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THE HEALTH ACT'S SAME OLD STORY, DIFFERENT CONGRESS DILEMMA: OVERHAULING THE HEALTH ACT AND UNIFYING CONGRESS AS A REMEDY FOR TORT REFORM

In the spring of 2003, physicians in south Florida conducted a “slowly building walkout” in which they gradually stopped seeing patients in hospitals (generally with the exception of emergency cases) and stopped performing elective surgeries.¹ The “walkout” followed a special session of the state legislature that failed to pass a package of medical malpractice tort reforms that included caps on monetary damages.² Citing the rising costs of medical liability insurance, one group of Palm Beach County doctors sought leaves of absence from local hospitals, choosing to see patients only in their offices, where the risk of lawsuits is lower.³

Consumer groups immediately decried such moves. The executive director of one group accused Florida doctors of “exploiting their unique position as caregivers and holding their patients’ lives and their patients’ well-being hostage in order to intimidate the Legislature into acquiescing to their demands.”⁴ The president of the Palm Beach physicians’ group said, however, that it was “not going to abandon any patients” but felt it had to act because “[t]he message doesn’t seem to be getting through to the politicians.”⁵

Just a few months earlier, thousands of doctors in New Jersey had participated in a statewide work stoppage that lasted five days.⁶ That work stoppage was followed by a “county-by-county ‘rolling’ strike” in mid-June, in

1. Bob LaMendola, *Doctors Insist They Won't Dump Patients: Malpractice Protest Aims at Legislators*, South Florida Sun Sentinel (Ft. Lauderdale) 4B (May 29, 2003). Examples of elective, non-emergency surgeries are biopsies, hernia repairs, hysterectomies, and joint replacements. Alex Frangos, *The Doctor Is Out . . . on Strike: As Physician Protests Mount, Patients Face Cancellations, Delays, Prescription Hassles*, The Wall Street Journal D1 (May 8, 2003).

2. LaMendola, *supra* n. 1.

3. *Id.*

4. Bill Newton, *Doctors' Tactic Wrong Approach to Bring Insurance Fees in Line*, S. Fla. Sun-Sentinel (Ft. Lauderdale) 21A (May 19, 2003).

5. LaMendola, *supra* n. 1.

6. In February, 2003, “[u]p to two-thirds of the state’s 22,000 physicians closed their offices, canceled appointments and elective surgery, and saw only sick patients, or referred them to emergency rooms. One day that week, several hospitals treated more patients in their emergency rooms than on any day in their histories.” Bob Groves, *Bergen Doctors to Strike for a Day: County-by-County Closings Slated on Malpractice Issue*, The Record (Hackensack, N.J.) A1 (June 17, 2003) (available at 2003 WL 4619719).

which each day saw the physicians of a different New Jersey county closing their offices and canceling elective surgeries.⁷ Again, the issue behind the strikes was medical malpractice tort legislation. New Jersey physicians threatened even more expansive action if the state legislature failed to pass medical malpractice tort reform legislation.⁸

Similarly, in May 2003, more than 5,000 doctors in Pennsylvania closed down their offices over the course of a week.⁹ Local officials were required to establish an “emergency operations center” much like those used in the aftermath of hurricanes.¹⁰ The reason cited? Again, failure of the state legislature to enact medical malpractice tort reform legislation.¹¹

These are representative but by no means exhaustive examples of the recent turmoil in the healthcare industry. One article revealed that doctors in 18 states protested during May of 2003 alone;¹² the American Medical Association (“AMA”) includes those states in its list of states in which there is a “medical liability crisis.”¹³

Support for tort reform comes from other quarters too. Insurance companies blame increases in medical liability premiums on poor industry performance, which they say is caused by “the rapidly rising costs of medical liability claims.”¹⁴ Even the President of the United States supports tort reform. In a recent speech to the AMA, President Bush remarked that “if lawsuits are running up the cost of medicine [and] driving docs out of business, we’ve got to do something.”¹⁵ And in his January 2003 State of the Union address, he underscored his belief in the need to limit meritless claims: “No one has ever been healed by a

7. *Id.*

8. *Id.*

9. Frangos, *supra* n. 1. Frangos noted that emergency room physicians did not participate in the walkout; they stayed behind to handle the floods of patients being referred to emergency rooms by their physicians’ offices. *Id.* Other physicians kept their offices open for limited purposes (e.g., delivering babies) or with reduced staff. *Id.*

10. *Id.*

11. *Id.*

12. Frangos, *supra* n. 1, at D3.

13. AMA, *America’s Medical Liability Crisis: A National View*, <http://www.ama-assn.org/ama/noindex/category/print/11871.html> (accessed Sept. 11, 2004). As of July, 2003, those states included Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, West Virginia, and Wyoming. *Id.* Twenty-six other states (including the District of Columbia), according to the AMA, are currently “showing problem signs.” *Id.* The AMA lists only six states in the entire country—California, Colorado, Indiana, Louisiana, New Mexico, and Wisconsin—as being “currently okay.” *Id.*

14. H.R. Jud. Comm., *Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2003, Hearing on H.R. 5*, 108th Cong. 38-39 (Mar. 4, 2003) [hereinafter *Hearing on Health Act*] (testimony of Lawrence Smarr, President, Physician Insurers Association of America). The Physician Insurers Association of America (“PIAA”) is an association of professional liability insurance companies that are owned and operated by their insureds (including physicians, dentists, hospitals, etc.). *Id.* at 38. Smarr estimates that PIAA member companies insure more than 60 percent of the doctors in the United States. *Id.*

15. Devra Marcus, *I’m a Doctor, Not an Adversarial Unit of the Health Care Industry*, Wash. Post B2 (Mar. 16, 2003).

frivolous lawsuit.”¹⁶ To that end, President Bush has supported significant federal tort reform, in the form of the Help Efficient, Accessible, Low-cost, Timely Healthcare Act (“Health Act”).¹⁷ The Health Act was initially introduced in the House of Representatives in 2002, as the first stand-alone medical malpractice tort reform bill in history.¹⁸

Although the Health Act of 2002 passed in the House of Representatives by a narrow vote¹⁹ and was introduced in the Senate shortly thereafter, the Senate failed to take any further action during the remainder of the legislative session.²⁰ A nearly identical Health Act was again introduced in the House soon after the First Session of the 108th Congress convened. After a public hearing and markup by the House Committee on the Judiciary, the bill again passed by a narrow vote, largely along party lines²¹—“but not before opponents voiced serious concerns about the legislation’s potential effect on patients who are injured or killed by preventable medical errors.”²² Again, the companion bill was introduced in the Senate, but was never referred to any committee and saw no further action.²³ In fact, Senate Democrats explicitly discussed their plan to “block the bill, which they [said protected] insurance companies at the expense of victims.”²⁴

Undeterred, the Health Act’s proponents again introduced an identical version of the bill early in the Second Session of the 108th Congress.²⁵ This time,

16. Kristin Loiacono, *Forgotten Faces*, 39 Tr. 11, 11 (Mar. 2003).

17. H.R. 4280, 108th Cong. (May 12, 2004); H.R. 5, 108th Cong. (Mar. 13, 2003); H.R. 4600, 107th Cong. (Sept. 26, 2002).

18. Kristin Loiacono, *A Good Fight in the House over Medical Malpractice “Reform,”* 39 Tr. 11 (May 2003). Loiacono reports that previous medical malpractice reforms “had simply been incorporated in broader, unsuccessful proposals and in amendments.” *Id.*

19. The vote was 217-203. *Id.* Loiacono reports that 203 was “one of the largest numbers of representatives to vote against tort ‘reform’ since the present majority leadership assumed control in 1995.” *Id.*

20. Lib. Cong., *Bill Summary & Status for the 107th Congress*, Sen. 2793, <http://thomas.loc.gov/cgi-bin/bdquery/z?d107:SN02793:@@L&summ2=m&> (accessed Dec. 3, 2004).

21. The vote was 229-196. H.R., *Final Vote Results for Roll Call 64*, <http://clerk.house.gov/evs/2003/roll064.xml> (accessed Sept. 29, 2004). Two hundred thirteen of the “aye” votes were by Republicans; sixteen were by Democrats. *Id.*

22. Loiacono, *supra* n. 18.

23. Lib. Cong., *Bill Summary & Status for the 108th Congress*, Sen. 607, <http://thomas.loc.gov/cgi-bin/bdquery/z?d108:SN00607:@@L&summ2=m&> (accessed Dec. 3, 2004).

24. Joseph B. Treaster, *Malpractice Insurance: No Clear or Easy Answers*, 152 N.Y. Times C1, C3 (Mar. 5, 2003).

25. Lib. Cong., *Bill Summary & Status for the 108th Congress*, H.R. 4280, <http://thomas.loc.gov/cgi-bin/bdquery/z?d108:HR04280:@@L&summ2=m&> (accessed Dec. 3, 2004) [hereinafter *H.R. 4280 Status Report*]. Upon introduction of the 2004 version, one state representative humorously compared the United States Congress to the movie *Groundhog Day*, in which Bill Murray plays a character who relives the same day over and over again: “What does Congress do?” he asks. “We take up legislation that we have taken up before that is going nowhere and going nowhere fast. It is Groundhog Day here in this Congress.” 150 Cong. Rec. H4141 (daily ed. June 15, 2004) (statement of Rep. Rahm Emanuel).

The proponents of the Health Act’s tort reforms are nothing if not persistent. In addition to the three times the Health Act itself has been considered in the House of Representatives between 2002 and 2004, its primary tort reforms have been proposed in substantially the same form in the text of other bills on at least two occasions. See *Medicare Solvency and Enhanced Benefits Act of 2002*, H.R. 4942, 107th Cong. (June 13, 2002); *Common Sense Medical Malpractice Reform Act of 2003*, H.R. 321, 108th Cong. (Jan. 8, 2003). Neither passed the House. Lib. Cong., *Bill Summary & Status for the 107th Congress*, H.R. 4942 <http://thomas.loc.gov/cgi-bin/bdquery/z?d107:HR04942:@@L&summ2=m&>

however, the bill went straight to the House floor for a vote—without the opportunity for hearing or amendment.²⁶ For a third time, the bill narrowly passed in the House of Representatives.²⁷ Again, the companion bill saw no action in the Senate during the remainder of the Second Session.²⁸ This pattern suggests a dogged determination on the part of the Health Act's supporters to enact federal medical malpractice tort reform—but an equal resolve on the part of its opposers to prevent that from happening.

Clearly, medical malpractice tort reform has blossomed into a highly controversial topic. Contrary to what doctors, insurance companies, and even the president are saying, many people deny that a medical malpractice crisis exists today.²⁹ Others assert that even if a crisis does exist, it is not as severe as some people would make it out to be.³⁰ Both sides cite statistics in their favor.³¹ A thorough consideration of all relevant information—including the nature and causes of the current medical liability situation—reveals that the tort reforms proposed by the Health Act are poorly researched, poorly designed, poorly written, and likely to be ineffective if passed. This comment will first address the evidence for and against the existence of a malpractice “crisis” and consider the factors that are driving up liability insurance premiums. Second, it will provide a detailed consideration of the history and provisions of the controversial Health Act repeatedly introduced in the House of Representatives and will set forth several reasons why it should not be passed. Finally, it will suggest alternate types of tort reforms that have been suggested to more effectively address the problems plaguing the healthcare industry today.

