors. If a company chooses not to cooperate, however, the State Board of Insurance does not have the authority to require settlement of claims disputes.

When complaints result in a finding that the insurer is in violation of sections of the Texas Insurance Code, and the insurer does not respond by resolving the complaint, a recommendation is made to the Deputy Commissioner to cite the company for alleged violations. If the allegations are found by the Legal Section to be legally valid, a public hearing is held and the parties are advised in writing of the resulting findings and directives.

The Investigation Section is responsible for licensing insurance agents and adjusters and, in cooperation with the Claims and Complaints Section, also looks into alleged improper acts of insurance agents, adjusters, and companies. Violations of the Texas Insurance Code may result in the Commissioner cancelling, or suspending licenses or issuing consent orders.

In addition to the work of the Claims and Complaints and Investigation Sections, during FY 1981 more than 1100 complaints and an unknown but

significant number of inquiries were processed by other Divisions of the State Board of Insurance.

The State Board of Insurance retains data on complaints to detect patterns of problems with specific companies and agents as well as to measure the work performed by its staff. Beginning in 1981, this tracking effort has been enhanced with the aid of a computer system.

The effectiveness of the State Board of Insurance's Claims and Complaints Section is difficult to estimate. Listed below are two common indicators, the amount of dollars paid to claimants as a result of SBI action and the number of complaints received.

	Claims Paid	Complaints Received
1979	\$5,435,147	10,281
1980	\$7,222,082	11,791
1981	\$9,577,051	11,938

The average time required for processing a complaint is not available, but the State Board of Insurance has indicated that most claims can be settled within three weeks provided that the insurance company or agent responds promptly.¹

Alaska Division of Insurance

The Alaska Division of Insurance is a line agency within the Department of Commerce and Economic Development. The laws under which the Division operates are set forth in Title 21 of the Alaska Statutes and in Chapters 21-31 of Title 3 of the Alaska Administrative Code.

The Division's mission is to make certain that, "...insurance coverages are available to all citizens at equitable prices from solvent and reputable sources."² Additionally, the Division collects about \$12 million of insurance taxes and fees every year.

¹ Texas State Board of Insurance, Texas State Board of Insurance. Photocopied document of 13 pages plus 3 exhibits, obtained from Dianne Longley, Information Services, Texas State Board of Insurance, Austin, Texas. October 20, 1982. Most of the information about the Texas State Board of Insurance was obtained from this document.

² Division of Policy Development and Planning, Office of the Governor, State of Alaska. Alaska Report of Performance FY 81. Page 53.

The Division of Insurance is structured into three sections responsible for the following program areas:

- 1) Licensing of agents, brokers, and insurance companies (this is also the section that collects taxes);
- 2) Financial audits, reviewing company solvency and the financial ability of companies to respond to claims; and
- 3) Marketing surveillance, reviewing rates, the wording and clarity of policy forms, and trade practices.

The Division employs eighteen individuals, five in Anchorage and thirteen in Juneau. Though the Division has grown over the years, its budget is still less than \$1 million annually (\$976,800 for FY 83). The Division is, of course, much smaller in size than the Texas State Board of Insurance, but is comparable to the Texas agency in terms of the number of employees on a per capita basis.

Of the five staff positions in Anchorage, two are "consumer complaints specialists" that handle nearly all of the consumer complaints for the Division.³ The Division responds to consumer complaints by investigating cases and informally attempting to resolve problems. When necessary, the Division holds hearings, issues orders, and revokes licenses.

The Division does not involve itself in determining the liability of an insurance company or the amount of an insurance settlement; the Division's regulatory role is limited to ensuring that premium rates are fair, companies are solvent, and insurance claims are properly dealt with.

During the calendar year 1981, the Division processed 291 complaints requiring an average of 44 days each to complete. During the first nine months of the 1982 calendar year, the Division has processed 208 complaints requiring an average of 41 days to complete. On the basis of the information available to me, it appears that the Division's complaint response time is substantially longer than its Texas counterpart, although an exact comparison is difficult due to the lack of specific Texas data.

In addition to the Division of Insurance, there is also a Division of Worker's Compensation within the Department of Labor that acts as staff to the Board of Worker's Compensation; they resolve disputes

³ Interview with Division Director Ken Moore, October 19, 1982. During this interview Director Moore indicated that two staff positions are sufficient to handle the Division's workload.

Representative Thelma Buchholdt
November 5, 1982
Page 6

surrounding claims and benefits under this program. In Texas, this function is handled by the State Board of Insurance.

The attached table provides a summary comparison of some of the key elements of insurance regulation efforts in Alaska and Texas.

I hope this information is useful. Please let me know if you have any further questions or would like any additional information.

Comparison of Alaska - Texas Insurance Regulatory Programs

	<u>Alaska</u>	<u>Texas</u>
Total In-State Premium Amount	\$600 million	\$6 billion
Fees & Taxes Collected	\$12 million (1982)	\$185 million (1980)
Agency Budget	\$976,800 (FY 1983)	\$17.5 million (FY 1982)
Number of Employees	18	651
Independent Board	No	Yes
Agency Sets Rates	No	Yes
Agency May Issue Orders/ Revoke Licenses	Yes	Yes
Number of Complaints Processed	291 (1981)	11,938 (1981)
Complaint Processing Time	44 day avg. (1981)	avg. is unknown but usually within three weeks
Amount of Claims Paid Through State Intervention	unknown	\$9,577,051

SCOMM

69:C

ALASKA STATE LEGISLATURE

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P. O. Box V
Juneau, Alaska 99811
(907) 465-3720

SAM COTTEN
SPEAKER OF THE HOUSE

MEMORANDUM

TO: Legislative Reference Library
FROM: Speaker Sam Cotten *SC*
DATE: January 2, 1991
RE: Liability Insurance Task Force

Enclosed in the box accompanying this letter are the records of the Liability Insurance Task Force from 1989 through 1990. I am forwarding these items to you for permanent filing.

