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A Chronic Concern No More: How Federal Medical Malpractice Caps Will Survive Under the Equal Protection Clause of the United States Constitution

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A CHRONIC CONCERN NO MORE: HOW FEDERAL MEDICAL MALPRACTICE CAPS WILL SURVIVE UNDER THE EQUAL PROTECTION CLAUSE OF THE UNITED STATES CONSTITUTION

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There is a great rift between the legal and medical professions over medical malpractice tort reform.[1] In fact, many doctors not only dislike lawyers, but also completely "mistrust the American adversarial system of justice."[2] Doctors and hospitals argue that there is a crisis in America as high jury awards in medical liability cases are forcing doctors to either practice "defensive medicine"[3] or halt their practice of medicine altogether.[4] Conversely, lawyers see doctors as selfish and unsympathetic towards their patients, especially those patients who become victims of medical malpractice.[5] Trial lawyers believe that their clients are entitled to the just compensation the judicial system

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1. *See* John Gibeaut, *The Med-Mal Divide*, A.B.A. J., March 2005, at 40. *See also* Kenneth Jost, *Courts and the Law: Malpractice Blame Game*, CQ WEEKLY, March 28, 2005, http://www.cq.com (last visited Aug. 25, 2005).

2. Gibeaut, *supra* note 1, at 40.

3. Defensive medicine is generally defined as the ordering of unnecessary and excessive tests by doctors in order to avoid medical malpractice suits. It is considered a factor in increasing costs for health care providers and thus the insurance providers. *See* U.S. Cong., OFFICE OF TECHNOLOGY ASSESSMENT, REP. NO. OTA-H-602, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE, 13 (1994), *available at* http://www.wws.princeton.edu/ ota/ disk1/ 1994/ 9405/ 9405.PDF; *but see* CONGRESSIONAL BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE 6 (2004), http://www.cbo.gov/ ftpdocs/ 49xx/ doc4968/01-08-MedicalMalpractice.pdf [hereinafter CBO] (the practice of defensive medicine may not translate into savings for rising health care costs).

4. *See generally* AM. MEDICAL ASS'N, AMERICA'S MEDICAL LIABILITY CRISIS (2005), http://www.ama-assn.org/ ama1/pub/ upload/mm/ 399/mlr_tp.pdf (there are numerous arguments that can be made in order to reform the medical malpractice tort system, but these points will not be discussed.)

5. *See* Jost, *supra* note 1.

allows.[6] Clearly, there is a schism between these professions, with much at stake for both sides.[7]

Consequently, medical malpractice tort reform is also a charged political issue. Since the 1970s, legislative bodies have come forward to reform medical malpractice litigation.[8] Legislatures have attempted to ameliorate the medical malpractice insurance system via various methods, including restrictions of lawyers' contingency fees, statutes of limitations on medical malpractice claims and limits on punitive damages.[9] Another popular reform method, similar to punitive damages restrictions, is capping noneconomic damages, i.e., damages given for "pain and suffering."[10] A number of states have passed noneconomic damages caps that have attempted to reform their medical malpractice tort systems.[11] Accordingly, it is worthwhile to

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6. *See generally* Press Release, Ass'n of Trial Lawyers of Am., The Truth about Caps—They Don't Work (Sept. 22, 2006) (on file with author). There are numerous arguments that can be made for not reforming the medical liability system, however, these arguments will not be discussed here. In fact, it has been frequently observed that both sides of the debate, always armed with "a welter of wrenching anecdotes," have conflicting statistics. Kenneth Jost, *Medical Malpractice: Are Lawsuits Out of Control?*, THE CQ RESEARCHER, vol. 13, no. 6, at 132-33 (2003) [hereinafter CQ RESEARCHER] (on file with author).

7. The driving forces behind these stakes are primarily financial. *See infra* Part I.A.

8. Currently, only state legislatures have enacted policies to curb medical malpractice litigation. The U.S. Congress has not passed any laws concerning medical malpractice reform. *See infra* Parts I.B and I.C.

9. *See* Staff Of Joint Econ. Comm., 109th Cong., Liability For Medical Malpractice: Issues And Evidence 20 (Comm. Print 2003), *available at* http://www.house.gov/jec/tort/05-06-03.pdf [hereinafter Joint Econ. Comm.]; *see also* Henry Cohen, Congressional Research Service, Medical Malpractice Liability Reform: Legal Issues And Fifty-State Survey Of Caps On Punitive Damages And Noneconomic Damages 3-11 (2005), *available at* http://shelby.senate.gov/legislation/ MedicalMalpractice.pdf.

10. *See* COHEN, *supra* note 9, at 3-5 (quoting W. PAGE KEETON, PROSSER AND KEETON ON TORTS § 31 (5th ed. 1984)). Noneconomic damages "refer to monetary losses that result from an injury . . . [and] consist primarily of damages for pain and suffering" while punitive damages are given under "circumstances of aggravation or outrage, such as spite or 'malice,' or a fraudulent or evil motive on the part of the defendant . . . ." *See also* CBO *supra* note 3, at 3 (listing definitions for frequently used tort terms). *See generally* COHEN, *supra* note 9, app. at 12-19 (providing a chart of state laws that limit punitive and noneconomic damages in medical malpractice cases).

11. Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damage Caps,* 80 N.Y.U. L. REV. 391, app. at 496 (2005) (stating that currently

focus on this type of reform. Some state and federal courts have struck down these caps as unconstitutional, while other courts have found these caps constitutionally valid.[12] State damages caps have been examined in light of such issues as equal protection, due process, separation of powers, and the right to a jury trial.[13]

In the past several sessions, the United States Congress has attempted to enact federal damages caps specifically for medical malpractice cases.[14] The 109th Congress is no exception; members have introduced numerous bills on this subject.[15] The language of these bills is similar to that from previous sessions, suggesting that the

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twenty four of the fifty states have damages caps specifically for medical malpractice cases and listing statutory citations for each law). *See also* William R. Paget, Comment, *Damage Limitation in Medical Malpractice Actions: Necessary Litigation or Unconstitutional Deprivation,* 55 S.C. L. REV. 215, 218 (2003). It is important to note that a limitation on noneconomic damages is different from abolishing a state's collateral-source rule. The collateral-source rule is the "doctrine that if an injured party receives compensation for its injuries from a source independent of the tortfeasor, the payment should not be deducted from the damages that the tortfeasor must pay." BLACK'S LAW DICTIONARY 256-57 (7th ed. 1999). *See e.g.,* Coburn v. Agustin, 629 F. Supp. 983, 997 (D.Kan. 1985) (striking down a state's ban on their collateral-source rule under equal protection concerns).

12. *See infra*, Part I.B.

13. *See* Michael Cetra, Comment, Damage Control: Statutory Caps on Medical Malpractice Claims, State Constitutional Challenges, and Texas' Proposition 12, 42 DUQ. L. REV. 537, 543-550 (2004).

14. *See* Adam D. Glassman, The Imposition of Federal Caps in Medical Malpractice Liability Actions: Will they Cure the Current Crisis in Healthcare?, 37 AKRON L. REV. 417, 421-31 (2004).

15. *See e.g.*, Healthy America Act of 2005, S. 4, 109th Cong. (2005); Help Efficient, Accessible, Low-cost, Timely Healthcare Act, H.R. 5, 109th Cong. (2005); S. 354, HEALTH Act of 2005, 109th Cong. (2005). There are also bills that deal with medical malpractice caps for specific areas of practice such as gynecology, *see* S. 366, 109th Cong. (2005), or pregnancy and trauma, *see* S. 367, 109th Cong. (2005). One measure allows the Secretary of the Department of Health and Human Services to provide grants to states that provide and foster "alternatives to current tort litigation." S. 1337, 109th Cong. (2005). This flurry of bills shows that medical malpractice tort reform is a priority of the Republican-controlled 109th Congress (and the White House). *See* Rebecca Adams, *Issues Redux: The Uninsured, Drug Prices and Medical Malpractice Awards*, CQ TODAY, Jan. 7, 2005, *available at* http://www.cq.com (last visited Aug. 25, 2005) [hereinafter Adams, *Issue Redux*].

general cap policies advanced in this session of Congress will be utilized by those who support such reform in the foreseeable future.[16]

Due to the fact that none of these bills have become law, the federal court system has not yet constitutionally analyzed a national law that places caps on noneconomic damages in medical malpractice cases. Nonetheless, the same constitutional concerns that states have had with their caps[17] are also applicable to federal legislation.[18] In fact, the bills now being put forth contain several provisions that would be challenged as unconstitutional by individuals who oppose tort reform.

This Comment will analyze recently proposed federal damages caps exclusively in light of the Equal Protection Clause (EPC) of the United States Constitution.[19] Considering modern Supreme Court (Court) jurisprudence on the EPC, a national cap on noneconomic jury damages in medical malpractice cases would be constitutional under EPC analysis by the Court. In order to properly perform this analysis, Part I provides a general history of the medical malpractice issue, establishing the context of the issue at hand. Section A presents the factors involved in the debate that have driven reform efforts. Section B gives a selection of state cap laws and how state courts have had varied reactions to the laws with regard to equal protection. Section C takes additional state cap laws and shows a more uniform response by the federal courts towards these laws concerning equal protection. Part II deals with the contemporary role of the United States Congress in medical malpractice reform. Section A reviews previously failed federal attempts to apply a uniform cap for noneconomic damages. In turn, Section B explains current federal medical malpractice reform proposals. Part III then shows how Congress' proposals will have no problems surviving scrutiny under the Supreme Court's jurisprudence

16. *Compare* Healthy America Act, § 104(b) *with* H.R. 1195, § 204(a), 104th Cong. (1995). It is, therefore, worthwhile to use such frequently utilized cap language as an example in this Comment.

17. *See infra*, note 47 and accompanying text.