I. THE MEDICAL MALPRACTICE “CRISIS”

A. *Does It Exist?*

Doctors and insurance companies—the major proponents of tort reform³²—claim that “[e]scalating jury awards and the high cost of defending against lawsuits” have caused medical liability premiums to skyrocket in the last several

(accessed Dec. 3, 2004); Lib. Cong., *Bill Summary & Status for the 108th Congress*, H.R. 321, <http://thomas.loc.gov/cgi-bin/bdquery/z?d108:HR00321:@@L&summ2=m&> (accessed Dec. 3, 2004).

26. *H.R. 4280 Status Report*, *supra* n. 25.

27. This time the vote was 229-197. 150 Cong. Rec. H2873-74 (daily ed. May 12, 2004).

28. In an interesting—and somewhat sneaky—move, the text of the Health Act of 2004 was appended to that of two other House bills, creating a package of proposed health care-related legislation. U.S. Senate, *Bill Summary & Status for the 108th Congress*, H.R. 4279, <http://thomas.loc.gov/cgi-bin/bdquery/z?d108:HR04279:@@S> (accessed Dec. 2, 2004). Nonetheless, the Senate never even voted on the measures before the Second Session adjourned. *Id.* See also H.R. 4279, 108th Cong. (May 12, 2004); H.R. 4281, 108th Cong. (May 12, 2004).

29. *Infra* nn. 43-51 and accompanying text.

30. *Id.*

31. *Infra* nn. 32-51 and accompanying text.

32. Eleanor D. Kinney, *Malpractice Reforms in the 1990s: Past Disappointments, Future Success?* 20 *J. Health, Pol., Policy & L.* 99, 123 (1995).

years, making it difficult or impossible for physicians to find or afford insurance.³³ Some malpractice insurance carriers—such as St. Paul, a company that formerly wrote approximately nine percent of the country's malpractice insurance policies—have pulled out of the industry as a result.³⁴ Those insurance companies that still write malpractice policies have sharply increased rates.³⁵ Physicians in high-risk practice areas, such as obstetrics and gynecology,³⁶ pay the highest yearly premiums, sometimes in the ballpark of six figures.³⁷ One study reported that obstetrician/gynecologist physicians paid 11.5% more in 2000 than they did in 1999; 9.2% more in 2001 than they did in 2000; and 19.3% more in 2002 than they did in 2001.³⁸ The end result, according to one reporter, is that “in many states it is getting difficult to find doctors who will deliver babies.”³⁹ Reports abound of physicians who are limiting their practices to medical specialties or geographical areas with lower malpractice premiums, refusing to perform high-risk procedures even in their areas of specialty, leaving the practice of medicine altogether,⁴⁰ or even worse—practicing without insurance.⁴¹ In a congressional hearing, the President of the AMA reported that “more than 26% of health care institutions

33. H.R. Subcomm. on Health of the Comm. on Energy and Com., *Assessing the Need to Enact Medical Liability Reform*, Hearing on H.R. 5, 108th Cong. 120 (Feb. 27, 2003) [hereinafter *Medical Liability Reform*] (testimony of Donald J. Palmisano, Pres., AMA). According to one source, one out of every six practicing physicians is on the receiving end of a medical liability claim each year. Michael D. Maves, Speech, *Jackpot Justice: The Need for Medical Liability Reform* (Omaha, Neb., Oct. 8, 2002) (transcript on file with *Tulsa Law Review*). Seventy percent of these claims are found to be meritless. *Id.*

As of March, 2003, insurance companies reported that they paid out—on average—\$1.65 for every dollar of premiums collected. William Tucker, *Legal Malpractice: Will Congress Side with the Lawyers or the Doctors?* 8 *Wkly. Stand.* 18 (Mar. 24, 2003). Another study reported that the average was \$1.40 for every dollar of premiums collected during 2001 and 2002, while the projection for 2003 was \$1.35. H.R. Subcomm. on Health of the Comm. on Energy and Com., *Harming Patient Access to Care: The Impact of Excessive Litigation*, Hearing on H.R. 4600, 107th Cong. 90 (July 17, 2002) [hereinafter *Harming Patient Access*] (testimony of Richard Anderson, M.D., The Doctor's Co.).

It is important to note, however, that an insurance company can collect less in premiums than it pays out in claims and still make a profit. Insurance companies rely in part on investment income to make up this difference. *Hearing on Health Act*, *supra* n. 14, at 71.

34. U.S. Dept. Health & Human Servs., *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing our Medical Liability System* 14 (July 24, 2002) [hereinafter *Improving Health Care*] (available at <http://aspe.hhs.gov/daltcp/reports/litrefm.htm>). This report also notes that other insurers have withdrawn from medical malpractice liability markets, either nationally or in certain states, including MIXX, PHICO, Frontier Insurance Group, and Doctors Insurance Reciprocal. *Id.*

35. *Id.* at 12.

36. “The average obstetrician is now sued twice in his or her career.” Tucker, *supra* n. 33, at 22.

37. Marcus, *supra* n. 15.

38. Maves, *supra* n. 33.

39. Tucker, *supra* n. 33, at 18.

40. Frangos, *supra* n. 1. *But see* John M.R. Bull, *Doctors Can't Prove Thinning Ranks: Medical Society Chief Admits Group Lacks Statistics to Show Physicians Are Leaving*, *Morning Call* (Allentown, Pa.) A1 (Apr. 23, 2004). Bull reports that after waging a three-year “intensive public relations and lobbying campaign to convince legislators and their constituents that doctors are fleeing the state en masse,” the chairman of the Pennsylvania Medical Society recently admitted that the organization has no statistical evidence to back its claims. *Id.* State Insurance Department statistics show that there has been “no appreciable reduction” in the number of physicians practicing in high-risk specialty areas in the state of Pennsylvania. *Id.* Local politicians have accused the group of “frightening people, particularly senior citizens,” without having its numbers right. *Id.*

41. Maves, *supra* n. 33.

have reacted to the liability crisis by cutting back on services, or even eliminating some units.”⁴²

On the other hand, lawyers and consumer groups dispute claims that increases in medical liability premium rates have been that extreme; these groups say that malpractice premium rates are rising no faster than other healthcare costs⁴³ or rates for other types of commercial insurance.⁴⁴ An economist at Princeton University remarked that “[s]ome doctors are hard hit, . . . but on average, this problem is overstated.”⁴⁵ One study indicated that on average, doctors only spend about 3.2% of their revenue on malpractice insurance, less than what they spend on rent.⁴⁶ One researcher even found that “[i]nflation-adjusted medical malpractice premiums have declined by one-third in the last decade.”⁴⁷

These groups dispute other claims made by tort reform proponents. For example, their studies have found no evidence to support claims that doctors are leaving certain areas because of high insurance rates; instead, they indicate that “doctors are flooding into many of these states.”⁴⁸ These groups note that legislatures in states such as Nevada, Mississippi, and Ohio have enacted the very tort reforms sought by physician groups and insurance companies—and yet doctors in those states “are still struggling to find affordable insurance.”⁴⁹ Thus

42. *Medical Liability Reform*, *supra* n. 33, at 122 (testimony of Donald J. Palmisano, Pres., AMA).

43. Peter Eisler, Julie Appleby & Martin Kasindorf, *Special Report: Hype Outraces Facts in Malpractice Debate*, USA Today 1A (Mar. 5, 2003) (available at 2003 WL 5306369).

44. *Harming Patient Access*, *supra* n. 33, at 108 (testimony of Travis Plunkett, Consumer Fedn. of Am.).

45. Eisler et al., *supra* n. 43.

46. *Id.* One thing to keep in mind is that physicians claim to be damaged by the “hidden” costs of the malpractice system: missed workdays to attend trials and depositions, “costly adaptations of practice style” (such as hiring additional or better office staff or seeing fewer patients), different or additional continuing medical education taken, etc. David J. Nye, Donald G. Gifford, Bernard L. Webb & Marvin A. Dewar, *The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances*, 76 Geo. L.J. 1495, 1510 (1988).

Another “hidden” cost widely discussed by proponents of tort reform is that of “defensive medicine.” The theory is that fear of lawsuits motivates physicians to do more than what is actually medically necessary for their patients. “From the increased ordering of tests, medications, referrals and procedures to increased paperwork and reluctance to offer off-duty medical assistance,” one study found, “the impact of the fear of litigation is far-reaching and profound.” H.R. Subcomm. on Commercial & Admin. L. of the Jud. Comm., *Health Care Litigation Reform: Does Limitless Litigation Restrict Access to Health Care? Hearing on H.R. 4600*, 107th Cong. 11 (June 12, 2002) (quoting Harris Interactive, Inc., *The Fear of Litigation Study—The Impact on Medicine* 8, <http://cgood.org/assets/attachments/57.pdf> (Apr. 11, 2002)). The estimated cost of defensive medicine is \$15 billion annually. Buddy Rake & Bobby Thrasher, *Medical Malpractice Myths, Truths and Solutions*, 32 Ariz. Atty. 20, 21 (Mar. 1996). Other studies conclude, however, that it is not that easy to determine the cost of defensive medicine; it “results from a complex relationship of factors that combine to increase health care costs.” *Id.* Further, some claim that defensive medicine is an “institutionalized practice,” the effect of which is to deter negligence—a desirable result. *Id.*

47. *Harming Patient Access*, *supra* n. 33, at 113 (testimony of Travis Plunkett, Consumer Fedn. of Am.).

48. Ctr. for Just. & Democracy, *CJ&D Report Refutes American Medical Association Claims of “Crisis”: AMA Ignores Contradictory Courtroom and Medical Evidence in 18 States*, <http://www.centerjd.org/press/release/030424.htm> (Apr. 24, 2003) [hereinafter *CJ&D Report*] (quoting Joanne Doroshov, Exec. Dir., Ctr. of Just. & Democracy).