A. Committee Tapes and Logs as follows:

1. Tapes for October 3-4, 1989, meeting (^{FIVE} ~~four~~ tapes)
2. Tapes and log for March 2, 1990 meeting (three tapes)
3. Tapes and log for March 3, 1990 meeting (five tapes)
4. Tape and log for March 16, 1990 meeting (one tape)

B. Set of 16 volumes of research data and index for same. Volumes are as follows:

1. Peer Review Panel Results, Etc.
2. Changes in Insurance Services: How the Public is Treated
3. Rand "Three Level" Study and Other Reports
4. Miscellaneous
5. Availability - Affordability Insurance Percentage
6. Availability of Services
7. Alternative Claim Resolution Mechanisms
8. Roles and Mechanisms of State Agencies
9. Claims Information Professional
10. Anti-Trust Suit Status
11. Impacts of U. S. Tort System Changes
12. Rates
13. Self-Regulation Materials
14. Changes in Time in Law of Liability and Damages

15. Comparisons of U. S. Tort System Changes
16. Legislative Research Agency Reports

C. Miscellaneous Handouts Used at 1989 Meetings as follows:

1. April 13, 1989 letter from Center for Study of Responsive Law.
2. MEDICAL ECONOMICS article "Tort Reform: What Works, and What Doesn't"
3. Copies of House Bill 166
4. February 17, 1989 memo from Michael F. Ford, Legislative Counsel, regarding Civil Action - HB 166
5. NATIONAL INSURANCE LAW REVIEW article "The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances"
6. "New Ideas Concerning Organizations: The PIAA Proposal: Establishment of Fault by Either Administrative Review or Normal Adjudication Followed by Indemnification Using a Fixed Benefit Program."
7. August 5, 1988 letter from Milliman & Robertson, Inc.
8. "Who Should Be Liable? A Guide to Policy for Dealing with Risk."
9. "Insurance Rates, Regulation, Commissioner, Initiative Statute"
10. April 27, 1989 memo from Ginger Baim to David Rogers regarding House Bill 166 - pros.
11. September 15, 1989 memo from Rep. Cotten to Liability Insurance Task Force members
12. February 1986 report by the Citizens Coalition for Tort Reform entitled "Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability."
13. March 1987 report by the Tort Policy Working Group entitled "An Update on the Liability Crisis."
14. January 26, 1989 letter, James P. Lynn of Aetna from Ralph Nader and February 8, 1989 response from Aetna.
15. House Research Agency March 15, 1989 report on "Hawaii Court Annexed Arbitration Program."
16. October 1, 1985, "Report of the Governor's Medical Malpractice Insurance Commission."
17. April 25, 1989 statement from J. Robert Hunter, President, National Insurance Consumer Organization.

D. Miscellaneous papers regarding 1990 hearings:

1. March 9, 1990 list of Task Force members and alternates.
2. Memo from David Rogers regarding "Fact Finding Efforts" dated January 19, 1990.
3. Memo from David Rogers regarding "Summary of Data: Almost everything you ever wanted to know about liability issues (and were afraid to ask??)" dated February 22, 1990 and marked "draft".
4. March 2, 1990, Summary of Highlights - Discussion Draft. Prepared by David Rogers for Task Force members.

5. Letters and articles discussed at March hearings:

- a. January 26, 1990 letter from Scott Wetzel Services
- b. January 26, 1990 letter from Nabors Alaska Petroleum Services
- c. January 8, 1990 letter from David E. Rogers
- d. January 31, 1990 letter from Phillips Petroleum Company
- e. January 31, 1990 letter from NANA Regional Corporation, Inc.
- f. February 16, 1990 letter from City/Borough of Juneau
- g. February 16, 1990 letters from Wilton Adjustment Service
- h. March 1, 1990 letter from Alaska Bar Association
- i. NEW YORK TIMES articles concerning medical profession
- j. December 1, 1989 memo from John B. Gaguine, Legislative Counsel, concerning civil jury trials in other countries.
- k. February 23, 1990 letter from MICA
- l. February 27, 1990 letter from National Society of Professional Engineers

6. March 19, 1990 note and draft memo from David Rogers concerning tentative summary of claims experience information.

7. April 2, 1990 memo from Rep. Cotten to Task Force regarding MacNeil Lehrer Report and Harvard Study.

8. April 12, 1990 memo from Rep. Cotten to Task Force concerning Harvard Study materials.

9. June 17, 1990 draft final report.

C.1

CENTER FOR STUDY OF RESPONSIVE LAW

P.O. Box 19367
Washington, DC 20036
(202) 387-8030

April 13, 1989

Dear Interested Persons:

We have enclosed the following materials, which we hope will be of interest to you.

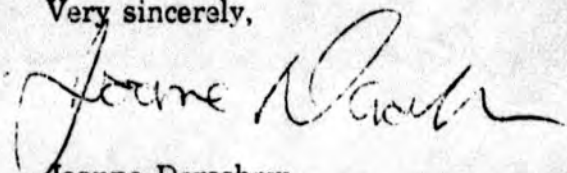
1. Fact sheets on automobile insurance and no-fault. Please be aware, however, that not all consumer groups agree on all points presented in the no-fault fact sheet. The National Insurance Consumer Organization, for example, supports a limited no-fault system, but only if full medical benefits are provided, as in Michigan -- something most insurance companies do not support. On the other hand, Ralph Nader does not support any type of no-fault system.

2. A detailed letter on what insurance companies should be doing in the area of safety and loss prevention, recently sent by Ralph Nader to Aetna chairman James P. Lynn. As you can see from Aetna's responses, which are also attached, the company has made no commitment to follow-up on the specific recommendations made in the letter.

This letter is valuable for several reasons. First, it is a comprehensive summary of what insurers could be doing to prevent accidents and why they have not made loss prevention a higher priority. Second, since Prop. 103 passed in California, the insurance industry has redoubled its efforts to co-opt consumer and public interest organizations at the national and state levels. Both publicly and privately, industry representatives have discussed the value of this "strategy" in their efforts to rebuild the insurance industry's public image. It is likely some of you may be approached by insurance representatives to discuss how you can "work together." This letter helps explain what public interest groups should expect from insurers, and what real commitment, as opposed to rhetoric, would look like.

We hope these materials are helpful. Please contact us if you have any questions.