18. A federal cap could have additional unique problems with the 10th Amendment, U.S. CONST. amend. X, and the Commerce Clause, U.S. CONST. art. I, § 8, because medical malpractice tort reform may be an issue reserved to the states. *See* Paget, *supra* note 11, at 226-27.

19. The Equal Protection Clause of the Fourteenth Amendment states that no state will "deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV, § 1. The Equal Protection Clause also applies to the federal government through the Due Process Clause of the Fifth Amendment. *See infra* note 158 and accompanying text.

for the Equal Protection Clause.[20] Such a conclusion first looks at Supreme Court case law relevant to damages caps and then shows how the Court's jurisprudence in this area poses no equal protection clause concerns. This outcome should be reached despite the lack of concurrence by state supreme courts.

PART I: MEDICAL MALPRACTICE REFORM: CAUSES, ISSUES, AND STATE RESPONSES

Origins of an Insurance Debacle

Doctors have been held liable for torts while practicing medicine throughout the history of American common law.[21] Malpractice cases were extremely rare before 1835, especially if anything but death resulted from the doctor's negligence.[22] It was not until the late 1830s, when orthopedic injuries led to an increase of lawsuits, that the first malpractice crisis has been cited.[23] It was not until the 1970s, however, that there was a noticeable upsurge of medical malpractice lawsuits.[24]

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20. Others who have written on this topic have expressed concerns that the Supreme Court would have trouble saying that such a cap would be found constitutional under the Equal Protection Clause. *See* Kevin J. Gfell, Note, *The Constitutional and Economic Implications of a National Cap on Non-Economic Damages in Medical Malpractice Actions*, 37 IND. L. REV. 773, 779 (2005). (claiming that those who draft a federal noneconomic damages cap will have a hard time finding evidence that will enable the law to pass the Court's rational basis review). This piece takes the position that the evidence is more than ample, *see infra* Part III; the purpose of this piece is to assure lawmakers and academics that they should have no such concern.

21. *See* David Studdert et al., *Medical Malpractice*, NEW ENG. J. MED. 284 (2004). The first reported case in the federal appeals circuit was in 1974. KENNETH ALLEN DE VILLE, MEDICAL MALPRACTICE IN NINETEENTH-CENTURY AMERICA 7 (New York University Press 1990).

22. *See* DE VILLE, *supra* note 21, at 7-9.

23. CQ RESEARCHER, *supra* note 6, at 139. The term medical malpractice crisis can have varied meanings, especially when comparing the conditions of the 19th to the 20th centuries. Today, however, there is some consensus that a crisis occurs when, ultimately, citizens cannot receive proper health care. *See infra* note 37.

24. *See* Cetra, *supra* note 13, at 538; Padget, *supra* note 11, at 217. Insurance premiums before the 1970s, however, were on a sharp increase. Between World War II and 1968, insurance premiums increased three times faster than the rate of inflation. James Reuter, CONGRESSIONAL RESEARCH SERVICE, REP. NO. 84-114 EPW, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE 8 (1984) (on file with author) (citing a report by the AMA Committee on Professional Liability).

Before this time, "[v]ery little [was] known about the malpractice liability insurance industry."[25] Several professors from Harvard's School of Public Health and School of Medicine provide a summation of the reasons for the rise in medical malpractice suits in the 1970s:

> Judges discarded rules that had traditionally posed obstacles to litigation. For example, most jurisdictions rolled back charitable immunity for hospitals. Courts also moved toward national standards of care and abandoned strict interpretations of the "locality rule," which had required plaintiffs to find expert witnesses within the defendant's immediate practice community. At the same time, expansion of doctrines such as informed consent and *res ipsa loquitur* (the rule that certain events, such as the retention of instruments after surgery, carry an inference of negligence) paved new pathways to the courtroom. The more plaintiff-friendly environment fostered by these changes altered the cost-benefit calculus for plaintiffs' attorneys, leading to a steady growth in litigation.[26]

From these developments, an unfortunate chain of events materialized. With more opportunities for malpractice victims to bring their cases to court, an increasing number of plaintiffs were winning their malpractice claims.[27] Increased victories in courts forced many insurance companies to pull out of the medical malpractice market.[28] At this point, a "crisis of availability" developed, where numerous doctors and healthcare providers were unable to attain insurance with only a few insurance carriers available in the market.[29] State legislatures responded with various tort and insurance reform initiatives which temporarily solved the problem.[30]

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25. This lack of knowledge is due in part to a lack of data from the industry. *See* Rueter, supra note 24, at 15-16.

26. Studdert et al., supra note 21 (citations omitted). *See also* PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL (Harvard University Press 1991).

27. *See* Studdert et al., *supra* note 21.

28. Cetra, *supra* note 13, at 538; Paget, *supra* note 11, at 217. *See generally* Baird Webel, CONGRESSIONAL RESEARCH SERVICE, MEDICAL MALPRACTICE INSURANCE: AN ECONOMIC INTRODUCTION AND REVIEW OF HISTORICAL EXPERIENCE 8-9 (2005), available at http://www.law.umaryland.edu/ marshall/ crsreports/ crsdocuments/ RL3188601192005.pdf (explaining specific developments of the insurance market, including the insurers involved in the market).

29. Cetra, *supra* note 13, at 538; Paget, *supra* note 11, at 217.

30. Studdert et al., *supra* note 21. Specifically, for example, "[l]egislatures established quasi-public bodies called joint underwriting associations to serve as insurers of last resort, special state patient-compensation funds were introduced to

In the 1980s, market forces took hold of the medical malpractice insurance system, where the large size of the market coupled with only a few carriers permitted the few remaining insurance carriers to increase their rates. This spike in premiums resulted in a new crisis of affordability.[31] In response, state legislatures relied more on noneconomic and punitive damages caps to reduce the risk and cost insurers were sustaining.[32] After states instituted the damages caps, there was little growth in premium rates for the health care field up until the mid-1990s.[33]

Recently, however, rates have drastically increased.[34] Between 2000 and 2002, premiums for all physicians have increased by fifteen percent.[35] Put in a broader context, premiums doubled in the ten years

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absolve commercial insurers of responsibility for specified dollar portions of malpractice payments, and public reinsurance mechanisms were established to fill gaps in the underwriting market." *Id.* at 284.

31. Cetra, *supra* note 13, at 538; Paget, *supra* note 11, at 217. This new crisis could also be attributed to a steady increase, in the 1970s and 1980s, in the frequency and severity of medical malpractice suits. In the 1960s, one in every 100 doctors had a malpractice claim filed against him or her. That increased to thirteen per 100 at the end of the 1980s. Awards have also increased drastically in this period. Additional factors during this time were revenue lag for doctors and cost-cutting measures enacted by the health care industry to curtail the national health care budget. *See* PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL, 2-7 (Harvard Univ. Press 1991).

32. *See* Studdert et al., *supra* note 21.

33. *See id.* More insurance providers were entering the market, thus leading to a soft market and lower rates. WEBEL, *supra* note 28, at 9. A soft market is "characterized by slowly rising premium rates, less stringent underwriting standards, expanded coverage and strong competition among insurers." GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE INSURANCE, MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES, GAO-03-702, 33 (2003), *available at* http://www.gao.gov/ new.items/ d03702.pdf [hereinafter GAO, MEDICAL MALPRACTICE INSURANCE RATES]; *see also* WEBEL, *supra* note 28, at 4.

34. *See* GAO, MEDICAL MALPRACTICE INSURANCE RATES, supra note 33, at 3-5; but see Meg Fletcher, State Tort Reform Measures, Loss Control Programs Bring Stabilization to Medical Malpractice Market, 39 BUS. INSURANCE, Nov. 14, 2005, available at 2005 WLNR 18676837 (claiming insurance rates are leveling off). There are numerous factors that have increased the premium rates. *Id.* at 4. These factors are too many to discuss here. Additionally, both sides in the debate have their own lists as to what specifically resulted in the rate growths. *See supra* notes 4, 6. *See also* CBO, *supra* note 3, at 3-5. There are certain specialty practices that have seen disproportionate median rate increases. For example general surgeons have had their rates tripled. JOINT ECON. COMM., *supra* note 9, at 6.

35. CBO, *supra* note 3, at 1.

leading to 2001.[36] There is also evidence that jury awards in medical malpractice cases have increased in the past several years. For instance, the U.S. Department of Justice's Bureau of Justice Statistics reported that despite a decrease in the estimated median damages awards in the mid-1990s, there has been a 164% increase in that number between 2002 and 2003 to $1.35 million.[37] Such figures help explain why the American Medical Association has identified twenty states as existing in a "medical liability crisis."[38] Both sides in the reform debate acknowledge that health care costs have been

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36. This was an average increase of 8.1 percent a year. JOINT ECON. COMM., *supra* note 9, at 1 ("In 2001, total premiums for medical malpractice insurance topped $21 billion . . . .)

37. U.S. Dep't of Justice, Office of Justice Programs, Bureau of Justice Statistics, Federal Tort Trials and Verdicts, 2002-03 11 (2005) [hereinafter BJS], *available at* http://www.ojp.usdoj.gov/ bjs/pub/ pdf/fttv03.pdf. *See also* Press Release, U.S. Department of Justice, Bureau of Justice Statistics, Civil Justice Survey of State Courts, 2001, table 3 (April 2004), *available at* http://ojp.usdoj.gov/ bjs/pub/pdf/mmtvlc01.pdf (finding a forty-one percent increase in the median final amount awarded to plaintiffs between 1992 and 2001). Another considerably higher figure shows a 176 percent increase in awards between 1994 and 2001. JOINT ECON. COMM., *supra* note 9, at 1, 7 (citing a study from Jury Verdict Research, *Current Award Trends in Personal Injury: 2002 Edition* (Horsham PA: LRP Publications 2003), at 18). This study also reports that fifty-four percent of awards between 2000 and 2001 were at least one million dollars. *Id.* at 8. These figures appear even more astronomical when compared to the case of Dr. Asabel Humphrey, who, in 1829 had to pay $500 in damages for an irreparable injury to someone's arm. Dr. Humphrey was extremely shocked at the award and "declared that the case should 'excite the astonishment of every medical man.'" DE VILLE, *supra* note 21, at 1.