49. *Id.*

they conclude that “the cause and solutions lie with the insurance industry, not the legal system.”⁵⁰ These individuals and groups accuse physicians and insurance companies of “relying on scare stories” that are unsupported by the evidence “to make their case.”⁵¹

It is clear that whether there is a “crisis” or not largely depends on which statistics one finds to be credible. However, even if it is true that medical malpractice premium rates have risen disproportionately in recent years, it is still important to understand the cause before trying to determine the appropriate solution.⁵² It would be foolish to implement any tort reforms without identifying the underlying problems: experts believe that “poorly crafted” reforms could actually increase losses—which would only cause even higher rates.⁵³

B. Cause of the Problem

Assuming, for purposes of this Comment, that the healthcare industry now faces a crisis, what factors have caused the dramatic increases in the cost of liability insurance? Doctors and insurance companies allege that the single most important factor behind the increase in insurance rates is the medical malpractice tort infrastructure—what one physician described as “a rapidly growing income-transfer system from doctors to lawyers.”⁵⁴ The American Medical Association has referred to the tort litigation system as a “‘lawsuit lottery,’ where a few patients and their lawyers receive astronomical awards and the rest of society pays the price.”⁵⁵ In testimony the AMA submitted to Congress, it noted that the average cost of defending a medical malpractice claim is \$24,000 and that 70% of claims end with no payment to the plaintiff, which shows “the degree to which substantial economic resources are being squandered on fruitless legal

50. *Id.*

51. Lorraine Woellert, *A Second Opinion on the Malpractice Plague*, Bus. Week 98, 100 (Mar. 3, 2003). Woellert noted that:

Both sides in the debate—doctors and insurers fighting for caps, and trial lawyers and patients fighting against them—are waging a war-by-anecdote. But clear away the dubious studies, the exaggerated line charts, the hysterical press releases, and look at the numbers, and the statistical case for caps is flimsy.

Id. at 98. Another study reported that claims that doctors have quit doing high-risk procedures because of high malpractice rates are not supported by statistics; rather, those making these claims ignore several contradictory studies. Eisler et al., *supra* n. 43.

52. “If dramatically increased medical malpractice premiums pose a compelling societal problem, then understanding the causes of increased premiums should precede enactment of any legislative measures to remedy the problem.” Nye et al., *supra* n. 46, at 1511.

Fran Visco, President of the National Breast Cancer Coalition, testified before Congress:

While medical malpractice insurance rates are increasing, there is no conclusive evidence as to why. There also seems to be a lack of clarity about what this really means for patients . . .

We must ensure that we are addressing the real issue, the right way, rather than rushing to enact a solution before we truly understand the problem.

Harming Patient Access, *supra* n. 33, at 38.

53. *Medical Liability Reform*, *supra* n. 33, at 35 (testimony of James Hurley, Am. Acad. of Actuaries).

54. Marcus, *supra* n. 15.

55. *Medical Liability Reform*, *supra* n. 33, at 122 (testimony of Donald J. Palmisano, Pres., AMA).

wrangling.”⁵⁶ One research firm reported that medical malpractice jury awards increased 175% between 1994 and 2000, to a median of \$1 million.⁵⁷ The AMA noted that while overall tort costs have risen 9.4% per year since 1975, medical malpractice costs have risen 11.6%.⁵⁸ The AMA, other doctors’ groups, and insurance companies argue that these are the most important factors affecting malpractice insurance premiums, and that they are severe enough to warrant federal intervention.⁵⁹

Again, there is another side to the debate, with statistics of its own. Lawyers and consumer groups argue that there has not been an explosion in the number of claims filed. Rather, one source noted that “[c]laims against the industry as a whole have actually been flat since 1996.”⁶⁰ Another reported that a study conducted by the National Center for State Courts showed minimal fluctuation in the number of medical malpractice cases filed, “with an overall 1 percent *decrease* in per capita filings.”⁶¹ In fact, several studies have concluded that most patients who are injured by doctors or hospitals never file claims.⁶²

These groups also attack the allegations that the dollar amount of jury verdicts has increased disproportionately in recent years, causing liability insurance premiums to rise. In fact, one study indicated that “claims against doctors are actually falling or have held steady” in most of the states the AMA has identified as crisis states.⁶³ These lawyer and consumer groups claim that studies by doctors and insurance groups are skewed or incomplete.⁶⁴ For example, one group pointed out the fact that the median malpractice verdict is significantly lower than the mean, because the former takes into account the fact that the vast majority of medical malpractice lawsuits end with a defense verdict; the latter does not.⁶⁵ Because the median is literally the middle number when all verdicts are grouped from smallest to largest, it is less likely to be disproportionately influenced by verdicts that are either unusually small or unusually large.⁶⁶ Doctors’ groups frequently rely on the mean, rather than the more representative

56. *Id.*

57. Grace Vandecruze, *Has the Tide Begun to Turn for Medical Malpractice?* 15 *Health Law* 15 (Dec. 2002).

58. *Medical Liability Reform*, *supra* n. 33, at 124 (testimony of Donald J. Palmisano, Pres., AMA).

59. *Id.*

60. Woellert, *supra* n. 51, at 100.

61. Ctr. for Just. & Democracy, *News Release: New Data Shows Medical Malpractice Filings Have Dropped over Last Decade: Refutes American Medical Association Claims of “Crisis” in Several States 1*, <http://www.centerjd.org/press/release/030811.pdf> (Aug. 11, 2003) (emphasis in original). Also of interest is the fact that seven out of 17 states studied by the National Center for State Courts reported larger decreases in medical malpractice filings, and that five of those seven states are on AMA’s “crisis” list. *Id.* This led the authors to conclude that “[t]he AMA has used this arbitrary classification to push for caps on damages in those states, even though court filings are *down*.” *Id.* (emphasis in original).

62. Rake & Thrasher, *supra* n. 46, at 21 (citing a Harvard University study finding that only one in eight patients injured by medical negligence files a claim).

63. *CJ&D Report*, *supra* n. 48.

64. *Id.*

65. Rake & Thrasher, *supra* n. 46, at 23.

66. Nye et al., *supra* n. 46, at 1547.

median, in making their arguments for tort reform.⁶⁷ The same authors acknowledged that the median jury award has gradually increased with time, but stated that the increase “has remained relatively constant in proportion to the increase in health care costs.”⁶⁸ And though it may be true that a few victims receive what may be considered “excessive awards,” the majority of such awards are reduced on appeal.⁶⁹

In addition, these groups point out something that physicians and the insurance industry tend to minimize or overlook completely: the cyclical nature of the insurance industry. The mid-1970s and mid-1980s both saw their own medical liability crises remarkably similar to the present one.⁷⁰ It is a pattern that “occurs with sufficient frequency” that it is known as the “underwriting cycle” or “liability insurance cycle.”⁷¹ Unlike other economic cycles, the underwriting cycle is primarily driven by changes in supply.⁷² It begins when the insurance market is highly profitable: high returns attract capital and encourage new companies to enter the market.⁷³ The new companies cut rates to attract customers, forcing existing companies to cut rates as well in order to “protect their market share.”⁷⁴ The rate cuts continue, resulting in artificially low premiums and causing ever-increasing underwriting losses, until the losses become too great and some insurers leave the market—“either voluntarily or because of insolvency.”⁷⁵ As a result, supply shrinks, making it possible for the remaining insurers to quickly raise rates to more realistic levels.⁷⁶ Higher rates once again result in industry profitability, beginning the cycle anew.⁷⁷

Lending further support to this insurance cycle theory is the fact that medical malpractice rates are not rising alone; commercial insurance rates are on the rise generally.⁷⁸ Making things in this cycle even worse were the terrorist attacks of September 11, 2001, which insurance analysts believe aggravated—but not caused—the problem.⁷⁹ To completely discredit the effect of the insurance cycle is

67. Rake & Thrasher, *supra* n. 46, at 22-23.

68. *Id.* at 23.

69. *Id.* at 22.

70. Eisler et al., *supra* n. 43.

71. W. Kip Viscusi & Patricia Born, *Medical Malpractice Insurance in the Wake of Liability Reform*, 24 J. Leg. Stud. 463, 469 (1995). Another source noted that “[t]he phenomenon known as the ‘underwriting cycle’ is unique to the insurance industry and represents a significant cause of the periodic malpractice insurance crises.” Nye et al., *supra* n. 46, at 1525.

72. Nye et al., *supra* n. 46, at 1525.

73. *Id.*

74. *Id.*

75. *Id.*

76. *Id.*

77. Nye et al., *supra* n. 46, at 1525.

78. *Harming Patient Access*, *supra* n. 33, at 108 (testimony of Travis Plunkett, Consumer Fedn. of Am.).

79. *Id.* Plunkett testified before Congress that there are a number of factors recognized by the National Association of Insurance Commissioners that may cause underwriting cycles, including: (1) adverse loss shocks; (2) changes in interest rates; and (3) under pricing in soft markets. *Id.* Immediately before September 11, a hard market was developing and insurance rates were rising: “Item 1, the shock loss was all that was missing. September 11th provided that in an aching painful way.” *Id.* at 112.

to “swallow the dubious line, that trial lawyers have managed to time their million dollar jury verdicts to coincide precisely with the bottom of the insurance cycle three times in the last 30 years.”⁸⁰

The investment activities of insurance companies also lead to rate increases. In the 1990s, when interest rates were high, insurance companies could invest premium dollars between the time they were received and the time they were paid out.⁸¹ Because interest rates were high, investment income was high and could be used to subsidize premium rates.⁸² This investment income allowed insurers to artificially lower premiums to deal with strong competition from new companies.⁸³ During these profitable times, insurers also overextended themselves by entering new markets or by insuring riskier practitioners in the old ones.⁸⁴ When financial conditions worsened, however, insurers had to sharply increase rates just to stay in business.⁸⁵

Both of the previous “crises” caused similar conditions to those seen today, such as physicians going on strike or out of business because they were unable to afford liability insurance.⁸⁶ And the political climate was much the same: a contemporaneous law review article, written in 1988, reported that “[p]hysicians . . . blamed lawyers, and lawyers . . . blamed the insurance industry and physicians.”⁸⁷ The major difference between the current “crisis” and the earlier ones, according to one researcher, is that the current malpractice climate is

80. *Id.* at 109. Even some insurance industry leaders acknowledge the nature of the underwriting cycle. “I don’t like to hear insurance company executives say it’s the tort system,” said Donald J. Zuk, CEO of Scpie Holdings, Inc., “it’s self-inflicted.” Ams. for Ins. Reform, *Industry Insiders Admit Over and Over Again: Insurance Business Practices and Investment Cycle to Blame for Insurance Liability “Crisis”* 2, <http://www.insurance-reform.org/pr/Quotes.pdf> (June 2, 2003). Similarly, the Ad Hoc Insurance Committee of the National Association of Attorneys General found that “the causes of, and therefore solutions to, the current crisis lie with the insurance industry itself.” *Id.*

81. Eisler et al., *supra* n. 43; Am. for Ins. Reform, *supra* n. 80, at 1 (quoting Victor Schwartz, Gen. Counsel, Am. Tort Reform Assn.).

82. Eisler et al., *supra* n. 43.

83. *Id.*

84. When business is good, insurers will often “write outside of their historical footprint” by entering new markets. Vandecruze, *supra* n. 57, at 15. To “gain traction” in these new markets, they lower policy prices to undercut the competition. *Id.* “As the competition increase[s], profitability [begins] to fall precipitously . . .” *Id.* To make up for increasing losses, insurers have to increase rates. *Id.*

85. *Id.* One analyst noted that the response by insurers when a market turns from “soft” to “hard” is completely predictable: “They shift from inadequate under pricing to unconscionable over pricing . . . cut back on coverage and . . . blame large jury verdicts for the problem.” *Harming Patient Access*, *supra* n. 33, at 109 (testimony of Travis Plunkett, Consumer Fedn. of Am.).