Very sincerely,



Joanne Doroshow
Staff Attorney

FACTS ABOUT AUTO INSURANCE

- * During the past three years, auto insurance rates have risen at more than four times the rate of inflation, with even larger increases in some states.
- * Approximately 35 cents of each auto insurance premium dollar goes to pay expenses of various kinds, compared with 10 percent for health insurance. Agents' commissions and expenses connected with commissions account for about 16 cents out of each premium dollar. The total expense is approximately \$24.5 billion per year. This percentage has stayed constant over the past ten years: (34.2 for 1976-1981; 35.3 for 1981-1986; 34 for 1983-1988.)
- * Some major efficient and good service providers sell insurance for about 20 percent in expense costs. If the industry as a whole were able to compete at this level, auto insurance premiums could be reduced by 16.8 percent, or \$11.8 billion.
- * Insurance companies operate on a "cost plus percentage of costs basis." Their profit is based on a percentage of their projected costs, so the higher the cost, the greater the absolute dollar profit. Therefore, as presently constituted, insurance companies lack incentive to reduce claims and costs through better health and safety conditions.
- * The insurance industry is the only U.S. industry that is exempt from federal antitrust law, federal rate regulation, most state antitrust laws and meaningful state regulation in most states. In addition, most state laws prohibit insurance agents from competing, or lowering prices by reducing their commissions.
- * About 33 percent of the auto premium dollar goes for bodily injury costs, and 39 percent for property damage and theft.
- * Insurers frequently refuse to insure applicants with spotless driving records, forcing these consumers into a state "assigned risk" plan with generally higher rates. In New Jersey, for example, 78 percent of all assigned risks are clean, and this percentage is greatest in areas where the percentage of black and hispanic drivers is greatest.
- * Insurance companies do not advertise their prices, and applicants who ask agents for comparisons get the wrong answer one-third to one-half of the time.
- * According to data from the National Highway Traffic Safety Administration, approximately 5,000 lives are now being saved each year because of new laws which have taken effect this decade. Yet over this same period of time, auto rates have increased rapidly.
- * In its 1987 report "Trends in Tort Litigation," the insurance industry-funded Rand Corporation found that: auto litigation is a declining percentage of case filings; plaintiffs in auto cases involving modest injuries and expenses continue to obtain modest awards and, at least in recent years, these awards generally hold after trial; between 1980 and 1985, the average annual growth rate in insured defendants' average legal fees and expenses paid per claim was about 6 percent for auto (i.e., less than the rate of inflation); and, routine personal injury torts such as auto cases are growing slowly in frequency and costs, and their outcomes -- inflation adjusted -- have not changed much over the last 25 years.

HOW AUTO INSURANCE RATES CAN BE REDUCED

1. *Reduce expenses, or the costs an insurance company pays to run its business and pay claims.* This can be done through more effective state regulation, and removal of the current anti-competitive protections.

* **Repeal Antitrust Exemption.** Currently, the Insurance Services Office (ISO) sets "advisory" rates which all insurers use as a reference point in pricing, even though not all insurers adhere to these rate levels. ISO rates reflect what the least efficient company needs to make a profit. Repealing the antitrust exemption would prohibit ISO from issuing advisory rates. While companies would still have access to historical loss data, each company would have to project that data into the future itself using its own expense and profit factors to determine its rates.

* **Repeal Anti-Group Laws.** Unlike in the health or life insurance areas, most states currently prohibit auto insurance "group" plans. By banding together in a group, individual customers can increase their leverage, obtain lower rates and prod insurers to be more efficient. Consumers spend less time shopping and insurers expend fewer resources selling. (In 1986, Congress repealed anti-group laws for commercial risks).

* **Repeal Anti-Rebate Laws.** Currently, most states (not, for example, Florida or California) prevent competition among insurance agents by making it illegal for an agent to sell an insurance policy at a lower price by reducing his or her commission. The agents charge commissions set by the insurance companies. Thus, efficient agents can not lower commissions to compete for market share. These laws should be repealed.

* **Regulatory Rollback of Rates.** Where there has been an absence of competition and effective state rate regulation, insurers have raised rates to unreasonable and unjustified levels in many instances. A rate rollback, at 20 percent, for example, would be equivalent to a modest refund for prior years of insurance gouging.

* **Regulatory Approval of Rates.** The state department of insurance must be given authority to approve rates before their becoming effective, or approve those rates which fall above or below a certain range -- no more than 15 percent over the previous 12-month period. This authority should be combined with a public hearing requirement.

* **State Mandated Underwriting and Rating Criteria -- "Good Driver" Discount.** With very few exceptions, insurance companies now can reject an applicant for any reason or for no reason. In setting rates, most insurers give primary weight to territory (neighborhood), occupation, gender and marital status. Often times insurers will reject drivers with clean records. The state should establish, at a minimum, that an individual who meets "good driving" criteria have a legal right to buy insurance from any company doing business in the state and get a 20 percent discount. In setting rates, the key criteria should be: 1. driving record, 2. mileage (driving exposure) and 3. years of driving experience.

* **Computerized Consumer Information Service.** This should be set up by the state to allow insurance buyers to comparison shop. In addition to price information, the

state should make available information on: how long it takes to settle claims, the percentage of claims which go to court, the costs of providing insurance in the state, assessments of reserve accuracy, and similar information. Applicants would be able to either call an "800" number, or access computers to obtain this information.

* **More Accountable and Effective State Insurance Commissioners.** Insurance commissioners should be elected by the citizens, rather than serve as a revolving door advocate of the insurance industry. And commissioners' offices should be upgraded, with improved funding, systems for ongoing market conduct examinations, sufficient numbers of examiners and actuaries, automated systems and effective handling of consumer complaints.

* **Consumer Representation.** To foster effective and independent citizen representation, insurers should be required to notify all insureds, when they are billed, about the opportunity to join voluntary citizen advocacy organizations -- Citizen Insurance Boards -- for a small membership contribution. These groups would represent consumers' interests in rate proceedings and other insurance matters.

2. Reduce "loss cost," or the amount the insurance company estimates is necessary to pay claims. This can be done by requiring insurers to take into account risk factors that are likely to reduce or increase their costs, and to seek adoption of loss reduction policies by government and industry.

BODILY INJURY COSTS

* **Better Consumer Information.** The government should require ratings of vehicle crashworthiness placed on new car window stickers to assist buyers in selecting safer cars.

* **Air Bags.** In addition to mandatory regulations for air bags or their equivalents, insurance companies should retro-fit their cars with air bags, and equip their own entire company fleets with air bags as Travelers Insurance Co. has done.