38. These states are: Washington, Oregon, Nevada, Wyoming, Missouri, Illinois, Arkansas, Mississippi, Kentucky, Florida, Georgia, North Carolina, West Virginia, Ohio, Pennsylvania, New Jersey, Connecticut, New York, Rhode Island, and Massachusetts. AM. MEDICAL ASS'N, AMERICA'S MEDICAL LIABILITY CRISIS: A NATIONAL VIEW (2005), http://www.ama-assn.org/ amal/ pub/upload/mm/ 450/med_liab_may05.pdf. There are also twenty-four additional states who are nearing a crisis. AM. MEDICAL ASS'N, AMERICA'S MEDICAL LIABILITY CRISIS, *supra* note 4. A crisis condition, according to the American Medical Association, is when escalating jury awards and settlements (along with the costs of taking on medical malpractice suits) force insurance premiums to rise. In turn, this may lead to, *inter alia*, the closing of trauma centers, deterrence of young physicians from high-risk specialties, and a decrease in patient access to care. *Current Issues Related to Medical Liability Reform Before the Subcomm. on Health of H. Comm. on Energy and Commerce*, 109th Cong. 2 (2005) (statement of the Am. Medical Ass'n).

increasing;[39] however, the causes of these high costs are in dispute.[40] Nevertheless, states have attempted to legislatively address the problem of inaccessible medical care. Such attempts are addressed below in Sections B and C.

State Damages Caps, Equal Protection, and State Courts

Starting in the 1970s, states began reacting to the crises of availability and affordability.[41] Tort reform measures were varied. Some states instituted controls on the insurance market such as the creation of trusts and funds for victims of medical malpractice.[42] Additionally, states have tried to limit such variables as damages, attorneys' fees, and joint and several liability, in order to reduce insurers' costs.[43] Of all these solutions, however, noneconomic damages caps have been the states' "primary vehicle."[44] Since 1975,

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39. *See* Am. Medical Ass'n, America's Medical Liability Crisis, *supra* note 4; *Cf.* Ass'n of Trial Lawyers of Am., Debunking the Top 5 Myths About Medical Malpractice (2005), http://www.atla.org/pressroom/FACTS/medmal/Top5Myths.aspx (responding to an assertion that medical malpractice claims lead to rising health costs, the Association of Trial Lawyers of America cites the Congressional Budget Office report, *supra* note 3, stating that less than two percent of total health care costs are from such claims. By claiming that medical malpractice claims have not led to cost inflation, this argument assumes that costs are high.).

40. Those against reform claim, among other things, that it is not medical malpractice claims that force premiums to rise, citing reports that damage caps have not affected insurance premiums. *Id. See also* WEISS RATINGS INC., MEDICAL MALPRACTICE CAPS THE IMPACT OF NON-ECONOMIC DAMAGE CAPS ON PHYSICIAN PREMIUMS, CLAIMS PAYOUT LEVELS, AND AVAILABILITY OF COVERAGE (2003), http://www.weissratings.com/MedicalMalpractice.pdf [hereinafter WEISS STUDY]. Those for reform claim just the opposite. *See* AM. MEDICAL ASS'N, AMERICA'S MEDICAL LIABILITY CRISIS, *supra* note 4. As seen, there are valid numbers on both sides about the insurance system. It truly "is a complex blend of competing studies and economic models, points and counterpoints." John Cochran, *'Tort Reform' Battle: A Simple Case of Complexity*, CQ WEEKLY, Jan. 31, 2005, http://www.cq.com (last visited on Aug. 25, 2005). This Comment is not a policy analysis, but rather a constitutional analysis of proposals to fix the insurance system.

41. *See supra* notes 26, 28 and accompanying text.

42. WEBEL, *supra* note 28, at 10. *See supra* note 27.

43. WEBEL, *supra* note 28, at 11.

44. WEISS STUDY, *supra* note 40, at 5.

nearly half the states have established caps on noneconomic damages.[45] Many of these caps have been challenged in their respective state court systems.[46] As will be discussed in the examples of Nebraska, New Hampshire, and Wisconsin, some of these caps have been upheld and some have been struck down as a violation of equal protection.[47]

To give proper context, under equal protection examination, a court will generally apply one of three tests. The first, the rational relationship test (or rational basis review), requires that a classification made by the law must have a rational relationship to a legitimate constitutional end of government.[48] There is also the strict scrutiny test that applies only when a fundamental right or a suspect class is affected.[49] Finally, there is the rarely used intermediate level of review, where there must be a substantial relationship with an important government end.[50] In all of the cases to follow, the victimized party

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45. *Id.* The amounts that states cap off damages vary from $250,000 to $1 million. *Id.* See also COHEN, *supra* note 9, app. at 12-19 (providing a chart of each state's caps). Some states have different caps for certain situations, like emergency services or whether the plaintiff has medical insurance; furthermore, some state constitutions expressly prohibit caps on damages for those who are injured or die.

46. *See infra* pp. 8-12.

47. This Comment will only deal with laws that have been examined under equal protection clauses; however, other constitutional issues have been involved when determining the state constitutionality of a damage cap, *see supra* note 13 and accompanying text. For example, the Supreme Court of Nebraska found Nebraska's cap on jury awards in medical malpractice cases, NEB. REV. STAT. §44-2825 (2005), to be constitutional with respect to concerns of equal protection, separation of powers, right to a trial by jury, open courts and right to a remedy and special legislation. Gourley v. Nebraska Methodist Health Sys., 663 N.W. 2d 43 (Neb. 2003). *See also* Cetra, *supra* note 13, at 540-48 (summarizing the Nebraska Supreme Court's discussion and decision on each of the aforementioned issues); Gfell, *supra* note 20 (providing an excellent discussion of state caps and the various state and federal constitutional issues that are entailed). Each state constitution (and the rights granted therein) is unique; therefore, some state constitutions may give rise to different constitutional challenges.

48. JOHN E. NOWAK & RONALD D. ROTUNDA, Constitutional Law § 14.3, at 687 (7th ed. 2004).

49. *Id.* at 687. A suspect class contains traits that "seem[] to contravene established constitutional principles so that any use of the classification may be deemed 'suspect'." *Id.* at 688. Race, for example, is typically cited as a qualification for determining whether a class is suspect. *Id.*

50. *Id.* at 689. Therefore, if the party challenging the law is not in a suspect class or does not have a fundamental right involved by the law, the court will default to rational basis review. Under the strict scrutiny test, a law must have a necessary means to a compelling end of government. In comparison, rational basis

sought strict scrutiny review because the cap would be more vulnerable under equal protection clause analysis and thus more prone to being struck down. Under strict scrutiny, the state legislature is given less deference in its decision-making ability. This lack of deference usually shows that the cap has no compelling end and creates an unconstitutional classification that the court must strike down.[51]

Nebraska

Beginning in 1976, Nebraska began to place limits on the amount recoverable when a patient is injured or dies.[52] Currently, if one is a victim of medical malpractice in Nebraska, one is not entitled to more than $1.75 million in noneconomic damages.[53] This law was applied by a Nebraska district court in a 2003 case involving Colin Gourley and his parents.[54] Colin Gourley was born with brain damage and cerebral palsy. His parents sued an OB/GYN group claiming that the disease that gave him his ailments was a result of the group's improper monitoring.[55] The jury awarded the Gourleys $5.6 million, but the trial court initially reduced the verdict to $1.25 million.[56] After the Gourleys and the OB/GYN group both moved for new trials, on different grounds,[57] the court reversed its earlier decision and found

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review gives deference to the legislature in formulating the law, while strict scrutiny calls for judicial determination of a law. *Id.*

51. *See* NOWAK & ROTUNDA, *supra* note 48, § 14.3. All of these tests have been developed by the Supreme Court, however, state courts and the lower federal courts have utilized them as well. *See also infra* Parts II.C, III.

52. Neb. Rev. Stat. § 44-2825 (2004).

53. *Id.* § 44-2825(1)(d). The cap amount is tiered according to when the tort occurred. *Id.* at § 44-2825(1). As time goes on, the cap increases (i.e. tort occurring between January 1, 1984, and December 31, 1992, has a cap of $1 million). *Id.* at § 44-2825(1)(b). Of particular note is that the cap is not specific to noneconomic damages– it includes any type of damage reward given. *Id.* at § 44-2825.

54. Gourley v. Neb. Methodist Health Sys. 663 N.W.2d 43, 56 (Neb. 2003).

55. *Id.* at 55-56.

56. At the time of the Gourley's injury in 1993, the cap was only $1,250,000. *Id.* at 56.

57. The Gourleys moved for a new trial because the cap violated their rights, including equal protection, life liberty and the pursuit of happiness and due process. The OB/GYN group moved for a new trial because of alleged procedural errors at the trial. *Gourley*, 663 N.W.2d at 56.

the cap in violation of the Nebraska constitution's equal protection clause.[58]

The Nebraska Supreme Court applied the traditional test to see which equal protection review was applicable, rational basis review or strict (heightened) scrutiny review.[59] If a suspect class or fundamental right was involved, then the former was to be used. The Gourleys contended that "a heightened level of review should be applied to [their] case because the cap affects fundamental rights such as the right to a jury trial, full remedy, property, and medical care."[60] They also believed that those with disabilities that qualify for damages above the cap are considered a suspect class.[61] Both of the Gourleys' classifications were triggers recognized by the court to require strict scrutiny review.[62] The Nebraska Supreme Court disagreed, however. The court distinguished the fundamental right of access to the courts from that of a limitation on the plaintiff's potential recovery. The Gourleys were in the latter category and therefore had no claim to a fundamental right.[63] Furthermore, the court did not believe that "plaintiffs with damages awards over the cap are a [traditional] suspect class."[64]

Therefore, the Nebraska Supreme Court performed a rational basis review, and deferred to the legislature's rationale. It held that the legislature's goals of reducing health care costs and encouraging access to medical care were legitimate ones.[65] The court reasoned that the damages cap was a rational method to achieve these goals.[66]

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58. *Id.* The Nebraska Constitution provides that "[n]o person shall be deprived of life, liberty, or property, without due process of law, nor be denied equal protection of the laws." NEB. CONST. art. I, § 3.