86. Nye et al., *supra* n. 46, at 1496-97. The exact words from this 1988 article could be seamlessly superimposed onto any article describing today’s crisis:

Pregnant women in smaller communities in a number of states no longer had access to obstetrical services as a result of increased malpractice premiums.

The crisis became life-threatening when neurosurgeons and other physicians stopped work to protest increased malpractice premiums; as a result, some emergency rooms closed and others curtailed services. The *Palm Beach Post* recounted the story of a patient rendered brain-damaged and paralyzed because of the lack of neurosurgical care.

Id. at 1495-97 (emphasis in original and footnotes omitted).

87. *Id.* at 1497.

more difficult for doctors than it is for insurers.⁸⁸ This is because changes in the healthcare market have made it more difficult—if not impossible—for physicians to pass increases in malpractice insurance costs through to their patients.⁸⁹ Managed care organizations, Medicare, and Medicaid all limit reimbursements to physicians.⁹⁰

Many groups advocating tort reform like the Health Act also overlook another important factor: the actual amount of medical malpractice that occurs on a yearly basis. One recent study, cited by the United States Department of Health and Human Services, found that up to 98,000 deaths caused by medical errors occur each year in the United States.⁹¹ In addition, studies have found that a relatively small number of physicians with multiple claims are responsible for the majority of medical malpractice payouts. The National Practitioner Databank, which is maintained by the Department of Health and Human Services, indicates that from 1990 to 2002, only five percent of physicians were involved in 54 percent of the total malpractice payouts.⁹² Only eight percent of the 35,000 doctors with multiple claims were disciplined by their state medical boards “in any way.”⁹³ These figures suggest that effective medical malpractice tort reform should include a method of disciplining physicians that is more effective than self-policing.⁹⁴ Another suggestion to improve healthcare quality is to create an atmosphere in which healthcare professionals feel free to work together to discuss errors, problems, and potential solutions; in the current system, fear of lawsuits keeps this from happening.⁹⁵

The foregoing information suggests that there is indeed a crisis in liability insurance affordability. Its severity, however, is difficult to gauge. Furthermore, it is evident that its causes are far more complex than physicians believe them to be. Major factors other than the malpractice tort system substantially contribute to the problem. As a result, any proposed solution must take all of these factors into

88. Eisler et al., *supra* n. 43.

89. *Id.*

90. *Id.*

91. *Improving Health Care, supra* n. 34, at 11. This report, called “To Err is Human: Building a Safer Health System,” was conducted by the Institute of Medicine in 2000. *Id.*

92. Sidney M. Wolfe, *Bad Doctors Get a Free Ride*, 152 N.Y. Times A25 (Mar. 4, 2003). The same study reported that approximately 35,000 doctors made two or more payouts between 1990 and 2002. *Hearing on Health Act, supra* n. 14, at 68. Another study, conducted in Nevada, found that only two physicians were responsible for more than half of the medical malpractice payouts in that state in 2002 (\$14 million out of \$22 million). Woellert, *supra* n. 51. Similarly, a study conducted in Florida in the late 1980s found that physicians with two or more paid claims were responsible for almost half of Florida’s total paid claims between 1975 and 1986. Nye et al., *supra* n. 46, at 1500.

93. *Hearing on Health Act, supra* n. 14, at 68.

94. Rake & Thrasher, *supra* n. 46, at 23. The authors present two possible solutions: (1) legislatively—or judicially—monitored review boards whose function is to discipline doctors who have committed malpractice, and (2) imposition of minimum practice guidelines to standardize the standard of care and make clear to physicians what is expected of them. *Id.* These practice guidelines would be designed to help juries understand the appropriate standards of care for a particular situation and how to differentiate between adverse effects caused by malpractice and naturally-occurring effects of age or disease. *Id.* at 23, 25.

95. *Improving Health Care, supra* n. 34, at 6.

consideration.⁹⁶ Proposed tort reform should address the two “fundamental objectives” of tort law: compensation of wrongfully injured patients and deterrence of negligent behavior by healthcare providers.⁹⁷ It should also fairly balance the needs of plaintiffs and of defendants.⁹⁸ The Health Act fails to meet all of these criteria.

II. HISTORY OF THE HEALTH ACT

The congressional sponsors of the Health Act report that it is modeled after “highly successful” tort reform enacted in California in the mid-1970s.⁹⁹ In 1975, California physicians faced a dramatic increase in medical malpractice premiums.¹⁰⁰ In response, some physicians went on strike, some moved to states with lower liability insurance rates, some limited their practices to low-risk areas, and some began to practice without any liability insurance coverage.¹⁰¹ Then-governor Jerry Brown called an emergency session of the state legislature to address the problem.¹⁰² The result of that emergency session was California’s Medical Injury Compensation Reform Act (“MICRA”).¹⁰³ Through MICRA, the legislature sought to address the problem in three ways: (1) by enacting significant tort reforms aimed at reducing the frequency and severity of medical malpractice lawsuits;¹⁰⁴ (2) by reducing the incidence of medical malpractice by “strengthening governmental oversight of the education, licensing and discipline of physicians and healthcare providers”;¹⁰⁵ and (3) by becoming more proactive in the insurance industry itself, authorizing “alternative insurance coverage” and setting new review procedures for rate increases.¹⁰⁶

Not surprisingly, MICRA’s effects in California are hotly disputed. Statistics indicate that although insurance premiums are rising in California, they are rising

96. As one consumer advocate testified to Congress while H.R. 4600 (the 2002 Health Act) was pending in the House of Representatives, “It doesn’t make sense that this legislation is being contemplated as a solution to skyrocketing insurance rates when the Congress has not yet investigated the industry’s justifications or its accounting practices.” *Harming Patient Access*, *supra* n. 33, at 49 (testimony of Lauren Townsend, Coalition for Consumer Just.). Similarly, one author remarked that “[j]ust as ‘junk’ scientific or sociological evidence cannot carry the burden for a proponent in court, ‘junk’ legislative findings should be disallowed.” David A. Saichek, *Putting a Lid on Caps*, 69 *Wis. Law. 5*, 5 (Dec. 1996).

97. Kinney, *supra* n. 32, at 100.

98. *Harming Patient Access*, *supra* n. 33, at 119 (testimony of Victor E. Schwartz, Partner, Shook, Hardy & Bacon, LLP). “If it is not fair,” said Schwartz, “it is not good.” *Id.*

99. *Hearing on Health Act*, *supra* n. 14, at 1.

100. Jonathan J. Lewis, *Putting MICRA under the Microscope: The Case for Repealing California Civil Code Section 3333.1(a)*, 29 *W. St. U. L. Rev.* 173, 174 (2001).

101. *Id.* at 174-75.

102. *Id.* at 173.

103. 1975 *Cal. Stat.* 3949-4007.

104. MICRA’s tort reform provisions are codified in part at *Cal. Civ. Code* § 3333.1(a) (West 1997) (eliminating the common law collateral source rule), *Cal. Civ. Code* § 3333.1(b) (West 1997) (eliminating collateral source providers’ subrogation rights), *Cal. Civ. Code* § 3333.2(b) (West 1997) (capping non-economic damages at \$250,000), *Cal. Civ. Proc. Code* § 667.7(a) (West 1987) (providing for periodic payments in any case where the verdict is \$50,000 or more), *Cal. Bus. & Prof. Code* § 6146 (West 2003) (setting statutory limits on attorney contingency fees).

105. *Am. Bank & Trust Co. v. Community Hosp.*, 683 P.2d 670, 672 (Cal. 1984).

106. *Id.*

at a slower rate than those in other states.¹⁰⁷ One study revealed that while medical liability insurance rates in the rest of the country increased by 505% between 1976 and 2000, California saw increases of only 167%.¹⁰⁸ This slower rate of increase has reportedly resulted in savings of more than \$1 billion per year.¹⁰⁹ California is one of only six states that the AMA classifies as “currently okay.”¹¹⁰ The issue, however, is whether these savings are attributable to MICRA. In 1988, thirteen years after MICRA, California adopted a measure designed to control insurance prices.¹¹¹ This measure, known as Proposition 103, required insurance companies to freeze rates, mandated a rate rollback, and established a regulatory scheme to prevent “unjustified rate changes.”¹¹² Some analysts contend that it is Proposition 103—not MICRA—that has led to the stabilization of California’s malpractice insurance market.¹¹³ They claim that medical liability insurance rates continued to increase drastically in the years between MICRA and Proposition 103—to the tune of 571%.¹¹⁴ It is Proposition 103, they say, that has brought about “the greatest drops in premiums and, so far, the most consistent.”¹¹⁵ California’s insurance commissioner, John Garamendi, has stated that both MICRA and Proposition 103 have contributed to the relatively stable liability insurance costs in California.¹¹⁶

Even if we assume, for purposes of this Comment, that MICRA is solely responsible for the relatively stable liability insurance climate in California, it does not necessarily follow that the Health Act will have the same result nationally. The Health Act completely omits some of MICRA’s most significant—and arguably most effective—provisions.¹¹⁷ Like MICRA, it provides for significant medical malpractice tort reforms; unlike MICRA, however, it does not impose stricter guidelines for disciplining bad doctors¹¹⁸ or establish any regulatory mechanism for the insurance industry.¹¹⁹ Opponents of the Health Act accuse its drafters of “cherry picking” MICRA’s provisions dealing with the tort liability system while “totally ignoring” these other types of reforms.¹²⁰ These criticisms support the allegations that the Health Act is a poorly researched and poorly planned response to only part of the problem.¹²¹

107. *Medical Liability Reform*, *supra* n. 33, at 2.

108. *Id.*

109. *Id.* at 127 (testimony of Donald J. Palmisano, Pres., AMA).

110. *Supra* n. 13 and accompanying text.

111. Treaster, *supra* n. 24, at C1.

112. *Medical Liability Reform*, *supra* n. 33, at 49 (testimony of Harvey Rosenfield, Pres., Found. for Consumer and Taxpayer Rights); Treaster, *supra* n. 24, at C1.

113. Treaster, *supra* n. 24, at C1.

114. *Medical Liability Reform*, *supra* n. 33, at 136 (testimony of Harvey Rosenfield, Pres., Found. for Consumer and Taxpayer Rights).

115. Treaster, *supra* n. 24, at C3.

116. *Id.*

117. *Hearing on Health Act*, *supra* n. 14, at 64-65.

118. *Id.*

119. *Medical Liability Reform*, *supra* n. 33, at 8.

120. *Hearing on Health Act*, *supra* n. 14, at 65.

121. *Supra* n. 96 and accompanying text.