* **Side Impact Protection.** Side impact protections standards should be upgraded to reduce thoracic/abdominal injuries, head injuries from contacts with the A-pillar, and side door ejection, particularly in car-to-car side impact crashes.

* **Rollover Protection.** A new safety standard for vehicle stability is needed, with a requirement for antilock brakes for these vehicles. Current minimal roof crush requirements should be upgraded and applied to vans and light trucks.

* **Light Truck and Van Safety.** The vehicles in this rapidly growing segment of the automotive market are used commonly as substitutes for cars, yet they do not have to comply with some key car safety standards. The car requirements for automatic restraints, head restraints, roof crush and side impact protection should be applied to these vehicles.

* **Large Truck Safety.** With 62 percent of truck occupant fatalities occurring in rollover crashes, improved handling and stability requirements are needed.

- * **Improved Steering Assemblies.** Steer assembly technologies which are more forgiving -- self-aligning, self-centering and padded -- should be required.
- * **Interior Component Improvements.** Better management of crash energy in frontal crashes is possible, such as eliminating hard surfaces on instrument panels, improving windshields, and padding the A-pillar and roof headers.
- * **Rear Seat Shoulder Harnesses.** Rear shoulder harness/lap belts are 8 percent to 10 percent more effective than lap belts alone.
- * **Pedestrian Crash Protection.** Pedestrians are consistently involved in 2 percent of highway crashes but account for 16 to 18 percent of fatalities. Long delayed standards to make striking vehicles more forgiving, and rules to soften the front ends of cars, reduce hood stiffness, lower underhood components, eliminate frontal protrusions and lower the impact surface below the bumper, are needed.
- * **Stronger Rules of the Road.** Insurance companies should push more strongly for:

Nationwide enactment of seat belt use laws;
 Repeal of the 65 mph speed limit;
 Better alcohol control on the highway;
 Motorcycle helmet use laws.

PROPERTY DAMAGE COSTS

- * **Reduce Damage in Low Speed Crashes.** The 5 mph bumper standard set in 1980 has been reduced to 2 1/2 mph, resulting in hundreds of millions more each year in unnecessary repair costs. The Department of Transportation should reissue this standard at 5 mph.
- * **Increase Competition to Lower Prices of Parts.** Aftermarket crash parts for years have been overpriced because of monopoly control by original equipment manufacturers, but this is beginning to change as more competition occurs, particularly from imports. State laws that prevent use of competitive replacement parts should be changed.
- * **Labor and Repair Cost.** If cars were better designed for repairability, there could be significant labor cost savings. Also, NHTSA should issue information by make and model of crashworthiness and damage susceptibility data. This information should be placed on new car window stickers.
- * **Control of Theft and Fraud.** Existing steering wheel lock, crash parts marking, and other federal standards to deter motor vehicle theft and fraud should be re-evaluated and upgraded. In addition, insurers should push auto companies to design more theft-resistant locks, especially GM whose locks car thieves have long known are easy to defeat.

From March, 1989 report, "Consumer Plan: To Cut Auto Insurance Rates 25%," National Insurance Consumer Organization and Public Citizen. Prepared by Center for Study of Responsive Law; (202) 387-8030.

###

THE PROBLEM WITH NO-FAULT AUTO INSURANCE

- **WHAT IS NO-FAULT AUTO INSURANCE?**

No-fault auto insurance is a system of compensating people injured in car accidents. It requires the victim to recover medical costs, lost wages and certain other economic expenses from his or her own insurance company and prohibits the victim from suing the individual at fault in the car accident.

- **WHAT ARE THE GOALS OF NO-FAULT AUTO INSURANCE?**

The major goals of no-fault are: to allow more injured victims to obtain quicker compensation for injuries; and to lower auto insurance rates.

- **HOW WELL DOES NO-FAULT AUTO INSURANCE ACCOMPLISH THESE GOALS?**

- **Compensating Victims**

Auto no-fault plans, particularly those which do not provide compensation for full medical benefits, can reduce the amount of compensation payable to most victims in the following ways:

- **No "Pain and Suffering" or "General Damages" are Allowed.** No-fault plans provide compensation for some amount of medical expenses, wage loss and other economic loss, depending on the benefit levels established by the no-fault law. However, no-fault plans preclude any compensation for the special circumstances of an individual injury, such as the extent to which the injury has permanently disrupted and reduced the quality of the victim's life, or caused pain and suffering.

For example, a victim immobilized by torn ligaments or painful massive muscle spasms can receive no compensation either for the pain suffered or for the effect the injury might have on the victim's daily life and family.

Senior citizens, homemakers and children, whose damages are not typically based on economic worth, are hit hardest by such limits.

In order for a victim who is not at fault in the accident to obtain compensation for this type of loss, the individual must bring a court action. However, most no-fault laws have strict monetary or verbal "thresholds" which prohibit such a "tort action" unless certain conditions are met.

- **Thresholds.** A "verbal threshold" means that a victim must suffer serious impairment of body function, permanent serious disfigurement, or death, to be able to sue. Monetary thresholds require the victim's medical damages to meet a certain limit before a court action is permitted. Verbal thresholds

are usually much more difficult to meet -- and much less fair to the victim -- than medical thresholds. They also invite litigation since verbal threshold categories are often vague and are subject to varying interpretations. New York, Michigan and Florida have "verbal thresholds."

- **Medical and Other Economic Losses Are Limited.** Most state no-fault plans preclude compensation for full medical expenses. Michigan is one notable exception. Michigan provides for unlimited medical and hospital expenses and past wages up to \$1,475 per month, adjusted annually to keep up with the Consumer Price Index. Florida's plan, on the other hand, limits medical benefits to only \$10,000, reimbursing only 80% of medical expenses and 60% of lost income. Many other plans are worse than Florida's.

- **Victims Are Without Assistance of Counsel in Dealing With Insurance Companies.** Insurers' resistance to pay a claim is the same, whether involving a third party under traditional liability rules, or a first party under no-fault. (No-fault pays only for the medical expenses of which an insurer approves.) The tendency to delay payment is the same, particularly if a large sum is at issue. Because victims under no-fault lose their rights to sue in court, they lose the best advantages they have in dealing with insurance companies -- access to attorneys, and the threat of a personal injury lawsuit.