59. *Gourley*, 663 N.W.2d at 70-71.

60. *Id.* at 71.

61. *Id.* The Gourleys therefore attempted to portray themselves as falling into both categories that call for strict scrutiny. If the law were to be reviewed under strict scrutiny, there would have been a better chance that it would have to be struck down under the state's equal protection clause, NEB. CONST. art. I, § 3.

62. *Gourley,* 663 N.W.2d, at 70.

63. *Id.* at 71.

64. Id.

65. *Id.* at 72.

66. It also did not violate any other portion of the Nebraska Constitution. *See supra* note 43. Other state supreme courts have upheld their caps under a rational basis test. *See, e.g.,* Robinson v. Charleston Area Medical Center, Inc., 414 S.E.2d 877 (W. Va. 1991); Morris v. Savoy, 576 N.E.2d 765 (Ohio 1991) (the cap was struck down as unconstitutional under due process concerns, however); Butler v.

New Hampshire

The State of New Hampshire enacted a damages cap of $250,000 in 1977.[67] In *Carson v. Maurer*, the cap was challenged in the Supreme Court of New Hampshire under the state and federal equal protection clauses.[68] The plaintiffs asserted that the statute "distinguishes between medical malpractice victims whose non-economic loss exceeds $250,000 and those whose non-economic loss is $250,000 or less. . . ."[69] This differentiation denied equal protection of the law for those whose noneconomic losses exceeded the $250,000 cap. The plaintiffs further contended that such a classification infringed upon the fundamental right to be compensated for personal injuries.[70]

The New Hampshire Supreme Court did find a classification,[71] but did not find this class distinction to be suspect,[72] nor did it believe that the affected right was fundamental.[73] Although it found strict scrutiny inapplicable, the court stated that the rights involved with medical malpractice awards were too important for rational basis review.[74] Consequently, the New Hampshire Supreme Court invoked the intermediate review test, requiring that the "challenged classifications are reasonable and have a fair and *substantial* relation to the object of the legislation."[75] This time, however, the noneconomic damages cap did not pass this test. The classification, by limiting the awards given to those who are most injured, did not have a substantial relation to

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Flint Goodrich Hospital of Dillard University, 607 So. 2d 517 (La. 1992); Pulliam v. Coastal Emergency Services of Richmond, Inc., 509 S.E.2d (Va. 1999); Scholz v. Metropolitan Pathologists, 851 P.2d 901 (Colo. 1993).

67. "[C]ompensation for non-economic losses shall in no event exceed the sum of $250,000." N.H. REV. STAT. ANN. § 507-C:7(II) (2005).

68. 424 A.2d 825, 829-30 (N.H. 1980). The case before the New Hampshire Supreme Court was a consolidation of actions from the state's district and superior courts as well as the U.S. District Court for the District of New Hampshire. *Id.* at 829.

69. *Id.* at 830.

70. The statute, therefore, would have to advance a compelling government interest to remain intact. *Id.*

71. *Id.*

72. *Id.* at 831.

73. *Id.* at 830.

74. *Carson*, 424 A.2d at 830.

75. *Id.* at 831 (emphasis added by author). The court recognized that the goal of the legislation was "to codify and stabilize the law governing medical malpractice actions and to improve the availability of adequate liability insurance for health care providers at reasonable cost." *Id.* at 830.

the goal of reducing insurance rates.[76] Specifically, the New Hampshire Supreme Court found that these large awards were only a fraction of the total insurance premium costs.[77] Furthermore, these caps had no relation to decreasing the amount of nonmeritorious claims, an alleged factor in the rising cost of insurance.[78] Unlike Nebraska, the New Hampshire Supreme Court struck down the damages cap. Its differing conclusion was most likely due to the fact that the New Hampshire Supreme Court applied an intermediate, rather than a rational basis, standard of review.[79]

Wisconsin

Added to this scattered analysis of damages caps is *Ferdon v. Wisconsin Patients Compensation Fund*, one of the more recent state court decisions on the issue.[80] The case involved Wisconsin's $350,000 state cap for noneconomic damages.[81]

Matthew Ferdon was born with a paralyzed and deformed right arm due to doctor negligence during his birth.[82] The jury, giving Ferdon a life expectancy of sixty-nine years, awarded him $10,000 a year.[83] Ferdon's judgment was reduced significantly by a county circuit court, as per the state cap.[84] The plaintiffs challenged the law under the state constitution's EPC clause.[85] The Wisconsin Supreme Court did not believe that those whose damages are limited by the cap constitute a suspect class; nor did such a group have any fundamental rights affected by the cap.[86] Therefore, the court applied a rational basis

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76. *Id.* at 836.

77. *Id.* (citing Jenkins, California's Medical Injury Compensation Reform Act: An Equal Protection Challenge, 52 S. CAL. L. REV. 829, 951 (1979)).

78. *Id.* at 837.

79. North Dakota also used an intermediate test that required a "close correspondence between statutory classification and legislative goals." Arneson v. Olson, 270 N.W.2d 125, 133 (N.D. 1978) (*quoting* Johnson v. Hassett, 217 N.W.2d 771 (N.D. 1974)).

80. 701 N.W.2d 440, (Wis. 2005).

81. *See* WIS. STAT. §§ 655.017, 893.55(4)(d), 895.04(4)(2000-01). The cap, like most state caps, is adjusted annually for inflation. *Id.* § 893.55(4)(d).

82. *Ferdon*, 701 N.W.2d at 446. The suit before the Wisconsin Supreme Court actually was between Ferdon and several private companies that sought to reduce the damages pursuant to the law. *Id.*

83. *Id.*

84. The court decreased Ferdon's award to $5,900 a year. *Id.*

85. *Id.* at 455. *See also* WIS. CONST. art. 1, § 1.

86. *Ferdon*, 701 N.W.2d at 457.

review.[87] Much like the *Carson* case, the *Ferdon* court did not find a relationship between the cap and its goal of lowering insurance premiums.[88] What is surprising about *Ferdon*, however, is that it did not find a rational relation under such a low level of review.[89]

The Wisconsin legislature has recently resurrected the issue, passing another $350,000 cap on noneconomic damages.[90] The cap was vetoed by the governor who wanted to avoid another rebuking of the cap by the state's supreme court.[91]

When looking at the three state court examples above, it is evident that state courts have approached the constitutionality of these damages caps in a variety of ways. This area of law appears to be very unpredictable on the state level.[92] Fortunately, federal district and circuit courts have applied a more uniform response concerning state caps on medical malpractice awards.

State Damages Caps, Equal Protection and the Federal Courts

Federal district and appellate courts have also entertained numerous medical malpractice cases.[93] These courts have a sizeable body of case

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87. At first, it appeared that Ferdon has an uphill battle under rational basis review. In fact, the court noted that the burden is on Ferdon and it is presumed that the law is constitutional. *Id.* at 457-58. Specifically, the court stated, "[A] statute will be upheld against an equal protection challenge if a plausible policy reason exists for the classification and the classification is not arbitrary in relation to the legislative goal." *Id.* at 489.

88. Especially by preventing doctors from practicing defensive medicine. *Id.* at 489.

89. *Carson*, 424 A.2d at 831, had a higher level of review in looking for a substantial relationship. The Ferdon court focused on defensive medicine as the key element that has led to an increase in insurance costs. It cited three legislative agency studies that showed no affect of caps on whether doctors practiced defensive medicine. *See Ferdon,* 701 N.W.2d, at 487-89.

90. *See* Tony Anderson, Wisconsin Senate Passes Medical Malpractice Cap, WIS. L. J., Nov. 16, 2005, available at 2005 WL 18675493.

91. See Stacy Forster & Derrick Nunnally, Doyle Vetoes Medical Malpractice Caps Limits Too Similar to Those Overturned by Court, Government Says, MILWAUKEE J. SENTINEL, Dec. 3, 2005, available at 2005 WL 19517568.

92. There is a "split of opinion in state courts when these statutes are attacked on varying state [and federal] constitutional grounds." Cetra, *supra* note 13, at 555. These inconsistencies are also used as justification for federal action. *Compare* U.S. CONST. amend. XIV, § 1 *with* WIS CONST. art. I, § 1 *and* N.H. CONST. pt. I, arts. 2, 12 *and* NEB. CONST. art. I, § 3.

93. Concerning the district level, between 1990 and 2003, U.S. district courts have handled 1,685 medical malpractice trials. BJS, *supra* note 37, at 9

law analyzing state caps on noneconomic damages.[94] The vast majority of these cases, especially those at the circuit level, have upheld the caps as constitutional under both the state and federal equal protection clauses.[95] Examples, in chronological order, from the Ninth, Fourth and Sixth Circuits will showcase how the circuit courts have handled the matter.