III. THE HEALTH ACT IS NOT THE SOLUTION

A. Constitutional Challenges

Although this comment's main focus is the effectiveness of the Health Act, it is important to realize that there are significant potential constitutional challenges to its validity: (1) tort law is an issue to be regulated at the state level;¹²² (2) the Health Act exceeds Congress's power under the Spending Clause of the Constitution;¹²³ and (3) the Health Act exceeds Congress's power under the Commerce Clause of the Constitution.¹²⁴

1. Tort Law is an Issue to Be Regulated at the State Level.

There is a strong argument to be made that medical malpractice tort reforms are state issues to be dealt with by state legislatures because that is the long-standing tradition in this country.¹²⁵ Under traditional federalism doctrine, the states are considered better qualified than the federal government to shape tort policy to fit local needs.¹²⁶ Federalism thus provides a check on the federal government's power¹²⁷ and allows the states to "remould [sic], through experimentation, our economic practices and institutions to meet changing social and economic needs."¹²⁸ The states thus "serve as a laboratory," free to experiment with new policies "without risk to the rest of the country."¹²⁹ So when states, through their constitutions, have granted rights to their citizens, it is "inappropriate for Congress to limit" those rights.¹³⁰

Supporters of the Health Act have argued that federal action is necessary because the fact that "many state liability reform laws have been nullified by activist state courts or stripped of their most effective provisions under state constitutions"¹³¹ shows that it is not "within the ability of every state to enact

122. *Infra* nn. 125-37 and accompanying text.

123. U.S. Const. art. I, § 8, cl. 1 (setting forth Congress's spending power: "Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States").

124. U.S. Const. art. I, § 8, cl. 3 (giving Congress the power "To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes").

125. H.R. Rpt. 108-32 pt. 1 at 253 (Mar. 11, 2003). The Tenth Amendment to the Constitution requires that "[t]he powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." U.S. Const. amend. X.

126. Thomas A. Eaton & Susette M. Talarico, *Testing Two Assumptions about Federalism and Tort Reform*, 14 Yale L. & Policy Rev. 371, 372 (1996).

127. Betsy J. Grey, *The New Federalism Jurisprudence and National Tort Reform*, 59 Wash. & Lee L. Rev. 475, 511 (2002).

128. *New St. Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

129. *Id.*

130. H.R. Rpt. 108-32 pt. 2 at 39.

131. *Medical Liability Reform*, *supra* n. 33, at 125 (testimony of Donald J. Palmisano, Pres., AMA). Perhaps surprisingly, some of the Health Act's opposers come from states that have already enacted medical malpractice tort reforms. 150 Cong. Rec. E867 (daily ed. May 14, 2004) (statement of C. A. Dutch Ruppersberger). Representative Ruppersberger expressed his belief that caps on damages have been effective in addressing the needs of both doctors and patients in his home state of Maryland; nonetheless, he argued that Congress should "allow for the states to address their individual needs"

legislation to effectively resolve their [sic] respective medical liability crisis.”¹³² This argument is untenable. The fact that a particular law is not valid under a state’s constitution does not make that law a matter for federal legislation, and neither does the fact that states may disagree as to the constitutionality of a law. This is one of the very arguments for leaving tort policy under state control: to allow states to be responsive to the particular needs of their citizens.¹³³

Supporters of the Health Act in essence seek to limit this ability of the states to craft state-specific solutions to state-specific problems. They simply want Congress to “act as an uber-state legislature by passing a bill to significantly restructure what is most appropriately a matter for state governments.”¹³⁴ Over the last several years, however, the Supreme Court has repeatedly struck down federal legislation that has had the result of injecting the federal government into truly local matters.¹³⁵ In light of the Court’s most recent federalism jurisprudence, the Health Act will “almost certainly” face federalism challenges if passed.¹³⁶ Whether it will pass constitutional muster depends on whether Congress can prove that the federal interest that would be served by establishing uniformity in tort law outweighs the states’ interest in establishing their own local policies.¹³⁷

2. The Health Act Exceeds Congress’s Power under the Spending Clause.

One of the justifications the Health Act cites for congressional intervention in the area of healthcare is that “the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds.”¹³⁸ Specifically, the Act notes that the federal government funds Medicare and Medicaid, provides medical care to the armed forces and veterans, provides medical care through the Indian Health Service, and offers tax breaks to workers who are insured through their employers.¹³⁹ According to one source, the federal government has estimated it would save \$25

rather than impose a “forced federal one-size fits all solution.” *Id.*

132. *Medical Liability Reform*, *supra* n. 33, at 125 (testimony of Donald J. Palmisano, Pres., AMA).

133. Grey, *supra* n. 127, at 511.

134. H.R. Rpt. 108-32 pt. 2 at 40.

135. Grey, *supra* n. 127, at 479.

136. Allison H. Eid, *Tort Reform and Federalism: The Supreme Court Talks, Bush Listens*, 29 *Human Rights* 10, 11 (Fall 2002); Grey, *supra* n. 127, at 502.

137. Grey, *supra* n. 127, at 535.

138. H.R. 5, 108th Cong. at § 2(a)(3) (2003). Section 2(a)(3), describing the impact on federal funds, is reproduced here in full:

(3) Effect On Federal Spending.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

139. Eid, *supra* n. 136, at 11.

billion a year if the Health Act is passed.¹⁴⁰ And President Bush stated that “any time a malpractice lawsuit drives up the cost of health care, it affects taxpayers. It is a federal issue.”¹⁴¹ These factors allegedly justify federal intervention under the Spending Clause.

The Supreme Court’s Spending Clause jurisprudence gives Congress broad discretion in determining how to use federal funds; this discretion is, however, somewhat limited. In *South Dakota v. Dole*,¹⁴² the Court held that Congress could exercise its power under the Spending Clause even to achieve objectives outside its “enumerated legislative fields”¹⁴³ as long as the exercise was “in pursuit of ‘the general welfare.’”¹⁴⁴ The Court further held that Congress could impose conditions upon states’ receipt of federal funds as long as those conditions are reasonable and relate to the purpose for which the funds are expended.¹⁴⁵ Unfortunately, the Court declined to “define the outer bounds” of this “relatedness” limitation, as the limitation was directly satisfied in the case before it.¹⁴⁶ In this case, Congress must show that the Health Act’s mandatory federal tort reform conditions are reasonably related to the federal interests that arise by virtue of federally funded medical programs. If it is unable to do so, the Health Act will not withstand constitutional scrutiny.

Although it is undeniable that some healthcare transactions are federally funded, the weakness in this logic is that the Health Act’s provisions extend to “all ‘health care lawsuits’—not just those brought by or against recipients of federal funds.”¹⁴⁷ Government spending is not a factor in a vast number of lawsuits. In those cases, it would seem unlikely that Congress could claim the authority to impose mandatory tort reforms under the Spending Clause,¹⁴⁸ especially with the present Supreme Court’s emphasis on protecting “state sovereignty and dignity.”¹⁴⁹

3. The Health Act Exceeds Congress’s Power under the Commerce Clause.

The Health Act also invokes Congress’s power under the Commerce Clause in order to justify federal intervention in the tort reform area. The theory is that the medical malpractice liability systems existing in various states “are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system

140. *Id.*

141. *Id.*

142. 483 U.S. 203 (1987).

143. *Id.* at 207 (quoting *U.S. v. Butler*, 297 U.S. 1, 65 (1936)).

144. *Id.* (quoting U.S. Const. art. I, § 8, cl. 1).

145. *Id.* at 208.

146. *Id.* at 209 n. 3.

147. *Eid, supra* n. 136, at 11.

148. *Id.*

149. *Grey, supra* n. 127, at 502.

providers.”¹⁵⁰ For Congress to claim authority to mandate federal tort reform under this power, however, it must show that the activities it seeks to regulate “substantially affect” interstate commerce.¹⁵¹

For decades, the Supreme Court’s jurisprudence in this area suggested that Congress’s power under the Commerce Clause was almost unlimited.¹⁵² Beginning in 1995, however, the Supreme Court has imposed more restrictions upon this power. In *United States v. Lopez*,¹⁵³ the Supreme Court struck down a federal law prohibiting the possession of a firearm in a school zone.¹⁵⁴ The test under *Lopez* is that the regulated activity must itself be economic in nature or must be “an essential part of a larger regulation of economic activity.”¹⁵⁵ The Court reiterated this position in 2000 in *United States v. Morrison*.¹⁵⁶ In that case, the Court held that the mere existence of congressional findings reciting a particular activity’s effect on interstate commerce is not, in itself, enough to make legislation constitutional.¹⁵⁷ Rather, the court must make a judicial determination as to whether the regulated activity is sufficiently economic in nature.¹⁵⁸

Under the Health Act, the activity to be regulated is medical malpractice litigation. The crux of the argument in favor of congressional power under the Commerce Clause is that “excessive malpractice litigation results in increases in malpractice premiums, which in turn force physicians and patients to cross state lines.”¹⁵⁹ The problem with this line of reasoning, however, is that some research, as discussed above, indicates that such stories of physicians relocating to other states is largely anecdotal¹⁶⁰ and may not actually amount to a “substantial effect” on interstate commerce.¹⁶¹ In addition, it is unclear whether the activities regulated by the Health Act would be characterized as economic in nature.¹⁶² Most torts do not involve the exchange of money from one person to another.¹⁶³ And although the “externalities associated with torts,” like insurance, “may involve commercial transactions with interstate repercussions[,] . . . the torts themselves do not.”¹⁶⁴ Under its most recent Commerce Clause cases, the Supreme Court could very likely strike down the Health Act because of its non-economic nature.

150. H.R. 5, 108th Cong. at § 2(a)(2).

151. *U.S. v. Lopez*, 514 U.S. 549, 559 (1995).

152. *Grey, supra* n. 127, at 492-93.

153. 514 U.S. 549.

154. *Id.* at 552. This was the first time since the New Deal era that the Supreme Court struck down legislation enacted under the Commerce Clause. *Grey, supra* n. 127, at 493.

155. 514 U.S. at 559-61.

156. 529 U.S. 598.

157. *Id.* at 614.

158. *Id.*

159. *Eid, supra* n. 136, at 11.

160. *Supra* n. 51 and accompanying text.

161. *Eid, supra* n. 136, at 11.

162. *Id.*

163. *Grey, supra* n. 127, at 502. Possible exceptions to this general rule include products liability and motor vehicle accident cases. *Id.*

164. *Id.*

B. *The Health Act's Tort Reforms*

Even if the Health Act is found to be constitutionally valid, its provisions are still poorly researched, poorly designed, poorly written, and fundamentally one-sided. To facilitate understanding of the types of tort reforms proposed in the Health Act, this section will first consider the differences between first- and second-generation tort reforms, including their goals, proponents, and effectiveness. It will then consider some of the most controversial provisions of the Health Act. Specifically, it will address the Health Act's provisions regarding the following:

- (1) the statute of limitations for medical malpractice cases;
- (2) the cap on non-economic damages;
- (3) the cap on punitive damages and the burden of proof for punitive damages;
- (4) the "Fair Share Rule";
- (5) the limitation on contingency fees;
- (6) the elimination of the common law collateral source rule; and
- (7) the periodic payments provision for future damages.