The threat of a suit is often a more important factor in assuring the victim gets fair compensation than litigation itself. Even in traditional liability states, litigation is only a last resort for most claimants. Most cases are settled before a suit is filed, or before trial. Only a tiny percentage of the total claimants ever proceed to actually litigate a case. However, it is ultimate access to the legal system and the threat of a suit, where a judge or jury makes the decision, that helps restrain the insurance companies from exploiting their more powerful bargaining position and affording less than the deserved compensation.

- Lowering Rates

- **No-Fault Does Not Lower Rates.** This is particularly true when no-fault plans provide adequate medical and economic benefits. Michigan's insurance department has concluded in several studies that Michigan's no-fault law does not save money. The Department of Transportation's 1984 report showed that no-fault premiums in the final year of the study were 40 percent higher than premiums in tort states.

New York has a verbal threshold, and limits compensation to \$50,000 for medical benefits, and 80% of actual wage loss, with no more than \$1,000 per month. Rates dropped when New York enacted the verbal threshold. However, this was due primarily to increased state regulatory control over rates. Even so, auto insurance rates in New York remain among the highest in the nation.

- **An Analysis Released by "Project New Start," that No-Fault will Save Consumers \$3.7 Billion Annually in Premiums, is Bogus.** A organization called "New Start," representing itself as a "consumer organization," is traveling to states throughout the country advocating the adoption of no-fault with a verbal threshold -- a concept supported by the insurance industry. The group says it is funded by membership contributions, but it has obtained support and plans to

seek financial contributions from insurance companies. Other consumer groups, including the National Insurance Consumer Organization, the Consumer Federation of America and Consumers' Union, have disassociated themselves from Project New Start.

The group argues that such a plan would save consumer's \$3.7 billion annually. This figure is bogus because it does not properly factor in varying benefit levels -- one of the key determinants of rates under no-fault plans. Rather, the analysis evaluates as a group three verbal threshold states -- New York, Michigan and Florida -- each with widely varying benefit levels. Florida's benefits are woefully inadequate. New York's are not much better. The unfairly low benefits in these two states are probably the major reason New Start's analysis shows any savings at all.

And while victims get less, the total rate savings predicted by New Start amount to only \$3.7 billion -- less than 5 percent of the total auto premiums paid in this country. Most of this savings can be attributed to the low benefit levels in Florida and New York.

- **Premium Increases in No-Fault States Contributed to the Repeal of No-Fault in Pennsylvania, Nevada and South Carolina.**

- **One Reason No-Fault May Not Lower Rates is Because It Does Not Significantly Reduce Litigation.** As one commentator put it, "No-fault ... is a new game with new rules, causing new controversies.... No-fault has inherited issues that have given rise to extensive litigation in medical payments, and uninsured motorist coverage, such as the meaning of 'occupying' an automobile.... Whatever the advantages of no-fault, a reduction in court cases and court costs would not appear to be one of them." Risjord, "Does No-Fault Reduce Litigation?" *Insurance Counsel Journal*, July, 1986 at 389. Verbal threshold no-fault plans also can lead to an increase in litigation because of the controversy surrounding application of the threshold.

- **WHAT ARE SOME ADDITIONAL PROBLEMS CREATED BY AUTOMOBILE NO-FAULT PLANS?**

- **Some Evidence Suggests that No-Fault Can Lead to More Auto Accidents.** In their 1987 book *The Economic Structure of Tort Law*, conservative theorists William M. Landes and Richard A. Posner wrote that tort law deters auto accidents, even though liability insurance is widespread and personal safety might be expected to be of greater concern than the potential financial consequences of an accident. (Others have observed that driver safety may stem from fear over premium increases resulting from receiving a citation for a moving violation.) Landes and Posner, who say their review of the empirical literature relating to the effects of tort law on automobile accidents suggests that tort law leads to lower accident rates, reason that if the incentive to take care is reduced, probabilistically, people will be less careful, and the infrequent but cumulatively significant result will be more fatal accidents.

- **Under No-Fault, Drunk or Reckless Drivers Are Not Held Personally Responsible for their Conduct.** Under no-fault, the costs of injuries are misallocated -- by category

of drivers who suffer injury, not by category of drivers who cause injuries. Drunk and reckless drivers are excused from paying for the harm they cause, and instead, the victims' insurance company pays. Careful drivers end up subsidizing negligent drivers.

- **WHAT ABOUT GIVING CONSUMERS THE OPPORTUNITY TO CHOOSE EITHER A NO-FAULT OR TRADITIONAL LIABILITY POLICY?**

Some have argued in favor of giving consumers a choice between a no-fault and a traditional liability policy. However, in practice, such a system is unworkable and discriminates against the individual who chooses the traditional liability policy. If a consumer who chose to remain in the tort system were hit and injured by a no-fault policyholder, this victim would not have a tort remedy. The victim would be precluded from suing the no-fault policyholder, and would be forced to sue his or her own insurance company for compensation -- as if the victim were hit by an uninsured motorist. As greater numbers of consumers chose no-fault policies, chances would increase that the remaining tort policyholders would end up suing his or her insurance company for compensation. Thus, traditional liability rates would rise and no-fault rates would drop. Eventually, rates would be so different that a realistic choice would no longer exist.

- **WHAT ARE THE SOLUTIONS TO THE AUTO INSURANCE CRISIS?**

No-fault is no solution. Whatever savings are achieved under no-fault are at the expense of victims. The only real solutions to the auto insurance crisis are to force the insurance industry to operate more efficiently by eliminating state and federal antitrust exemptions, repealing anti-rebate laws and fictitious group laws; to enact regulatory controls over insurers' rates and practices, and to eliminate and reduce costs of claims by preventing injuries and deaths, reducing health care and repair costs, and cracking down on abuse and fraud. As long as insurers are permitted automatically to pass these costs through to their policyholders, they will have no incentive to reduce these costs and lower rates.

In addition, the tort liability system can be greatly improved by dealing with court congestion and unjustified delays by counsel; by improving access to the courts for victims through the development of more efficient economies of scale for servicing similar liability cases by lawyers; and by adequately disciplining abuses or legal malpractice. For example, arbitrary protective orders, and settlements in which insurance companies require that information they provide victims be kept completely confidential, should be prohibited where important safety information is involved. Easy access to this information not only could lead to hazard alerts and policies, from consumers and public agencies, but also could cut legal discovery costs and legal fees.