Ninth Circuit

California instituted a $250,000 damages cap in 1975.[96] In 1981, Scott Hoffman underwent treatment for a lacerated tendon in his finger at a veteran's hospital in California; as a result of the treatment, he suffered a brain injury that left him permanently paralyzed.[97] The District Court for the Central District of California granted him one million dollars in noneconomic damages, declaring the California cap unconstitutional for violating equal protection guarantees.[98]

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94. Some of these cases reach the federal courts because federal laws are involved, *see e.g.*, Lucas v. U.S., 807 F.2d 414 (5th Cir. 1986) (Federal Torts Claim Act); Owen v. U.S., 935 F.2d 734 (5th Cir. 1991); Smith v. Botsford General Hospital, 419 F.3d 513 (6th Cir. 2005) (Emergency Medical Treatment and Active Labor Act); *see also* 28 U.S.C. §1331 (1980). The federal courts take other cases involving state caps because federally protected rights, specifically the right to equal protection under the laws, are similar to state protected rights see Davis v. Omitowoju, 883 F.2d 1155 (3rd Cir. 1989) (Seventh Amendment, right to a jury trial).

95. There are some infrequent instances when a district court has held that state damages caps are unconstitutional under the equal protection clause. *See e.g.*, Waggoner v. Gibson, 647 F.Supp. 1102 (N.D. Tex. 1986) (striking down a $500,000 Texas cap under rational basis review), *overruled by* Lucas v. U.S., 807 F.2d 414 (5th Cir. 1986).

96. CAL. CIV. CODE § 3333.2(b) (West 2005). This cap was part of one of the first medical malpractice tort reform initiatives, the Medical Injury Compensation Reform Act of 1975 (MICRA). Melissa G. Gregory, Note, *Capping Noneconomic Damages in Medical Malpractice Suits is not the Panacea of the "Medical Liability Crisis,"* 31 WM. MITCHELL L. REV. 1031, 1036 (2005). Some cite MICRA as a success sort for noneconomic damages caps because it has survived over thirty years of constitutional analysis, *see* JOINT ECON. COMM., *supra* note 9, at 19. Others feel that it has not worked at all, *see* Glassman, *supra* note 14, at 458-60.

97. Hoffman v. U.S., 767 F.2d 1431, 1433 (9th Cir. 1985).

98. The action was brought under the Federal Tort Claims Act, which utilizes the law of the state where the tort occurred. *Id.* It relied on *Carson's* rationale for finding the law unconstitutional. *Id.* Oddly enough, the district court did not note whether the cap ran afoul of the state or federal guarantee to equal protection. *Id.* at note 1.

In responding to the typical EPC arguments discussed above, the Ninth Circuit turned towards the United States Constitution's Equal Protection clause; it failed to see any suspect class or fundamental right involved in the case; thus, it had no reason to use strict scrutiny and applied the rational basis test.[99] In applying rational basis review, the court found that there was a "plausible reason" for California to enact the law; the court gave deference to the California legislature's decision that caps could decrease premiums because excessive jury awards were responsible for driving up premiums.[100] Much like some of the state supreme courts, the Ninth Circuit did not question the legitimacy of what the legislature asserted. Under rational basis review it simply looked for this "plausible reason."

Fourth Circuit

Currently, Virginia has a $1.8 million cap on all damages given in a medical malpractice trial.[101] This damages cap was challenged by Helen and Roger Boyd, whose daughter was left with mental retardation and cerebral palsy due to a doctor's negligence during her birth.[102] The Boyds and their daughter received over $2.5 million in damages each; however the statute reduced their total recovery to $750,000 each.[103]

In *Boyd v. Bulala*, the Fourth Circuit rejected the Boyd's claim that the cap violated their federal Fourteenth Amendment guarantees. In a succinct opinion, the court agreed with the Supreme Court of Virginia, which heard the case earlier that "the cap on liability bears a reasonable relation to a valid legislative purpose- the maintenance of adequate health care services in the Commonwealth of Virginia."[104] It rejected strict scrutiny review because the law did "not violate a fundamental right or create a suspect classification."[105] In coming to this conclusion, the court commented on the nature of damages cap legislation: the law, according to the court, was simply an economic regulation that should routinely be given rational basis review.[106] By classifying damages caps as an economic regulation, there was no need

99. *Id.* at 1436.

100. *Id.* at 1437.

101. The damage amount increases $50,000 each year until 2008. VA. CODE. ANN. § 8.01-581.15 (2005).

102. Boyd v. Bulala, 877 F.2d 1191, 1194-95 (4th Cir. 1989).

103. *Id.* at 1193-94.

104. *Id.* at 1197.

105. *Id.* at 1196.

106. *Id.* at 1196-97.

to look at any other type of review except for rational basis.[107] The court then concluded that there was a "reasonable relation to a valid legislative purpose."[108] No violation was found.

Sixth Circuit

Michigan's noneconomic damages cap is different from those previously mentioned. It has a $280,000 noneconomic cap in general, but if the court determines that the plaintiff was severely injured, the cap increases to $500,000.[109] Recently, the Sixth Circuit handed down a decision concerning Michigan's cap in *Smith v. Botsford General Hospital.*[110] The victim was Kelly Smith who died while being transferred between hospitals.[111] Smith's estate was awarded an astonishing five million dollars in noneconomic damages.[112] The cap reduced that award to $359,000.[113]

The court first considered which level of scrutiny to apply. Citing *Boyd*, the Sixth Circuit stated that the Michigan law was simply a form of economic regulation and was, by default, entitled to only rational basis review.[114] Then, very briefly, the court cited a Michigan appellate court's review of the law and found that the cap was rationally related

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107. *See id.* (quoting and citing Duke Power Co. v. Carolina Environmental Study Group, Inc., 438 U.S. 59 (1978)) (such a classification can, prima facia, give a federal statute automatic rational basis review in the federal court system); *see also infra* pp. 25-26.

108. *Boyd*, 877 F.2d at 1197.

109. MICH. COMP. LAWS § 600.1483(1) (2005) (These serious injuries include: (1) a result of the plaintiff as a hemiplegic, paraplegic, or quadriplegic, (2) permanently impaired cognitive capacity or (3) "permanent loss of or damage to a reproductive organ."). These numbers are also adjusted for inflation. *Id.* § 600.1483(4).

110. 419 F.3d 513 (6th Cir. 2005).

111. *Id.* at 515-16 (Smith weighed about 600 pounds and was in a car accident. The defendant-physician decided Smith needed to be transferred to a facility that could accommodate a man of his size. The action was brought forth under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) which requires hospitals to stabilize patients before transferring them to another medical facility).

112. *Id.* at 515.

113. *Id.* at 517 (stating that at the time of Smith's death, the cap was adjusted to the higher amount); *see also supra* note 88.

114. *Smith*, 419 F.3d at 519-20. (This test, of whether the law controls an economic activity, is a recent example of how the federal courts consistently analyze damage cap laws). *See also supra* note 87 and accompanying text.

to the purpose of controlling increases in health care costs.[115] Compared to the previous two examples from the circuit courts, the Sixth Circuit's analysis was significantly shorter in length. Perhaps such brevity means that this type of analysis of the issue is becoming routine in the federal courts.

Compared with the decisions of state supreme courts, federal circuit courts are more consistent in upholding the constitutionality of state noneconomic damages caps. As mentioned earlier, as states have attempted to repair the system, tensions between doctors and lawyers have only risen.[116] With these factors in mind, some members on Capitol Hill are calling for a national effort to control the situation; these members of Congress believe that "a new paradigm," federal in nature, is required.[117] The following part looks at previous and current federal efforts to fix the insurance debacle.

PART II: THE MODERN CONGRESS AND MEDICAL MALPRACTICE REFORM

Past Federal Legislative Attempts

As mentioned above, medical malpractice tort reform is a politically charged issue.[118] In recent history, the political divisions on the issue have been consistent. Generally, Republicans back the medical industry and advocate damages caps, while Democrats, who typically support the trial lawyers, are against virtually all caps on a victim's recovery.[119] Republicans claim to put doctors and patients ahead of

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115. *Id.* at 520 (quoting Zdrojewski v. Murphy, 657 N.W.2d 721, 739 (Mich. Ct. App. 2002)) (The Michigan appellate court found that "[b]y limiting at least one component of health care costs, the noneconomic damages limitation is rationally related to its intended purpose."). Much like the Michigan appellate court, the Sixth Circuit gives deference to the legislature and its rationale, *see Zdrojewski*, 657 N.W.2d at 739 (citing House Legislative Analysis, SB 270 and HB 4033, 4403, 4404, April 20, 1993, pp. 1-2).

116. *See supra* notes 1-7 and accompanying text.

117. *See* Gibeaut, *supra* note 1, at 44.

118. *See supra* pp. 1-2. *See also* Terry Carter, *Tort Reform Texas Style*, A.B.A. J., at 32 (discussing the political divisions on medical malpractice tort reform in general and in Texas' judiciary).

119. *See* Adams, *Issue Redux*, *supra* note 15; John Reichard, *The Drip, Drip, Drip of the Medical Malpractice Debate*, CQ TODAY, Feb. 11, 2005, http://www.cq.com (last visited Aug. 25, 2005). *See generally* Rebecca Adams & Kate Schuler, *Opposition to Shielding Drug Makers Makes Malpractice Bill a Longer Shot*, CQ WEEKLY – HEALTH, Jan. 10, 2005, http://www.cq.com (last visited

trial lawyers.[120] Conversely, Democrats point out how damages caps will hurt those who are vulnerable and deserve just compensation.[121]

When the 1970s and 1980s medical malpractice crises emerged, both Republicans and Democrats offered solutions. In the 1970s, bills were introduced to merely explore the phenomenon of medical malpractice lawsuits and the awards given to plaintiffs.[122] In the 1980s, however, members of Congress were introducing bills directly dealing with the losses that were involved in medical malpractice suits.[123] This shift in what solutions were presented is probably a result of the new affordability crisis that developed in the 1980s.[124] With the price of malpractice insurance rising at that time, policymakers appeared to turn towards the monetary aspect of the medical malpractice predicament. Hence, the investigatory phase of the 1970s became a problem that Congress dealt with from an economic standpoint.