1. First- and Second-Generation Tort Reforms

Tort reform—in all its various types—has been a topic of discussion since the first medical liability insurance crisis of the mid-1970s.¹⁶⁵ From these discussions have arisen the terms "first-generation" and "second-generation" reforms; the two are distinguished by their advocates, their primary goals, "their actual and expected effect" on the medical malpractice tort system, and the way courts have treated them when they have been challenged.¹⁶⁶ First-generation reforms are those that were widely adopted in the 1970s and 1980s in response to the "availability and affordability" crisis of the 1970s.¹⁶⁷ They are aimed at reducing claim frequency and severity by "making it more difficult for claimants to sue"¹⁶⁸ and are thus favored by insurers and health providers.¹⁶⁹ Second-

165. Kinney, *supra* n. 32, at 100.

166. *Id.*

167. *Id.* at 101.

168. *Id.*

169. *Id.* at 100. Interestingly, first-generation reforms also tend to be favored by Republicans, "who perceive physicians to be a natural Republican constituency." Kinney, *supra* n. 32, at 118-19. First-generation tort reforms, according to Kinney, include the following (this list is representative but not complete):

- Reforms aimed at claim severity (i.e., size of recoveries): caps on damages (both actual and punitive), periodic payment provisions, elimination of the collateral source rule, changes to the common law rule of joint and several liability. *Id.* at 102.
- Reforms aimed at claim frequency (i.e., number of suits): statutes of limitations, attorney fee controls, costs awarded as part of suit. *Id.*

generation reforms were developed later, primarily by academics.¹⁷⁰ They are based on the premise that “malpractice reform must do more than reduce the frequency and severity of malpractice claims and thereby negate unpredictable circumstances in underwriting medical liability insurance.”¹⁷¹ Their primary objective is to improve the medical malpractice tort system from the plaintiff’s perspective and to more directly address malpractice itself.¹⁷² These reforms have not been well-supported by the medical and insurance professions.¹⁷³

Research indicates that second-generation reforms are more likely to accomplish the major goals of the tort system: compensating wrongfully injured patients while deterring medical negligence.¹⁷⁴ Following the malpractice insurance crisis of the 1970s, when almost every state enacted one or more first-generation reforms,¹⁷⁵ courts in about half of the states in which they were challenged found them to be unconstitutional.¹⁷⁶ Courts gradually became “more receptive” to first-generation reforms during the 1980s, but research suggests that they have “actually had little effect on the malpractice adjudication and compensation system.”¹⁷⁷ Despite the promise that second-generation tort reforms hold, they are somewhat experimental and have likewise found little success to date.¹⁷⁸ Almost all of the Health Act tort reforms are classic first-generation reforms.¹⁷⁹

- Reforms aimed at the difficulty for plaintiff to win: expert witness requirements, limitations on res ipsa loquitur, and statute of frauds. *Id.*

- Reforms aimed at the judicial process: mediation, notice of intent to sue, calendaring and scheduling reforms. *Id.*

170. Kinney, *supra* n. 32, at 103.

171. *Id.*

172. *Id.* at 102-03. Second-generation tort reforms, according to Kinney, include the following (this list is representative but not complete): development of medical practice guidelines (standards of care), damage schedules, mandatory alternative dispute resolution, administrative fault-based systems, and no-fault approaches. *Id.* at 103.

173. *Id.* at 103.

174. Kinney, *supra* n. 32, at 99.

175. *Id.* at 101.

176. *Id.* at 120.

177. *Id.* at 119-20.

178. One reason suggested by Kinney for the seemingly minimal interest in second-generation tort reforms is that “states tend to be very responsive to business constituencies, including health care providers, often at the expense of consumer constituencies *in the interest of preserving the state’s competitive economic position.*” *Id.* at 122 (emphasis added). She concludes that a “strong consumer push” would be necessary in order for second-generation reforms to become widely adopted. Kinney, *supra* n. 32, at 124.

179. *See supra* n. 169 and accompanying text. In contrast, a substitute bill proposed during the House consideration of the 2004 Health Act contained a combination of both types of reforms. 150 Cong. Rec. H2869-H2872 (daily ed. May 12, 2004). Its first-generation reforms included a requirement that all medical malpractice plaintiffs submit a health care specialist’s affidavit of merit, as well as a provision for mandatory sanctions for frivolous actions. *Id.* at H2869-H2870. It also contained second-generation reforms such as mandatory mediation and a provision establishing an independent national commission to investigate (among other areas) ways to provide an increased sharing of information in the health care system. *Id.* at H2869-H2872.

2. The Health Act Statute of Limitations¹⁸⁰

Under the terms of the Health Act, an injured patient has three years from the date of manifestation of his or her injury (or one year from the date of discovery of the injury) in which to file a lawsuit. Actions by a minor must be brought within three years of the manifestation of the injury or by the minor's eighth birthday, whichever is later.¹⁸¹

This provision highlights one of the most basic problems with the Health Act: it is poorly drafted. What exactly does "manifestation" mean? It is not defined by the Act itself.¹⁸² How could the plaintiff's discovery of the injury occur before its manifestation? Because there are different time frames involved for the date of "manifestation" and the date of "discovery," the two terms must mean different things.¹⁸³ These questions remain unanswered.¹⁸⁴ The unclear language of this section may result in a judicially construed absolute time limit for filing a case, which would be a marked deviation from the common law "discovery rule."¹⁸⁵

3. The Health Act's Cap on Non-Economic Damages¹⁸⁶

The Health Act provides for unlimited damages for actual economic losses.¹⁸⁷ However, it caps non-economic damages at \$250,000. Non-economic damages are defined as:

180. H.R. 5, 108th Cong. at § 3. Section 3, "Encouraging Speedy Resolution of Claims," provides as follows:

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years after the date of manifestation of injury unless tolled for any of the following—

- (1) upon proof of fraud;
- (2) intentional concealment; or
- (3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor's 8th birthday, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

181. *Id.*

182. H.R. Rpt. 108-32 pt. 2 at 36.

183. *See id.*

184. *Id.*

185. *Id.*

186. H.R. 5, 108th Cong. at § 4(b), entitled "Additional Noneconomic Damages," provides, "[i]n any health care lawsuit, the amount of noneconomic damages, if available, may be as much as \$250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same injury."

187. H.R. 5, 108th Cong. at § 4(a) ("Unlimited Amount of Damages for Actual Economic Losses in Health Care Lawsuits").

[D]amages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.¹⁸⁸

Proponents of damage caps say they are necessary to prevent outrageous jury awards. A study conducted by the U.S. Department of Human Services found that “[u]nless a state has adopted limitations on non-economic damages, the system gives juries a blank check to award huge damages based on sympathy, attractiveness of the plaintiff, and the plaintiff’s socio-economic status (educated, attractive patients recover more than others).”¹⁸⁹

Patient advocate groups, however, say that caps on pain and suffering “put a price on a person’s life and are therefore offensive to the basic foundation of our social structure.”¹⁹⁰ Such caps objectify people by applying a “one-size-fits-all” limitation that minimizes “the uniqueness of their suffering.”¹⁹¹ Ironically, the patients who will be affected by damage caps the most are the most severely injured; those with lesser injuries will not likely be awarded damages above the cap.¹⁹²

Further, attorneys say caps make it more difficult to settle cases outside of court. One attorney in California, which has had MICRA’s \$250,000 cap on non-economic damages for more than 25 years, stated, “If you’re talking about getting the full \$250,000, you’re going to have to go to trial If the insurance company knows that’s the most they have to lose, they’re usually not going to offer that much before trial.”¹⁹³ Caps may even make it more difficult for injured patients to find lawyers to take their case. In a typical medical malpractice case, a lawyer invests up to \$100,000 to work a case up to trial.¹⁹⁴ Lawyers will have to be more selective in accepting potential cases because they know the potential recovery is limited.¹⁹⁵

Another major criticism of the cap specified in the Health Act is that it does not include a cost of living adjustment.¹⁹⁶ It is also not indexed to inflation. When California’s MICRA was enacted in the late 1970s, it too provided for a \$250,000 cap; that cap has never been indexed to inflation.¹⁹⁷ The problem is that \$250,000

188. H.R. 5, 108th Cong. at § 9(15).

189. *Improving Health Care*, *supra* n. 34, at 9.

190. Jane C. Arancibia, Student Author, *Statutory Caps on Damage Awards in Medical Malpractice Cases*, 13 Okla. City U. L. Rev. 135, 142 (1988).

191. *Harming Patient Access*, *supra* n. 33, at 95 (testimony of Jamie Court, Found. for Taxpayer & Consumer Rights).

192. Arancibia, *supra* n. 190, at 141.

193. Treaster, *supra* n. 24, at C3.

194. *Id.*

195. *Id.*

196. Although a cost of living adjustment was proposed for both the non-economic and punitive damages caps while the bill was pending in the House, it was soundly rejected. H.R. Rpt. 108-32 pt. 1 at 184-92. Similarly, a vote to increase the \$250,000 caps to \$1,600,000 (the equivalent of \$250,000 in 1975) was rejected as well. *Id.* at 202-08.

197. *Id.* at 35.

at the time MICRA was passed would be worth approximately \$40,000 today.¹⁹⁸ The California legislature has proposed adjustments to the cap on more than one occasion during the last 25 years, but has failed to pass them each time.¹⁹⁹ Similarly, with no adjustment provision in the Health Act, the value of non-economic damages will continue to decline until it is almost worthless, causing wrongfully injured patients to go without compensation for their pain and suffering.²⁰⁰

Another problem with damage caps is that they invade the traditional role of the jury. No matter how egregious the malpractice or how many defendants are involved, there is a hard-and-fast \$250,000 aggregate cap, and the jury has no discretion to make any adjustments whatsoever.²⁰¹ In fact, the jury will not even be informed of the damage cap;²⁰² instead, it will be treated as an automatic compulsory remittitur.²⁰³ This goes against a fundamental precept of our legal system: that an objective jury of one's peers is the fairest method to determine the value of a case based on its circumstances.²⁰⁴ Juries have been entrusted to assess damages "in a responsible manner" for hundreds of years,²⁰⁵ and generally do so. Juries are even trusted to make fair decisions regarding death penalty cases.²⁰⁶ To take decision-making power away from them in a purely monetary case is unwarranted.

Finally, those who oppose caps point out that there is no guarantee they will reduce health care costs or medical liability premiums.²⁰⁷ One independent financial-rating agency said that the "one thing that caps are sure to do" is to "boost insurance industry profits."²⁰⁸ In California, for example, insurers' operating profits under MICRA have been higher than their counterparts in other

198. *Id.*

199. *Hearing on Health Act*, *supra* n. 14, at 83-84.

200. H.R. Rpt. 108-32 pt. 1 at 184.

201. H.R. Rpt. 108-32 pt. 2 at 39. One article referenced two cases of medical malpractice that were highly-publicized in 2003: that of Jessica Santillan, the 17-year-old girl who received an organ transplant of the wrong blood type; and that of Linda McDougal, the woman who underwent a bilateral mastectomy after her doctor mixed up her and another patient's laboratory results. Eisler et al., *supra* n. 43. The article went on to note that under the Health Act, these two medical malpractice victims would be entitled to only \$250,000—"roughly the average annual salary for the types of surgeons who did their operations." *Id.*

An interesting comparison is Pennsylvania's tort reform legislation, which does not include a hard-and-fast cap on damages, but does allow health care providers to appeal a judgment "if paying those damages would force a doctor out of business or force a hospital to cut services, thereby affecting access to [health]care in the community." *Harming Patient Access*, *supra* n. 33, at 53 (testimony of Stuart H. Fine, Grand View Hosp. CEO).