**SEE THE ACCOMPANYING FACT SHEET
ON REDUCING AUTOMOBILE INSURANCE RATES**

Prepared by the Center for Study of Responsive Law, P.O. Box 19367, Washington, DC, 20036, (202) 337-8030.

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TORT REFORM: WHAT WORKS, AND WHAT DOESN'T

There are no sure bets. In some states, tort reform has reduced awards and slowed the rise in premiums. In others, it's been a flop.

By James E. Schutte SOUTHWEST EDITOR

Tort reform, say its critics, just isn't doing the job.

One of its chief goals—stabilizing malpractice premiums—hasn't been realized, despite round after round of legislative changes. Last May, in fact, the General Accounting Office concluded that tort reform offers no guarantee that insurance rates won't continue to increase.

Proponents, however, maintain that tort reform can pay off, making malpractice insurance not only more available but also more affordable. As proof, they cite the success of Indiana's Medical Malpractice Act of 1975.

Enacted while Otis R. Bowen, M.D., now U.S. Secretary of Health and Human Services, was governor, the Indiana statute limits a patient's total recovery to \$500,000. It also imposes a two-year statute of limitations on malpractice filings and provides for pretrial screen-

ing to determine the merits of a claim.

In the law's first 10 years, Indiana's major carrier posted no premium increases. When rates finally did go up, in 1985, the increase was just 12 percent. Premiums, which before the reforms had been higher than those of surrounding states, are now among the nation's lowest.

In some other states, though, tort reform has failed. In Florida, for instance, repeated legislative efforts have proved ineffective or, as in the case of the state's version of a pretrial screening panel, unconstitutional. Still, ever steeper malpractice premiums have goaded this state, like many others, to keep trying. Last February, the Florida legislature approved a statute that calls for increased arbitration of malpractice claims and ceilings on non-economic damages.

Meanwhile, the American

Medical Association, while saying it hasn't given up on efforts to fine-tune the jury system, wants to explore new alternatives. It recently unveiled a proposal to transfer medical-malpractice cases from the courts to a fault-based administrative system modeled along the lines of workers' compensation. For details on this proposal, see page 210.

Some "solutions" that haven't helped

Why are some reforms more effective than others? A number of studies have attempted to find out.

Several were written by Patricia Danzon, a health economist at the University of Pennsylvania and one of the most influential tort reform researchers. Another important study comes from the Physician Insurers Association of America, a coalition of doctor-owned mal-

went to trial. Indeed, PIAA projections conclude that an increase in arbitration would actually raise rather than lower its carriers' expenses.

Such concerns notwithstanding, Florida has enacted a new arbitration program. Though this program is voluntary, a number of built-in incentives may promote its use.

These reforms seem promising

While some so-called solutions haven't helped, other reforms look like they might have a positive impact. Experts disagree about how much money they'd save, but these seem to be the most promising:

Caps on damages. Although some state courts have struck them down, the PIAA favors these caps, which would limit so-called "pain-and-suffering" awards. The United States Supreme Court in 1985 refused to hear a challenge to California's \$250,000 ceiling, which bodes well for similar ceilings in other states.

Caps on damages reduce the size, though not the frequency, of malpractice awards, according to health economist Patricia Danzon. She estimates that limits on non-economic damage would lead to a 23 percent reduction in malpractice payouts. The PIAA puts possi-

ble savings at 5 percent to 18 percent.

Pretrial screening. The objective here is to weed out suits that aren't meritorious and to encourage quick settlement of those that are. The potential for savings stems from the fact that, according to PIAA statistics, carriers spend an average of \$7,000 to process a claim—even if, as in two suits out of three, the plaintiff is never awarded any money. In other words, fewer suits mean lower costs.

Several states have established mandatory pretrial screening panels. Their findings are non-binding but often admissible in court. In Indiana, where this has been the keystone of tort reform, one carrier spent an average of only \$2,100 to defend a claim in 1986—in part because only 2 percent of that insurer's claims went to court.

Although pretrial screening reduces the number of malpractice trials and the total amount of money paid out, it may increase the number of claims filed. That's because plaintiff's attorneys frequently use the system to get comparatively quick and inexpensive payouts for marginal cases they'd otherwise turn down. Even so, pretrial screening saves carriers money in the long run by dis-

couraging attorneys from taking non-meritorious cases to trial—especially where panel findings are admissible as evidence.

Subtracting other insurance reimbursements from the award. In many cases, a successful plaintiff can collect twice for medical expenses—once from his own health or disability insurer, then a second time from the sued doctor's malpractice carrier. In most states, collateral-source rules permit this kind of double dipping.

Advocates want the rules changed to require that multiple payments be revealed and subtracted from an award or settlement. How much would this save? Both Danzon and the PIAA foresee a 10 percent to 15 percent cut in malpractice carriers' expenses.

Periodic payments on large awards. Under these so-called structured settlements, awards beyond a certain threshold—typically \$100,000—are paid out in installments over a period of years. Should a plaintiff die before payment of the final installment, any money earmarked for ongoing medical care would not be paid.

Insurers contend that even plaintiffs benefit from such an arrangement, since it guarantees that their long-term needs

CORRECTION

**THIS DOCUMENT
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The tort system doesn't make bad doctors accountable. The damage they do is paid for by good doctors through higher premiums for liability insurance.

LOUIS R. ZAKO, M.D.
Family Physician, Dearborn Heights, Mich.

practice insurance companies.

These studies analyze the most—and least—promising solutions. The latter include:

No-fault insurance. This is supposed to speed up settlements and reduce doctor-patient friction. But eliminating the concept of fault allows virtually any patient who suffers an adverse result to apply for compensation without having to prove negligence. A no-fault system in New Zealand has led one in five of that nation's inhabitants to file claims every year.

The PIAA estimates that a no-fault system in this country would mean a threefold to tenfold increase in the number of payouts. Even though the average payment might be lower than it is now, with marginal claims getting paid off at comparatively low levels, the over-

all impact would probably be a big increase in total payments.

Doctor-patient contracts. According to the PIAA, no document that holds a doctor harmless in the event of malpractice is likely to survive judicial scrutiny. Even contracts that merely limit a doctor's liability or require the arbitration of malpractice claims will probably get shot down in court.