In 1994, the control of the House of Representatives changed for the first time in forty years. The Republican revolution of 1994 led to

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Aug. 25, 2005) [hereinafter Adams, *Longer Shot*] (discussing why the Democrats oppose malpractice damages caps). President George W. Bush is also a key Republican who supports damages caps, *id.*; *but see* Medical Malpractice Reform Act of 1985, H.R. 2659, 99th Cong. (1985) (proposing a $250,000 cap on noneconomic damages, authored by a Democratic House member).

120. *See* Republican Nat'l Comm., 2004 Republican Party Platform: A Safer World and a More Hopeful America 59 (2004), *available at* http://www.gop.com/media/ 2004platform.pdf.

121. *See* Senator Patrick Leahy, Comments of Senator Patrick Leahy (D-Vt.), Ranking Member, Senate Judiciary Committee, on the President's Medical Malpractice Proposal, Jan. 5, 2005, http://leahy.senate.gov/press/200501/010505a.html (last visited Sept. 22, 2006). The Democrats have even made the issue political, claiming the George W. Bush administration is proposing the caps in their zealous support for the large drug companies; *see* ELI RESEARCH, *Medical Liability Bill Passes House for Third Year in a Row: Inaction by Senate Stalls Pain and Suffering Award Caps*, MEDICINE & HEALTH, Aug. 8, 2005, at 1, *available at* 2005 WLNR 22611955.

122. *See, e.g.*, H.R. 5052, 93rd Cong. (1973) (a bill to establish a commission on medical malpractice rewards); H.R. 6293, 94th Cong. (1975) (a bill to establish a reinsurance program for medical malpractice awards); S. 1720, tit. V, 96th Cong. (1979) (a bill to investigate the condition of malpractice insurance in America at the time).

123. *See, e.g.*, H.R. Res. 386, 99th Cong. (1986) (a resolution to reform state tort law as to put caps on noneconomic losses in medical malpractice cases); Medical Malpractice Reform Act of 1985, H.R. 2659, 99th Cong. (1985) (directs states to place a $250,000 cap on noneconomic damages).

124. *See supra* pp. 5-6.

GOP control of the House, leaving the Democrats powerless.[125] Since that time, the House GOP has proposed bills with noneconomic damages caps.[126] The Senate has also put forth its own solutions,[127] but has been unable to pass any of the House's bills.[128] The past eight bills on malpractice caps have not been voted on by the Senate.[129] The same is true of the current Congress. As will now be discussed, there are bills in the 109th Congress that specifically call for caps on noneconomic damages awarded in medical malpractice cases.

Current Federal Legislative Endeavors

There are currently a variety of bills concerning medical malpractice caps before Congress.[130] The three bills discussed below were chosen for their adherence to past reform proposals on damages caps and their chance of political success. As discussed earlier, the punitive and noneconomic damages cap solution has been frequently suggested in bills since the 1980s.[131] Even if the bills in the 109th Congress do not become law, as some have suggested from both inside and outside of

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125. The "Republican revolution" was important in that it enabled the Republican Party to control the policy process in Congress. *See* John H. Aldrich & David W. Rohde, *The Republican Revolution and the House Appropriations Committee*, J. POL., Feb. 2000, at 1-33.

126. Most of these bills contained consistently recycled language. For example, each session of Congress from the 104th to the 108th had a bill with a $250,000 cap. *See, e.g.*, H.R. 229, § 7, 104th Cong. (1995); H.R. 1091, § 204, 105th Cong. (1997); H.R. 5344, § 4, 106th Cong. (2000); H.R. 1639, § 4, 107th Cong. (2001); H.R. 321, § 4, 108th Cong. (2003).

127. Senate versions usually adopt the language of their partner bill from the House (or vice versa). These bills were also introduced by Republican members. *See, e.g.*, S. 11, § 202, 104th Cong. (1995); S. 1370, § 6, 107th Cong. (2001).

128. *See* Robert A. Levy, *Constitutional Malpractice*, THE AMERICAN PROWLER, Apr. 22, 2003, *available at* http://www.cato.org/research/articles/levy-030422.html. *See e.g.*, H.R. 956, 104th Cong. (1995); H.R. 4600, 107th Cong. (2002). Both of these bills passed in the House, but not the Senate. *See* Glassman, *supra* note 14, at 422. *See also* H.R. 5, 108th Cong. (2003) [hereinafter H.R. 5, 108th] (this bill passed in the House but was filibustered in the Senate).

129. Kate Schuler, *House OKs Medical Liability Bill*, CQ WEEKLY, Aug. 1, 2005 [hereinafter Schuler, *House OKs*].

130. *See, e.g.*, S. 1337, 109th Cong. (2005) (gives grants to states to develop solutions to the medical malpractice crisis); H.R. 3378, 109th Cong. (2005) ($250,000 cap on noneconomic damages along with state grants). *See also supra* note 15 and accompanying text.

131. *See supra* p. 2 and text accompanying note 103.

Congress,[132] the three bills discussed below are of important academic value. If Congress is able to pass medical malpractice reforms in the future,[133] there is an excellent chance that the bills presented below may become law. Therefore, the provisions in the following bills may be potentially analyzed by the federal court system, including the Supreme Court. It is important to gauge the Supreme Court's analysis of such damages caps, particularly considering the various approaches taken by other jurisdictions.

HEALTH ACT

H.R. 5, The Help Efficient, Accessible, Low-cost, Timely Healthcare Act (HEALTH Act) was introduced on July 21, 2005, in the House of Representatives.[134] It was introduced by Republican Phil Gingery of Georgia, and quickly passed by a vote of 230 to 194 only seven days later, on July 28, 2005.[135] This bill is the furthest along in the 109th Congress' legislative process, and is awaiting action by the Senate Committee on the Judiciary.[136]

The HEALTH Act contains a $250,000 cap on noneconomic and punitive damages.[137] The bill also has a condition that "[n]o punitive damages may be awarded against the manufacturer or distributor of a medical product, or a supplier of any component . . ." that was approved by the Food and Drug Administration (FDA) or deemed in compliance with FDA statutes and regulations.[138] Other notable features of the bill include a statute of limitations limiting when a

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132. *See* Kate Schuler, *House Passes Liability Overhaul Again, but Diagnosis Shaky for Senate*, CQ TODAY - HEALTH, July 28, 2005, http://www.cq.com [hereinafter Schuler, *Diagnosis Shaky*] (the reform attempts will fail simply because of the partisan political environment in the Senate).

133. The issue is considered an emergency by both sides involved in the debate. *See supra* note 36 and accompanying text. There is a possibility that this emergency will force the Senate to take action on the issue.

134. *See* H.R. 5, *supra* note 15.

135. *Id.* (as passed by House of Representatives, July 28, 2005).

136. THOMAS, "Search Results," Library of Congress, http://thomas.loc.gov/cgi-bin/bdquery/ D?d109:1:./temp/~bdfq48:@@@R| /bss/109search.html (last visited Jan. 13, 2006).

137. H.R. 5, *supra* note 15, §§ 4(b) & 7(b)(2). Punitive damages may not exceed $250,000 or two times the amount of economic damages. *Id*, § 7(b)(2). If a state already had a cap or subsequently enacts a cap for monetary damages, the bill will not preempt state law. *Id.* § 11(c).

138. *Id.*, § 7(c)(1).

malpractice suit can be brought, a limitation of joint and several liability and constraints on lawyers' contingency fees.[139]

Healthy America Act

S. 4, the Healthy America Act of 2005 was introduced on July 27, 2005, by Senator Bill Frist of Tennessee.[140] The fact that Senator Frist introduced this bill is important for two reasons. First, Senator Frist is a medical doctor, and he has cited his own medical credentials when promoting the bill.[141] Second, and more importantly, Senator Frist is the majority leader for the Republican Party in the Senate. By utilizing his power as majority leader,[142] Frist gave medical malpractice reform additional attention.[143] Frist's devotion to the Act showcases the Republican Party's commitment to medical malpractice reform.

While the Healthy America Act contains the significant features of the HEALTH Act,[144] the Healthy America Act is more

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139. *See generally*, Henry Cohen, CONGRESSIONAL RESEARCH SERVICE, MEDICAL MALPRACTICE LIABILITY REFORM: H.R. 5, 109TH CONGRESS (July 29, 2005) (on file with author) (provides a summation of H.R. 5).

140. S. 4, *supra* note 15.

141. See Bill Frist, M.D., Spotlight on Healthcare, http://frist.senate.gov/index.cfm?FuseAction=IssuesLegislation.SpotlightOnHealthcare (last visited Jan. 13, 2006)

> As a heart and lung transplant surgeon, my life has been dedicated to improving individuals' lives through advances in health care. As a United States Senator, I am able to take the principles I learned as a physician . . . and apply them to my work on health care reform. While I continue to treat patients on an individual basis, I now have the privilege of being able to treat the collective health of the nation.

142. The Senate majority leader is the most powerful and influential member in that chamber. In the Senate, the leader sets the agenda, speaks for his party and promotes cohesion for his party. WALTER J. OLESZEK, CONGRESSIONAL PROCEDURES AND THE POLICY PROCESS 21 (6th ed., CQ Press 2004).

143. As majority leader, Frist took medical malpractice reform and packaged it with other GOP health care proposals for the 109th Congress. *See* Kate Schuler, *Frist Health Package Touts GOP Perenials to Curb Rising Costs and Uninsured*, CQ TODAY, 26 Sept. 2005, *available at* http://www.cq.com [hereinafter Schuler, *Frist Health Package*]. This package is still a priority of Frist in the second session of the 109th. *See* Kate Schuler, *Frist Plans to Revive a Plethora of Health Bills, But Many Have Already Floundered*, CQ TODAY, 1 Feb. 2006, *available at* http://www.cq.com.