202. H.R. 5, 108th Cong. at § 7(b)(2) (stating that "[t]he jury shall not be informed of [the] limitation" on punitive damages awards).

203. Saichek, *supra* n. 96, at 5.

204. Arancibia, *supra* n. 190, at 142.

205. *Id.*

206. *Medical Liability Reform*, *supra* n. 33, at 159-60.

207. Rake & Thrasher, *supra* n. 46, at 22.

208. Joanne Doroshov, *Ctr. for J. & Democracy, False Claims*, <http://www.centerjd.org/press/opinions/030618.htm> (accessed Nov. 28, 2004).

states.²⁰⁹ Insurers there have paid out less than fifty cents for every premium dollar they have taken in.²¹⁰ And yet industry insiders say that insurers have not passed these savings through to physicians in the form of reduced premiums.²¹¹

4. The Health Act's Punitive Damages Provisions²¹²

Although recovery for actual economic damages is unlimited under the Health Act, punitive damages are limited to the greater of \$250,000 or twice the amount of actual damages. This provision is a reaction to critics' claims that punitive damages have increased both in number and in size. Based on media coverage, one might assume this to be true. One attorney noted recently, however, that although extraordinarily large punitive damages awards receive thorough media attention, the public pays far less attention when the same awards are subsequently reduced by courts.²¹³ The same author pointed out studies that indicate punitive damage awards "have steadily declined and occur in only a fraction of civil cases."²¹⁴ She also noted that there are "valid public policy reasons" to support punitive damages, including protecting the public and

209. *Harming Patient Access*, *supra* n. 33, at 100 (testimony of Jamie Court, Found. for Taxpayer & Consumer Rights).

210. *Id.*

211. *Id.*

212. H.R. 5, 108th Cong. at § 7, "Punitive Damages," provides as follows:

(a) In General.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is rendered against such person, no punitive damages may be awarded with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages. At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

- (1) whether punitive damages are to be awarded and the amount of such award; and
 - (2) the amount of punitive damages following a determination of punitive liability. . . .
- (b) Determining Amount of Punitive Damages.—

(2) Maximum Award.—The amount of punitive damages, if awarded, in a health care lawsuit may be as much as \$250,000 or as much as two times the amount of economic damages awarded, whichever is greater. The jury shall not be informed of this limitation.

213. Michele M. Jochner, *Punitive Damages: The U.S. Supreme Court's Meandering Path*, 83 Ill. B. J. 576 (1995). Jochner provides several well-known examples of large punitive damages awards, including the \$2.7 million award against McDonald's in the hot coffee spill case, a \$7.1 million award to a California legal secretary in a sexual harassment case, a \$125 million award against the Upjohn pharmaceutical company in 1991, a \$101 million award against General Motors in a design defect case in 1994, and a \$5 billion award against Exxon Corporation related to the Valdez oil spill. *Id.*

214. *Id.* at 577. A study conducted by the Texas Trial Lawyer Association, the Texas Hospital Association, and the Texas Medical Association found that punitive damages "represent no significant economic factor in the health care system." Rake and Thrasher, *supra* n. 46, at 22.

detering wrong behavior.²¹⁵ In addition, punitive damages “fill a void where criminal sanctions for [wrongful] behavior are few and ineffective” and provide an incentive for plaintiffs who might otherwise hesitate to sue large corporate entities.²¹⁶

Despite the public policy purposes served by punitive damages awards, the Health Act requires the injured patient to meet a nearly impossible standard of proof in order to even put the issue of punitive damages before a jury. The Act requires a showing of “malicious intent” or “deliberate” failure to avoid injury on the healthcare provider’s part.²¹⁷ This provision “could increase the length and cost of malpractice actions because it prohibits plaintiffs from seeking punitive damages in an initial suit.”²¹⁸

Cap opposers also point out that ultimately, “[c]aps assign greater value to the limbs and lives of some people than the limbs and lives of others.”²¹⁹ This is because individuals like CEOs will be able to recover non-economic damages equal to twice their economic damages, which will almost inevitably be far higher than a woman or a child’s economic damages.²²⁰ Again, the compulsory cap is completely arbitrary and leaves no room for the exceptional case.²²¹

5. The Health Act’s “Fair Share Rule”²²²

Another controversial provision of the Health Act is its “Fair Share Rule.” This rule abolishes the common law doctrine of joint and several liability in the context of medical malpractice cases.²²³ Under common law, a plaintiff may obtain a judgment against a number of joint tortfeasors, and then collect the full amount against any one tortfeasor, regardless of its proportionate share of

215. Jochner, *supra* n. 213, at 577.

216. *Id.*

217. H.R. 5, 108th Cong. at § 7. One author noted that this “bill imposes a near-criminal standard for establishing whether punitive damages should be awarded, even in cases involving doctors who sexually abuse their patients or operate under the influence of alcohol. Proving flagrant disregard for a patient’s safety would not be enough, under this bill, to trigger an award of punitive damages.” Kristin Loiacono, *Medical Malpractice Bill Unveiled*, 38 Tr. 11 (June 2002).

218. H.R. Rpt. 108-32 pt. 2 at 36.

219. *Harming Patient Access*, *supra* n. 33, at 96 (testimony of Jamie Court, Found. for Taxpayer & Consumer Rights).

220. *Id.*

221. An interesting comparison is a products liability fairness bill that was passed by the Senate in 1995. Jochner, *supra* n. 213, at 578. It provides for a punitive damages cap of \$250,000 or twice the actual damages, but includes an “additur” provision that allows the judge to waive the cap in cases where the defendant’s conduct is “especially heinous.” *Id.*

222. H.R. 5, 108th Cong. at § 4(d). Section 4(d), “Fair Share Rule,” provides as follows:

(d) Fair Share Rule.—In any health care lawsuit, each party shall be liable for that party’s several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party’s percentage of responsibility. Whenever a judgment of liability is rendered as to any party, a separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant’s harm.

223. See H.R. Rpt. 108-32 pt. 1 at 223.

liability.²²⁴ A paying tortfeasor may then seek contribution from any of the other tortfeasors.²²⁵ The Health Act, however, requires the jury to determine each defendant's proportionate liability; the defendants are then only responsible for their percentage of any judgment against the group.²²⁶

On its face, this provision may not seem overly controversial. After all, many states have already modified the common law doctrine of joint and several liability, and a few have even abolished it altogether.²²⁷ The problem with abolishing the doctrine in the medical malpractice context, however, is that the end result requires the plaintiff to prove not only that each defendant was negligent, but also each defendant's proportionate amount of negligence.²²⁸ In many instances, the plaintiff is unconscious, anesthetized, or in great pain at the time of his or her injury and may not be able to state specifically what caused the injury.²²⁹ Further complicating the situation is the fact that many healthcare providers may be involved in the patient's treatment; identifying exactly who was responsible for what portion of the injury may be difficult, if not impossible.²³⁰ Additionally, if one tortfeasor is uninsured or bankrupt, the plaintiff will not be compensated at all for that person's share of the fault.²³¹ The potential ramifications of eliminating joint and several liability in such a case should be fully considered before being enacted into law.

224. See e.g. *Walt Disney World Co. v. Wood*, 515 S.2d 198 (1987) (holding theme park liable for entire damages award even though jury found it to be only one percent at fault).

225. *Hearing on Health Act*, *supra* n. 14, at 73.

226. While the 2003 Health Act was pending in the House, an amendment to reinstate the common law doctrine of joint and several liability was rejected. H.R. Rpt. 108-32 pt. 1 at 223. Arguments against it included the allegation that joint and several liability, a common law doctrine that has been in use for many years, "has led to a surge by plaintiffs' attorneys with deep pockets and a proliferation of lawsuits against those minimally liable or not liable at all." *Id.*

227. Eaton & Talarico, *supra* n. 126, at 379-80.

228. *Hearing on Health Act*, *supra* n. 14, at 72.

229. *Id.* at 76.

230. *Id.*

231. *Id.* at 73.

6. The Health Act's Limitation on Contingency Fees²³²

The Health Act limits attorney contingency fees based on a sliding scale depending on the amount recovered.²³³ While tort reform advocates claim that contingency fee limitations maximize recoveries for injured patients, what they really do is “[create] an uneven playing field for victims.”²³⁴ The contingency fee arrangement has been described as “a poor patient’s only hope of affording an attorney”²³⁵ because medical malpractice cases are very expensive to try, and most medical malpractice plaintiffs would be unable to pay their attorneys under any other payment arrangement. Research also indicates that limiting contingency fees will not reduce the number of medical malpractice lawsuits filed or healthcare costs.²³⁶ A healthy contingency fee environment already has that effect: attorneys who recognize that medical malpractice cases require extensive work-up and expensive expert testimony will not file claims they do not believe to be well-grounded in law and fact.²³⁷ Any attorney who does file a “nuisance” lawsuit is not only unethical or inexperienced, but will also find him or herself destitute—that is the nature of medical malpractice work.²³⁸

In addition, it seems fundamentally unfair to limit plaintiff contingency fees but not defense fees. As one consumer advocate noted, “[d]efendants can

232. H.R. 5, 108th Cong. at § 5. Section 5, “Maximizing Patient Recovery,” provides as follows:

(a) Court Supervision of Share of Damages Actually Paid to Claimants.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant’s damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity. In no event shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed the following limits:

- (1) 40 percent of the first \$50,000 recovered by the claimant(s).
- (2) 33 1/3 percent of the next \$50,000 recovered by the claimant(s).
- (3) 25 percent of the next \$500,000 recovered by the claimant(s).
- (4) 15 percent of any amount by which the recovery by the claimant(s) is in excess of \$600,000.

(b) Applicability.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section. The requirement for court supervision in the first two sentences of subsection (a) applies only in civil actions.

233. *Id.*

234. *Harming Patient Access*, *supra* n. 33, at 98 (testimony of Jamie Court, Found. for Taxpayer & Consumer Rights).

235. *Id.*

236. *Rake & Thrasher*, *supra* n. 46, at 22.

237. *Id.* While the 2003 Health Act was pending in the House, one representative proposed an amendment that would eliminate this limit on contingency fees. H.R. Rpt. 108-32 pt. 1 at 228. In support of his amendment, he argued that it is the contingency-fee arrangement itself that is a check on frivolous lawsuits: attorneys know that “when you lose you get paid nothing.” *Id.* His amendment was soundly rejected. *Id.* at 232.

238. *See* H.R. Rpt. 108-32 pt. 1 at 23 (noting that it is “just too expensive” to “take on a frivolous malpractice claim”).

typically afford very high priced attorneys who fly special expert witnesses in from out of state,” while “[a] contingency fee practice demands that a plaintiff’s attorney must front the cost of expert witnesses With caps on fees, such costs become prohibitive for the victim’s legal counsel.”²³⁹ It would be fundamentally unfair to give defendants such a large advantage by limiting plaintiff attorneys’ potential to recover their costs.