Assessing legal fees to the loser. The only state to try this ploy has been Florida, which quickly scrapped it once before resurrecting it as part of its most recent tort reform legislation. The idea is to discourage suits by plaintiffs who, under the contingency-fee system, have everything to gain and nothing to lose. Trouble is, when a plaintiff loses, he can simply declare bankruptcy and walk away.

When a doctor loses, he not only has to pay off the judgment and his own lawyers, but the plaintiff's attorneys as well.

Under the new law, someone who appeals an arbitration award will be liable for the opposing party's expenses, including legal fees, if he fares less well in court than he did in front of the arbitration panel.

Arbitration. While most states provide for *voluntary* arbitration, experts agree that any attempt to make arbitration both mandatory and binding will almost certainly be seen as an unfair restriction on the right to a jury trial.

Arbitration, moreover, tends to encourage non-meritorious cases. According to the PIAA, arbitrators often arrive at compromises that result in payments to plaintiffs who would probably lose if their disputes

went to trial. Indeed, PIAA projections conclude that an increase in arbitration would actually raise rather than lower its carriers' expenses.

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Insurers contend that even plaintiffs benefit from such an arrangement, since it guarantees that their long-term needs

will be met. Under the system of lump-sum payments, plaintiffs typically exhaust their awards within five years.

Backers of structured settle-

ments contend that if a plaintiff wants all of his cash up front, he should have to accept a smaller settlement. For this and other reasons, the PIAA esti-

mates that periodic payments would save its member carriers about 6 percent a year. For more on periodic payments, see page 157.

WHAT THE STATES HAVE TRIED

Here's a state-by-state tally compiled by the American Medical Association of major tort reforms as of the end of 1987.

	Caps on awards	Periodic payments	Collateral-source offsets	Arbitration	Limits on attorney fees	Pretrial screening
	1	1	1a	1		
	1	1	1	1		1
			2a		1b	2
						3
	2	2	2a	1	2	
	1		1		1b	1c
		3	1		1	1
			1a		1	1
	3	2	2	1	2	1c
	1		1a	1		
	1				1b	1c
	1		3		3	1c
	3	2	2	1	2	3
	2		1a		2	2
			2		1b	
	1	1	3		1b	1c
	1	1		1		2
		1		3	1	1
	1				1b	1
	1		1		1	2
	1	1	1	2	1	1d
	1		1			

1—Enacted

2—Upheld by state Supreme Court

3—No longer in effect (expired, overturned, or repealed)

a—Collateral sources must be disclosed, but court or jury will decide whether to subtract from award

b—Attorney fees not automatically limited, but will be reviewed by court for "reasonableness"

c—Decision of screening panel is not admissible during trial

d—Statute doesn't say whether or not panel's decision is admissible

Contingency-fee limits. The GAO-sponsored Tort Policy Working Group has proposed a sliding scale for attorney's fees. Under this scale, a plaintiff's at-

torney would get 25 percent of the first \$100,000 of an award and a lesser percentage of anything over that amount. Above \$300,000, an attorney's fee

would level off at 10 percent.

Plaintiffs would surely welcome this reform; under the present system, lawyers sometimes claim more than half of a

trial
ning

	Caps on awards	Periodic payments	Collateral-source offsets	Arbitration	Limits on attorney fees	Pretrial screening
	1	1				3
		1	1			2
	2		2		2b	2
						1
	1		3		1b	1c
			1		1	3
	1	1				1c
		1	1	1	1	2
	3	1	1	3		3
	1	1	1	1		2c
					1	
	1		1a		1	
			3		3	3
			1			3
		1				
	1	1	1a	1		
			1		1	3
	1					
	1	1	1	1	1	1c
				1		
	1			1		1
	1	1	1a		1b	
	1					
	1	3			1	3
					1b	1c

malpractice award. Many doctors also would like it—and the slap it takes at lawyers' earnings—even if it didn't save money for insurers. But the PIAA reports that contingency-fee limits would be likely to result in savings—an estimated 9 percent of payouts—by reducing the financial incentives for lawyers to hold out for large awards.

Shorter durations for statutes of limitation. This reform

THE AMA TRIES ITS HAND AT MALPRACTICE REFORM

Frustrated at being the passive victims of the malpractice crisis, the American Medical Association and 32 other medical groups have come up with their own ambitious solution.

In a plan released early this year, the AMA and its allies propose removing malpractice claims from the jury system, tightening the legal definition of liability, and beefing up discipline to help put bad doctors out of business.

"More patients injured by medical negligence will be compensated under this plan, and fewer dollars will be spent on meritless claims," says James S. Todd, M.D., AMA senior deputy executive vice president. He adds that several states have expressed interest in testing the plan, which would establish new state agencies to decide malpractice claims and take over physician licensing and discipline.

Under the proposal, any patient with a malpractice complaint could have it considered by his state's agency. Reviewers would start by deciding whether or not the case appeared to have merit. Patients with claims deemed to be legitimate would be offered free legal counsel. Others would have to hire their own lawyers if they chose to pursue their claims in the face of a negative assessment.

Each case would go to a state hearing examiner, who would have 90 days to decide whether to dismiss the matter or make an award. His decision would be reviewed by a medical board on which doctors would have minority representation. While the new system would supplant a patient's right to a jury trial, either doctors or patients could appeal procedural questions to state courts.

In deciding malpractice awards, the state agencies would adopt many popular features of recent malpractice reform legislation. Instead of having to prove that they'd met generally accepted standards of care, for example, accused doctors would have to show only that they'd acted as "prudent and competent practitioners."

The AMA would also change the liability standard to allow patients to recover damages anytime a doctor's negligence is a "contributing factor" in causing an injury—even if the physician is less than 50 percent at fault. The plan would cap non-economic damage awards at \$700,000, set periodic-payment schedules for damage awards exceeding \$250,000, and reduce awards by the amounts of collateral-source payments.

The new state agencies would also have investigatory branches assigned to monitor physician conduct, and they'd get expanded powers to put bad doctors out of business.

Because the AMA's proposal would limit frivolous claims and cut excessive pain-and-suffering awards, liability insurers say it could stabilize malpractice premiums. "The plan goes a long way toward dealing with some of the most serious problems of the current system," says Donald J. Fager, vice president of the Medical Liability Mutual Insurance Co.