144. *Compare* H.R. 5, *supra* note 15, §§ 3-8 *with* S. 4, *supra* note 15, tit. I, subtit. A. Many legislative endeavors have similar bills in the other chamber as they go

comprehensive. In addition to the HEALTH Act's noneconomic damage cap, the Healthy America Act, *inter alia*, would create a national office for the coordination of health information technology,[145] tax breaks within the health care industry,[146] loan repayment programs for medical students,[147] and additional aid to community health centers.[148] The Healthy America Act may be more appealing considering not only who introduced it, but also what it includes. The Healthy America Act may be more palatable to some Democrats due to its multifaceted approach towards the health care system.

Senate Bill 354 (the HEALTH Act)

S. 354, also known as the HEALTH Act of 2005,[149] is worthy of attention. The HEALTH Act of 2005 has the same key features of the previous HEALTH Act and the Healthy America Act, namely a $250,000 cap on noneconomic damages.[150] An important difference is that the HEALTH Act of 2005 does not have the lawsuit exemption available to entities with items approved by the Food and Drug Administration.[151] The Food and Drug Administration lawsuit exemption is important because many opponents of the HEALTH Act have pointed to the immunity as a reason to oppose the bill.[152] Further, this exemption was not received well by some members of the Republican Party, as well as by health care providers.[153] The HEALTH Act of 2005 may have more appeal than the base proposal in the HEALTH Act without the Food and Drug Administration lawsuit immunity.

To summarize, the major bills concerning medical malpractice reform all contain a $250,000 cap on noneconomic damages. No matter what the amount is, however, similar cap levels have posed legal troubles for state legislatures. State supreme courts have had various methods of treating constitutional guarantees of equal

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through the legislative process. *See* ROGER H. DAVIDSON & WALTER J. OLESZEK, CONGRESS & ITS MEMBERS 238 (10th ed. CQ Press 2006).

145. *Id.* § 2902.

146. *Id.* tit. II.

147. *Id.* § 333.

148. *Id.* tit. 3, subtit. A.

149. It is able to have the same title as H.R. 5 because it is a bill in a different chamber, the Senate.

150. *Compare* S. 354, *supra* note 15, §§ 4-9 *with* H.R. 5, *supra* note 15, §§ 3-8.

151. *See* H.R. 5 § 7(c); S. 4, *supra* note 15, § 107(c).

152. *See* Schuler, *House Oks*, *supra* note 129.

153. See Adams, Longer Shot, supra note 119.

protection. Although one can say that it is difficult to forecast how the Supreme Court of the United States would specifically handle such a varied response from the states if a federal cap is enacted, there is applicable Supreme Court jurisprudence on this issue which may shed some light on the future. In the next part, it will be examined whether such a cap would be a problem if placed before the Supreme Court.

PART III: A PROPOSED FEDERAL DAMAGE CAP & THE EQUAL PROTECTION GUARANTEES OF THE U.S. CONSTITUTION

The Equal Protection Clause of the Fourteenth Amendment of the United States Constitution[154] is considered a crucial cornerstone of American civil liberties.[155] The importance of the EPC has been highlighted by challengers to the state damage cap laws in the cases above, and others.[156] In fact, in the cases previously discussed, similar state constitutional provisions were cited with their respective versions of the EPC.[157]

Yet, as seen in the language of the EPC, its protections were rightly used against state denial of equal protection in the aforementioned cases. If a federal court were to examine a federal cap, however, the EPC clause, on its own, would not suffice. The Fourteenth Amendment is applied to the federal government via the Fifth Amendment;[158] therefore, any analysis of a federal cap will also be subject to Equal Protection Clause treatment.

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154. "No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV, § 1.

155. *See generally* WILLIAM E. NELSON, THE FOURTEENTH AMENDMENT: FROM POLITICAL PRINCIPAL TO JUDICIAL DOCTRINE (Harvard University Press 1988) (asserting that the Fourteenth Amendment attained its special prominence in American and judicial history by developing important constitutional rights); *but see* David A. Strauss, *The Irrelevance of Constitutional Amendments*, 114 HARV. L. REV. 1457 (2001) (arguing that considering the development of the law and tradition, the amendments to the Constitution were not necessary to change social order).

156. *See e.g.*, *Hoffman* 767 F.2d, at n.2; *Carson*, 424 A.2d, at 830.

157. *See, e.g.*, *Gourley* 663 N.W.2d 43 (arguing that the cap violated the equal protection clause of the Nebraska Constitution); *Hoffman*, 767 F.2d 1431 (arguing that the cap violated the equal protection clause of the California Constitution).

158. The Fifth Amendment assures all citizens that "[no person shall] be deprived of life, liberty, or property, without due process of law . . . ." U.S. CONST.

The Supreme Court has never taken a state damages cap case on its merits. The closest the Supreme Court has been in expressing its views was in the sole dissenting opinion by Justice White for a dismissal of appeal.[159] The case involved EPC concerns for California's cap. The appeal was dismissed because there was no substantial federal question; however, Justice White, in dissent, makes an astute observation about the issues surrounding state damages caps. He notes that there is much division among the states on whether a noneconomic damage cap violates one's equal protection and due process rights.[160] Justice White states that this occurrence, coupled with an emerging medical malpractice crisis, should have provided ample justification for the Court to take up the matter on the merits.[161] Nonetheless, the Court never provided any useful analysis for the topic at hand.

Yet there is still an applicable area of jurisprudence that has been formulated by the Court. When generally performing EPC analysis, the Supreme Court has recognized that a disputed law could fall into several categories, depending on its subject matter.[162] Concerning medical malpractice caps, an important category is that of tort reform, particularly with regard to the limitations placed on defendant liability.

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amend. V. The Supreme Court has held that "the concepts of equal protection [in the Fourteenth Amendment] and due process [from the Fifth Amendment], both stemming from our American ideal of fairness, are not mutually exclusive." Bolling v. Sharpe, 347 U.S. 497, 499 (1954); *see also* Schneider v. Rusk, 377 U.S. 163, 168 (1964) ("[W]hile the Fifth Amendment contains no equal protection clause, it does forbid discrimination that is 'so unjustifiable as to be violative of due process.'") (quoting *Bolling* 347 U.S. at 499).

159. Fein v. Permanente Medical Group, 474 U.S. 892 (1985), *dismissing appeal from* 695 P.2d 665 (Cal. 1985).

160. *Fein*, 474 U.S. 892 (White, J., dissenting).

161. *Id.* at 894.

162. Just within the context of a person's status are the categories of race and sex. *See* Stephanie M. Wildman, *Privilege, Gender, and the Fourteenth Amendment: Reclaiming Equal Protection of the Laws*, 13 TEMP. POL. & CIV. RTS. L. REV. 707, 710 (2004). There are also other areas such as free speech, *see* Alexander Gruber & Barbara Kritchevsky, *The Uneasy Coexistence of Equal Protection and Free Speech Claims in the Public Employment Context*, 31 U. MEM. L. REV. 559, 586-606 (2001), and even where one lives, *see generally* Gerald L. Neuman, *Territorial Discrimination, Equal Protection and Self Determination*, 135 U. PENN. L. REV. 261 (1987) (arguing that geographical status is not to be excluded from EPC analysis). The list continues. *See* NOWAK & ROTUNDA, *supra* note 48, § 14.3 (economic and tax classifications, mandatory retirement laws, mental status, etc.).

This specific tort reform category has triggered a rational basis review by the Supreme Court.[163]

Any cap on an award for medical malpractice, whether on punitive or noneconomic damages, is clearly a limitation on the liability of the defendant. The tortfeasor, even if found responsible, is not necessarily responsible for the damages a judge or jury finds as being proportional to his or her actions. Although the Supreme Court has yet to hear a case concerning caps on medical malpractice damages, there are analogous cases in the category of liability limitations.

An important case in this category is *Duke Power Co. v. Carolina Environmental Study Group, Inc.*[164] In *Duke Power* a federal cap found in the Price-Anderson Act was at issue.[165] With many private organizations refraining from investing in nuclear power plants, Congress passed the Act to encourage the developments of such plants.[166] Even though the risk of a nuclear catastrophe was minute, private investors did not want to be left vulnerable to that chance, which would entail a considerable amount of money.[167] To do so, the Act placed a $560 million cap on damages for which a plant could be held liable.[168] The District Court for the Western District of North Carolina held that this law violated the Equal Protection Clause, via the Fifth Amendment, because the Price-Anderson Act put the cost of sustaining the country's nuclear power industry "on an arbitrarily chosen segment of society, those injured by nuclear catastrophe."[169] State medical malpractice caps have been attacked on similar grounds.[170]

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163. *See* Usery v. Turner Elkhorn Mining Co., 428 U.S. 1 (1976).

164. 438 U.S. 59 (1978).

165. *Id.* at 64-65.

166. *Id.* at 64.

167. See id.

168. *Id.* at 65. Of note is that the cap was a combination of the maximum amount of private insurance and up to $500 million of indemnification by the federal government. *Id.* at 64-65. Nonetheless, there was still a cap on liability for the private entity.

169. *Id.* at 82 (quoting Carolina Envtl. Study Group v. U.S. Atomic Energy Comm'n, 431 F.Supp. 203, 225).