7. The Health Act and the Common Law Collateral Source Rule²⁴⁰

One of the Health Act’s most controversial provisions is the elimination of the common law collateral source rule.²⁴¹ At common law, a defendant is not allowed to introduce evidence of any compensation or benefits received by the plaintiff from any source “wholly independent” of the tortfeasor,²⁴² such as health insurance. Several justifications have been put forth for this rule. One is that a tortfeasor “should not garner the benefits of his victim’s providence.”²⁴³ Rather, if anyone is to benefit from the plaintiff’s “foresight and diligence,”²⁴⁴ it should be the plaintiff. Another is that the rule encourages people to maintain insurance.²⁴⁵ Still another is that the additional recovery under the rule offsets the plaintiff’s attorney fees and court costs.²⁴⁶ Regardless of its rationale, the effect of this rule is that tortfeasors are required to pay for the full amount of the harm they cause, whether or not the plaintiff has received compensation from any other source.²⁴⁷ If a plaintiff successfully recovers damages from the wrongdoer, then the collateral source provider may have a subrogation claim against the plaintiff. The Health Act would eliminate both the collateral source rule and the right of subrogation.²⁴⁸

239. *Harming Patient Access*, *supra* n. 33, at 98 (testimony of Jamie Court, Found. for Taxpayer & Consumer Rights).

240. H.R. 5, 108th Cong. at § 6. Section 6, “Additional Health Benefits,” provides (in part) as follows:

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant’s recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit involving injury or wrongful death. This section shall apply to any health care lawsuit that is settled as well as a health care lawsuit that is resolved by a fact finder.

241. *Id.* It is interesting to note, however, that while the House bill completely eliminates the collateral source rule, as well as any collateral source provider’s subrogation rights, the Senate bill retains the collateral source rule where the provider has a subrogation right. Sen. 607, 108th Cong. § 7(b) (Mar. 12, 2003).

242. *See e.g. Helfend v. S. Cal. Rapid Transit Dist.*, 465 P.2d 61, 63 (Cal. 1970).

243. Lewis, *supra* n. 100, at 183.

244. *Id.*

245. *Id.* at 196.

246. *Id.* at 184.

247. *Harming Patient Access*, *supra* n. 33, at 99 (testimony of Jamie Court, Found. for Taxpayer & Consumer Rights).

248. H.R. 5, 108th Cong. at § 6.

The absurd result of this provision is to allow healthcare providers guilty of medical malpractice to shift all or some of the financial burden arising from their negligence to third parties, “while all other tortfeasors . . . are liable for their negligent acts.”²⁴⁹ All this provision will do is “shift billions of dollars per year in malpractice injury costs caused by the negligent onto taxpayers and the health insurance system”²⁵⁰ (as health insurance provides the lion’s share of collateral source benefits).²⁵¹

8. The Health Act’s Periodic Payments Provision²⁵²

This provision of the Health Act allows for any jury award of \$50,000 or more to be paid by the defendant on a periodic basis. The result of this provision is that a defendant who is found liable for medical negligence will be allowed to “control, invest, and earn interest”²⁵³ on the victim’s damages award up until the time of full payment, which may be years later. In the meantime, the victim is left with an inflexible payment schedule that requires him or her to seek approval from the court in the event that early disbursement is required for unexpected medical expenses.²⁵⁴ As the defendant earns investment income on the plaintiff’s malpractice compensation, its value to the plaintiff actually *decreases* because the award is not adjusted to inflation or to account for increases in the cost of healthcare.²⁵⁵ Such a result is fundamentally unfair.

9. Other Health Act Problems

Another major criticism of the Health Act is its broad scope. In one congressional hearing, a law professor at George Washington University Medical Center testified that the language of the Health Act makes it almost unlimited in scope.²⁵⁶ The plaintiffs under the Act could be “any person,” including

249. Lewis, *supra* n. 100, at 189.

250. *Harming Patient Access*, *supra* n. 33, at 99 (testimony of Jamie Court, Found. for Taxpayer & Consumer Rights).

251. H.R. Rpt. 108-32 pt. 1 at 261.

252. H.R. 5, 108th Cong. at § 8. Section 8, “Authorization of Payment of Future Damages to Claimants in Health Care Lawsuits,” provides as follows:

(a) In General.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding \$50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments. In any health care lawsuit, the court may be guided by the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) Applicability.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this Act.

253. *Harming Patient Access*, *supra* n. 33, at 98 (testimony of Jamie Court, Found. for Taxpayer & Consumer Rights).

254. *Id.*

255. *Id.*

256. *Medical Liability Reform*, *supra* n. 33, at 84-85.

“government officials acting under the color of law.”²⁵⁷ Defendants under the bill include any manufacturer or provider of healthcare goods or services; again, the language here is virtually unlimited.²⁵⁸ And by its own terms, the Act would preempt claims “far, far beyond common law or statutory claims arising under State law.”²⁵⁹ The overly broad language of the Health Act is yet another example of its poor draftsmanship.

IV. RECOMMENDATIONS AND CONCLUSIONS

As discussed previously, there are several contributing factors to the liability insurance crisis that should be addressed in a comprehensive tort reform bill,²⁶⁰ some of those factors are noticeably absent from the Health Act. For example, the Health Act does absolutely nothing to regulate the insurance industry. Even fairly simple insurance reforms, such as “experience-rating” programs, which would require insurance companies to charge doctors with clean records less than doctors who have been disciplined or found guilty of medical negligence, are not even contemplated by the Act.²⁶¹ Unlike MICRA, its predecessor, the Health Act does nothing to regulate liability insurance rates in any way.²⁶² When the 2004 version of the Health Act was under consideration by the House, one representative noted that arbitrarily enacting medical malpractice tort reforms without even considering insurance industry reforms would be “akin to curing a headache by amputating an arm.”²⁶³

Similarly, none of the reforms necessary in the medical field itself are addressed. The Health Act contains no provisions regarding stricter disciplinary systems for repeat offenders.²⁶⁴ There is no provision to facilitate information-sharing systems to encourage identification of potential problems and their solutions.²⁶⁵ There is no provision requiring physicians to report very large or repeat judgments publicly.²⁶⁶ One author suggested that a physician who has been disciplined or who has lost his or her license in one state and is allowed to practice in another should be required to disclose this information to his or her patients.²⁶⁷ Interestingly, while the Health Act was pending in the House of Representatives, the Committee voted down an amendment that would allow states to retain

257. *Id.* at 84.

258. *Id.*

259. *Id.*

260. James Hurley, formerly of the American Academy of Actuaries, recently said that tort reform should be accompanied by “a number of other things,” including “efforts to improve patient safety, tougher review and discipline procedures for doctors and hospitals and a closer look at how the past decade’s effort to cut costs in health care may affect the quality of medical care.” Eisler et al., *supra* n. 43.

261. Loiacono, *supra* n. 217.

262. *Supra* nn. 106, 111-16, 119-20 and accompanying text.

263. 150 Cong. Rec. H2861 (daily ed. May 12, 2004) (statement of Rep. Diana DeGette).

264. *Supra* nn. 92-94 and accompanying text.

265. *Supra* n. 95 and accompanying text.

266. See Loiacono, *supra* n. 217.

267. *Id.*

control of the disciplinary process but would require any judgment or settlement of more than \$10,000 to be reported publicly.²⁶⁸ A similar amendment that would prohibit confidential settlements was also rejected.²⁶⁹ Again, the Health Act fails to follow MICRA's lead in more stringently regulating the healthcare industry.

These reforms would be fairly simple to include in the Act and to implement. Other tort reforms, including some second-generation tort reforms discussed previously,²⁷⁰ would be more revolutionary but "hold greater promise of actually improving the adjudication and compensation of malpractice claims from the perspective of patients, providers, and liability insurers."²⁷¹ One such approach is the development of medical practice guidelines,²⁷² which could be used in a number of different healthcare contexts. First, they could be used as an aid for providers and patients in making care decisions.²⁷³ They could facilitate settlements by providing a proxy of what an expert would testify in any given case.²⁷⁴ They may cut down on the practice of defensive medicine by shielding physicians from liability for failing to order tests or procedures universally recognized as not being indicated.²⁷⁵

Other not so well established reforms include mandated alternate dispute resolution, which would make the decision reached through ADR equally as binding as a jury verdict. It could only be overturned upon allegations of corruption, fraud, or the like.²⁷⁶ Perhaps the most intriguing alternative—and one that is complex enough to merit entire articles devoted to it²⁷⁷—is an administrative fault system, similar to state workers compensation programs that have been almost universally adopted.²⁷⁸ Proponents of such reforms say that the current tort system fails to compensate wrongfully injured plaintiffs,²⁷⁹ fails to achieve the goal of deterrence,²⁸⁰ and exacts too high a price from society.²⁸¹

These second-generation tort reforms have received significant attention on both the state and national level, but have received little support overall.²⁸² Because doctors and lawyers are the major proponents of tort reform, most of the attention in this area has been directed toward first-generation reforms aimed at

268. H.R. Rpt. 108-32 pt. 1 at 164-75.

269. *Id.* at 176-83.

270. *Supra* nn. 170-74, 178.

271. Kinney, *supra* n. 32, at 120.

272. *Supra* n. 94.

273. Kinney, *supra* n. 32, at 103.

274. *Id.* at 104.

275. *Id.*

276. *Id.* at 105.

277. See e.g. Kirk B. Johnson, Carter G. Phillips, David Orentlicher, & Martin S. Hatlie, *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 *Vand. L. Rev.* 1365 (1989).

278. Kinney, *supra* n. 32, at 106.

279. Johnson et al., *supra* n. 277, at 1367-71.

280. *Id.* at 1371-73.

281. *Id.* at 1373-75.

282. Kinney, *supra* n. 32, at 110-15.

decreasing the severity and frequency of claims.²⁸³ States, in turn, are sympathetic to business constituencies.²⁸⁴ But a failure to thoroughly consider—and perhaps even experiment with—second-generation tort reforms forfeits the benefits they could offer, such as “expedited adjudication and compensation of claims in ways that would reduce stress for both patients and physicians.”²⁸⁵

A failure on behalf of its drafters to consider all possible causes and all possible solutions has led to a poorly designed Health Act that has failed to be passed in three consecutive legislative sessions. Without some measure of compromise, political divisions will continue to prevent the enactment of any legislation that will “end the logjam on tort reform.”²⁸⁶ A more balanced bill, one that would more likely be enacted, would recognize that multiple factors contribute to the current medical liability affordability crisis and that possible solutions lie outside the universe of first-generation tort reforms. But because the tort reform movement is driven largely by physicians, such creative second-generation reforms will not become reality unless consumers take a more active role in this controversial area.

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283. *Supra* nn. 168-69.

284. Kinney, *supra* n. 32, at 122.

285. *Id.* at 120.

286. 150 Cong. Rec. E845 (daily ed. May 14, 2004) (statement of Rep. Mark Udall).

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