But plaintiff's attorneys claim the plan could be challenged successfully on constitutional grounds. "In this country people have a right to a jury trial and redress for injuries and economic loss," says Baltimore plaintiff's attorney Marvin Ellin. "If the AMA doesn't like that, it'll just have to change the constitution."

XANAX® Tablets
(alprazolam) G

INDICATIONS AND USAGE

Anxiety disorders, short-term relief of the symptoms of anxiety, and anxiety associated with depression. Anxiety or tension associated with the stress of everyday life usually does not require an anxiolytic. Effectiveness for more than four months has not been established; periodically reassess the usefulness of the drug for the individual patient.

CONTRAINDICATIONS

Sensitivity to XANAX or other benzodiazepines, and in acute narrow angle glaucoma.

WARNINGS

Benzodiazepines can cause fetal harm in pregnant women, hence women who may become pregnant should be warned. Avoid during the first trimester. Withdrawal seizures have been reported upon rapid dose reduction or abrupt discontinuation, thus reduce dose gradually. (See Drug Abuse and Dependence and Dosage and Administration.)

PRECAUTIONS

General: If XANAX is combined with other psychotropics or anticonvulsants, consider drug potentiation. (See Drug Interactions.) Use the usual precautions in patients with renal or hepatic impairment and regarding prescription size in depressed and suicidal patients. In elderly and debilitated patients, use the lowest possible dose. (See Dosage and Administration.) Hypomania and mania has been reported in depressed patients.

Information for Patients: Alert patients about: (a) consumption of alcohol and drugs, (b) possible fetal abnormalities, (c) operating machinery or driving, (d) not increasing dose of the drug due to risk of dependence, (e) not stopping the drug abruptly.

Laboratory Tests: Not ordinarily required in otherwise healthy patients.

Drug Interactions: Additive CNS depressant effects with other psychotropics, anticonvulsants, antihistamines, ethanol and other CNS depressants. Plasma levels of imipramine and desipramine are increased. Pharmacokinetic interactions with other drugs have been reported. Cimetidine can delay clearance of benzodiazepines.

Drug/Laboratory Test Interactions: No consistent pattern for a drug or test.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No carcinogenic potential or impairment of fertility in rats.

Pregnancy: See Warnings. **Nonteratogenic Effects:** The child born of a mother on benzodiazepines may be at some risk for withdrawal symptoms, neonatal flaccidity and respiratory problems.

Labor and Delivery: No established use.

Nursing Mothers: Benzodiazepines are excreted in human milk. Women on XANAX should not nurse.

Pediatric Use: Safety and effectiveness in children below the age of 18 have not been established.

Adverse Reactions: Side effects are generally observed at the beginning of therapy and usually disappear with continued medication. In the usual patient, the most frequent side effects are likely to be an extension of the pharmacologic activity of XANAX, e.g., drowsiness or lightheadedness.

Central nervous system: Drowsiness, lightheadedness, depression, headache, confusion, insomnia, nervousness, syncope, dizziness, akathisia, and tiredness/sleepiness.

Gastrointestinal: Dry mouth, constipation, diarrhea, nausea/vomiting, and increased salivation.

Cardiovascular: Tachycardia/palpitations, and hypotension.

Sensory: Blurred vision.

Musculoskeletal: Rigidity and tremor.

Cutaneous: Dermatitis/allergy.

Other side effects: Nasal congestion, weight gain, and weight loss.

Withdrawal seizures with rapid decrease or abrupt discontinuation. (See Warnings.)

The following adverse events have been reported with benzodiazepines: dystonia, irritability, concentration difficulties, anorexia, transient amnesia or memory impairment, loss of coordination, fatigue, seizures, sedation, slurred speech, jaundice, musculoskeletal weakness, pruritus, diplopia, dysarthria, changes in libido, menstrual irregularities, incontinence, and urinary retention.

Paradoxical reactions such as stimulation, agitation, rage, increased muscle spasticity, sleep disturbances, and hallucinations may occur. Should these occur, discontinue the drug.

During prolonged treatment, periodic blood counts, urinalysis, and blood chemistry analysis are advisable. Minor EEG changes, of unknown significance, have been observed.

Liver enzyme elevations, gynecomastia and galactorrhea have been reported but no causal relationship was established.

DRUG ABUSE AND DEPENDENCE

Physical and Psychological Dependence: Withdrawal symptoms including seizures have occurred following abrupt discontinuance or rapid dose reduction of benzodiazepines. (See Warnings.) Dosage should be gradually tapered under close supervision. Patients with a history of seizures or epilepsy should not be abruptly withdrawn from XANAX. Addiction-prone individuals should be under careful surveillance.

Controlled Substance Class: XANAX is a controlled substance and has been assigned to schedule IV.

OVERDOSAGE

Manifestations include somnolence, confusion, impaired coordination, diminished reflexes and coma. No delayed reactions have been reported.

DOSE AND ADMINISTRATION

Dosage should be individualized.

The usual starting dose is 0.25 to 0.5 mg, t.i.d. Maximum total daily dose is 4 mg. In the elderly or debilitated, the usual starting dose is 0.25 mg, two or three times daily.

Reduce dosage gradually when terminating therapy, by no more than 0.5 mg every three days.

HOW SUPPLIED

XANAX Tablets are available as 0.25 mg, 0.5 mg, and 1 mg tablets.

CAUTION:

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION.

THE UPJOHN COMPANY
Kalamazoo, Michigan 49001, USA

1-9134
April 1988

Tort reform

would have three major benefits—reduced uncertainty and liability for carriers, faster resolution of claims, and more defensible cases for physicians. With a shorter statute, a doctor's memory would be fresher and he'd be less likely to lose track of records and witnesses.

According to Patricia Danzon, trimming one year from the statute of limitations—regardless of the length of a state's current limit—would reduce the frequency of claims by an average of 8 percent.

**How to make
tort reform pay off**

There are two keys to getting the benefits of tort reform. One is realistic expectations. The other is patience.

Tort reform won't magically eliminate malpractice nightmares, and it probably won't even roll back premiums. But according to Danzon, it does offer other benefits.

She argues that the real crisis in malpractice insurance is caused by the present inability of carriers to predict future losses. In her view, most reforms that make payouts less volatile and more predictable are worthwhile, even if payouts continue to get bigger.

The advocates of patience point to California, where 10 years passed before doctors and insurers could enjoy the full