170. *See e.g.*, *Carson*, 424 A.2d, at 830 ("The plaintiffs argue . . . that [the cap] improperly singles out victims of medical negligence, as distinct from victims of other kinds of negligence"); *Hoffman*, 767 F. 2d, at 1433 ("The court found that [the cap] . . . discriminated between medical malpractice victims with noneconomic losses that exceed $250,000 and all other tort victims with noneconomic losses . . ."). The only difference is that the classifications allegedly created in the state cap

With this categorization in mind, the Court conducted a due process analysis.[171] The Court first determined which standard of review was appropriate. To make this assessment, Chief Justice Warren Burger needed to determine the nature of the Act: was it a law of economic regulation or a regulation that involved the fundamental rights of the plaintiffs?[172] This determination was crucial because if the law was an economic regulation, it deserved rational basis review, and thus "the traditional presumption of constitutionality generally accorded. . . and that it be upheld absent proof of arbitrariness or irrationality on the part of Congress."[173] Conversely, as the appellees argued, if the law involved interests "more important than those in the economic due process and business oriented cases," then the Court would utilize a higher standard of review.[174] In examining the legislative history of the Act, the Court saw it as an economic regulation and thus applied rational basis review.[175]

Yet the issue does not end here; the *Duke Power* Court continued to look at the law, as an economic regulation, under the rational basis test. The Court found that the liability limitation was necessary to "encourage private industry participation and hence bears a rational relationship to Congress' concern for stimulating"[176] such participation. The Court then specifically analyzed the $560 million cap to see if it was an "acceptable method for Congress to utilize in encouraging the private development"[177] of nuclear energy. The cap was justified by its reasonableness and support from experts in the nuclear energy field.[178] The cap was found to be rational and not arbitrary as liability

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cases were not highlighted as being "arbitrarily chosen." Nevertheless, all of these classifications consist of individuals who are economically limited in a negligence claim.

171. The Court utilized the term "due process" throughout its analysis, however, it later stated that due process and equal protection arguments are synonymous. *Duke Power*, 438 U.S. at 93.

172. *Id.* at 82-83.

173. *Id.*

174. *Duke Power*, 438 U.S. at 83. Within this argument, the appellees appear to be attempting to define their class. If a class is seen as suspect or a fundamental right of that class is affected, strict scrutiny of the law must be used. *See supra* n. 49. The alternative given by the appellees tried to show that those who were capped at $560 million had a fundamental right affected.

175. *Duke Power*, 438 U.S. at 82-83.

176. *Id.* at 84.

177. *Id.* at 86.

178. *Id.* at 89-90.

limitation.[179] It therefore did not violate the Equal Protection Clause of the Fourteenth Amendment.

In carefully reading *Duke Power*, two crucial tenets emerge that are applicable to federal malpractice caps. First, a federal cap on noneconomic damages would almost certainly be viewed automatically as an economic regulation, thus calling for rational basis review. A Justice would not even have to look at the legislative history of such a bill.[180] The findings and purpose sections of the bills discussed above in Part II, as well as those most likely to be proposed in the future contain ample evidence for the Court to classify the bills as economic in nature. For example, there is the use of Congress' power under the Commerce Clause,[181] which implicitly involves trade and financial matters between the states.[182] Additionally, these bills attempt to deal with the effects of the medical malpractice crisis on the cost of health care[183] and federal spending. Such an intent by the bill is, prima facia, an economic regulation.[184] Therefore, such a cap will almost certainly be given the rational basis review.[185]

Second, after *Duke Power*, legislation that is challenged as denying equal protection is generally presumed to be valid.[186] The Supreme Court will only hold such a statute unconstitutional under the Equal Protection Clause if it does not rest "on grounds wholly irrelevant to the achievement of the State's objective."[187] Congress has recognized a legitimate goal in the bills relevant to this discussion: to reduce medical insurance premiums and thus increase patient access to health care

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179. *See id.* at 86-87.

180. Such legislative history includes hearing transcripts, committee reports, and floor debates. In fact, the committee report on H.R. 5 (from the 108th Congress) treats the cap as a key factor in the economics of the malpractice insurance system. *See* H.R. REP. NO. 108-32, pt. 1, at 21, 38 (2003).

181. Congress has power "[t]o regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes." U.S. CONST. art. I, § 8, cl. 3.

182. *See* H.R. 5, *supra* note 15, § 2(a)(2); S. 4, *supra* note 15, § 102(a)(2).

183. *See* H.R. 5, *supra* note 15, § 2(a)(1); S. 4, *supra* note 15, § 102(a)(1).

184. *See* H.R. 5, *supra* note 15, § 2(a)(3); S. 4, *supra* note 15, § 102(a)(3).

185. The Court could also look to previous federal precedent that has already classified similar state caps as deserving rational basis review and not strict scrutiny or intermediate review. *See e.g.*, *Hoffman*, 767 U.S. at 1435.

186. *See* City of Cleburne v. Cleburne Living Center, 473 U.S. 432, 439-40 (1985).

187. McGowan v. Maryland, 366 U.S. 420, 425 (1961).

through, inter alia, a damage cap.[188] There is ample evidence provided by Congress that shows how a medical malpractice cap may be necessary to reach these particular goals.

Segments of the legislative branch have presented evidence that there most likely is a link between insurance premiums and high jury awards in medical malpractice cases. A recent House Judiciary Committee report on the HEALTH Act is an excellent starting point. The report has an abundant number of referrals to statistics on insurance premiums and jury awards drawn from business magazines, medical liability reports, and insurance industry reports.[189] Additionally, in 2004, the Congressional Budget Office, an independent and nonpolitical arm of Congress, reported that "[e]vidence from the states indicates that premiums for malpractice insurance are lower when tort liability is restricted than they would be otherwise."[190] More specifically, Congress' Joint Economic Committee stated in 2003 that when medical malpractice insurance decreases in cost, the practice of defensive medicine also declines, and the amount of the number of Americans with health insurance increases.[191] The Committee also noted that medical malpractice reforms, such as caps on noneconomic damages will "reduce health care spending by 5 percent to 9 percent," a savings of billions of dollars.[192] These several findings will only bolster the Supreme Court's finding that there is a close and rational relationship between the means and the goal expressed by Congress.[193]

When looking at the totality of this evidence, the Court will almost certainly see a legitimate goal set by Congress that can rationally be attained by placing caps on noneconomic damages. The Court, under rational basis review, should not demand of Congress an explanation of its purpose or rationale for enacting such damages caps.[194] Further,

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188. *See* H.R. 5, *supra* note 15, § 2; S. 4, *supra* note 15, § 102. *See also* JOINT ECON. COMM., *supra* note 9, at 12-14, 19.

189. H.R. REP. NO. 108-32, pt. 1, at nn. 1, 66 & 85.

190. CBO, *supra* note 3, at 1, 5-6. CBO also admits, however, that "[e]ven large savings in premiums can have only a small direct impact on health care spending—private or governmental—because malpractice costs account for less than 2 percent of that spending." *Id.* at 1.

191. JOINT ECON. COMM., *supra* note 9, at 22-23.

192. *Id.* at 19, 23.

193. *But see* Gfell, *supra* note 20, at 799.

194. *See* Nordlinger v. Hahn, 505 U.S. 1, 15 (1992) ("To be sure, the Equal Protection Clause does not demand for purposes of rational-basis review that a

the Court has stated that they will not pass judgment on the legislature's wisdom, so long as it passes rational basis review.[195] Specifically, in the area of economic regulation, the Congress does not run afoul of the Equal Protection Clause and the Fifth Amendment "merely because the classifications made by its laws are imperfect. If the classification has some 'reasonable basis,' it does not offend the Constitution simply because the classification 'is not made with mathematical nicety or because in practice it results in some inequity.'"[196] Based on this Supreme Court jurisprudence it will be extremely difficult to strike down federal medical malpractice damages caps simply because they discriminate against victims whose tort caused more than $250,000 (or whatever determined amount) in noneconomic damages, and victims whose tort awards total less.

CONCLUSION

The liability system for medical malpractice cases is in need of repair.[197] Whether the cause of such disarray is from high jury awards or higher health care industry operating costs, or both, proponents and opponents of medical malpractice reform agree that the status quo is less than ideal.[198] In order to relieve the stress on the health care industry, some have suggested limiting damages given for noneconomic loss, commonly known as "pain and suffering." Several state legislatures have enacted caps on noneconomic damages. In turn, state courts have given mixed reviews of these laws when challenged as not providing guarantees of equal protection under the law.[199] Federal courts have been far less inconsistent when examining state damages caps.[200] Yet, for the most part, federal district and circuit courts have upheld these damages caps under rational basis review.

Considering an impending crisis and the mixed reactions to these state laws, the Republican-controlled Congress made attempts at

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legislature or governing decisionmaker actually articulate at any time the purpose or rationale supporting its classification.").

195. *See* Schweiker v. Wilson 450 U.S. 221, 234 (1981) ("The Court has said that, although this rational-basis standard is 'not a toothless one,' it does not allow us to substitute our personal notions of good public policy for those of Congress . . ." (citation omitted)).

196. Dandridge v. Williams, 397 U.S. 471, 485 (1970) (quoting Lindsley v. Natural Carbonic Gas Co., 220 U.S. 61, 78 (1911)).

197. *See* JOINT ECON. COMM., *supra* note 9, at 24.

198. *See supra* note 37 and accompanying text.

199. *See supra* Part I.B.

200. *See supra* Part I.C.

enacting a federal cap on damages awarded in medical malpractice cases.[201] These bills are using recycled language and will almost certainly be included when Congress finalizes and passes a medical malpractice reform bill.

When looking at this language, in all likelihood, trial lawyers and medical malpractice victims in danger of receiving limited damages, will challenge a federal cap under the Equal Protection Clause of the United States Constitution. As shown, the Supreme Court should uphold a federal cap on noneconomic damages under the EPC. This conclusion can be verified through both the federal courts' case law in regard to similar state damages caps[202] and the Supreme Court's jurisprudence concerning federal limitations on liability in other fields of federal regulation.[203] If Congress ultimately decides to enact a cap on damages and overcomes the legislative gridlock,[204] it appears that the EPC will mount little opposition to such a cap in the Supreme Court.

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201. The caps have been targeted at both punitive and noneconomic damages regularly since the Republicans took Congress in 1994. *See supra* Part II.A, II.B.

202. *See supra* Part I.C.

203. *See supra* Part III.

204. *See supra* p. 17 and accompanying notes.