AN EMPIRICAL EXAMINATION OF THE EQUAL PROTECTION CHALLENGE TO CONTINGENCY FEE RESTRICTIONS IN MEDICAL MALPRACTICE REFORM STATUTES

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INTRODUCTION

During a January 2004 speech at an Arkansas medical center, President Bush remarked, "[W]e've got too many darn lawsuits, too many frivolous and junk lawsuits that are affecting people. . . . [W]e need medical liability reform to make sure that medicine is affordable and available. . . . Lawsuits don't heal patients. That's a fact."[1] Despite the fact that medical malpractice reform has been the subject of political speeches and legislation for nearly three decades, it continues to attract a great deal of attention from both state and federal politicians who aim to solve the perceived medical malpractice crisis.[2] With health care costs continuing to soar, frustrated consumers and voters have proven to be receptive audiences for politicians with legislative reform proposals. Many of the proposed reforms, however, have also drawn sharp criticism from groups like consumer watchdogs and trial lawyer associations.[3]

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1. President George W. Bush, Remarks at the Baptist Health Medical Center, Little Rock, Arkansas (Jan. 26, 2004) (transcript available at http://www.whitehouse.gov/news/releases/2004/01/20040126-3.html).

2. *See* Libby Sander, *2005 Settlement Survey: Looking Ahead to Litigation under the Med-Mal Caps*, CHI. LAW., Oct. 2005 (noting that in 2005 alone, more than 500 bills addressing medical liability reform were introduced in forty-eight state legislatures).

3. Whether a medical malpractice crisis actually exists is a subject of much contention. As one commentator put it:

> Depending on one's perspective, there is too much medical malpractice litigation or not enough; contingent fee arrangements create an obscene form of bounty hunting or are absolutely necessary to ensure justice; physicians should not be second-guessed by those too dumb to avoid jury service or the jury system works just fine; and

In an effort to reduce medical malpractice costs, reformers in the early years of the twenty-first century have focused on reducing contingency fees—fee arrangements in which the lawyer represents the client for a fixed percentage of the amount recovered.[4] The most common proposal to reduce medical malpractice costs has traditionally been to place a cap on noneconomic damages. Since at least 2003, however, commentators and insurance companies have challenged the effectiveness of such caps in reducing medical malpractice insurance premiums, prompting the shift to contingency fee reform efforts.[5] Proponents of such reform argue that the contingency fee system creates incentives for lawyers to take on numerous nonmeritorious cases that have little likelihood of success, in expectation that the windfall from a few successful cases will exceed the cost of the rest.[6] Even if the lawsuits are unsuccessful, however, insurance companies must still expend resources to defend

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> legislators who enact tort reform are protecting fat-cat doctors or have prudently restrained a tort system run amok.

David A. Hyman, *Medical Malpractice and System Reform: Of Babies and Bathwater*, 19 HEALTH AFF. 258, 258 (2000).

4. *See* A.B.A. TORT TRIAL & INS. PRACTICE SECTION TASK FORCE ON CONTINGENT FEES, REPORT ON CONTINGENT FEES IN MEDICAL MALPRACTICE LITIGATION 3 (2004), http://www.abanet.org/tips/contingent/MedMalReport092004DCW2.pdf (last visited Aug. 15, 2006) ("Attorney contingent fees have become the focus of efforts by medical professionals and allied organizations to address medical liability problems.").

5. A memorandum from The Medical Protective Company, the largest malpractice insurance company in the United States, argues that recent legislation in Texas capping noneconomic damages at $250,000 will not result in a significant decrease in medical malpractice payouts and thus insurance premiums. "Noneconomic damages are a small percentage of total losses paid. Capping noneconomic damages will show loss savings of 1.0%." Memorandum from Melissa Coker, Regulatory Specialist, The Medical Protective Company, to Hon. Jose O. Monlemayor, Ins. Comm'r, Tex. Dep't of Ins. (Oct. 30, 2003) (on file with the *Duke Law Journal*). *But see* Terry Maxon, *Hospitals Finding Healthy Savings: Liability Insurance Costs Have Been Eased by Proposition 12*, DALLAS MORNING NEWS, Aug. 23, 2004, at 1D (reporting the Christus Health System, which owns or manages forty-eight Texas hospitals and facilities, would likely save $21 million on medical liability insurance in 2004 due to the Texas tort reform legislation); Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms*, W4 HEALTH AFF.—WEB EXCLUSIVE 20, 26 (Jan. 21, 2004), http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.20v1.pdf (last visited Aug. 15, 2006) (finding that states that had enacted damage caps had 17.1 percent lower medical malpractice premiums than those that had not).

6. *See* CONG. OF THE U.S., CONG. BUDGET OFFICE, THE EFFECTS OF TORT REFORM: EVIDENCE FROM THE STATES 8 (June 2004), *available at* http://www.cbo.gov/ftpdocs/55xx/doc5549/Report.pdf (noting that contingency fees "create incentives for attorneys to take on a large number of cases, each with a low probability of success, with the expectation that the fees earned from the successful cases will be large enough to subsidize the unsuccessful cases").

them[7] and may even settle nonmeritorious claims for fear of adverse jury verdicts. Proponents also argue that plaintiffs, not lawyers, deserve the bulk of any damage awards.[8] Opponents of contingency fee reform, however, stress that contingency fee arrangements allow access to the courtroom for plaintiffs who would otherwise be unable to risk paying high fixed hourly rates with the possibility of no financial return.[9] Thus, measures to restrict contingency fees could hurt the poor's ability to file personal injury lawsuits.

In an attempt to curb excess contingency fees and thereby reduce medical malpractice litigation expenses, the federal government has repeatedly proposed comprehensive national medical malpractice reform bills that include limitations on contingency fees.[10] Although the malpractice reform bills have passed the House of Representatives the past two years, they have failed to make it out of the Senate. Contingency fee reform has been more successful at the state level with many states enacting statutes, court rules, or even passing constitutional amendments to limit the percentage of medical malpractice awards that attorney's may collect.[11] These statutes have been repeatedly attacked in state courts as a violation of due process, the right to counsel, separation of powers, and most often equal protection. The attacks have had mixed results, with the majority of states upholding the statutes as constitutional and two states invalidating their laws as unconstitutional.[12] The main difference between the two camps is that courts upholding the contingency fee limiting statutes under equal protection claims have found that such statutes are an effective measure to reduce medical malpractice costs, whereas those courts invalidating the statutes have found the statutes

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7. *See* AM. MED. ASS'N, AMERICA'S MEDICAL LIABILITY CRISIS (Feb. 2005), http://www.ama-assn.org/ama1/pub/upload/mm/399/mlr_tp.pdf (last visited Aug. 17, 2006) ("In cases where [the plaintiff's] claims were dropped or dismissed, costs to defendants averaged $17,408. In cases that went to trial and the defendant prevailed, the average cost jumped to $87,720.").

8. *See, e.g.*, Dean J. Kereiakes & James T. Willerson, *Health Care on Trial: America's Medical Malpractice Crisis*, 109 CIRCULATION 2939, 2941 (2004).

9. *See infra* note 62 and accompanying text.

10. *See infra* notes 14–19 and accompanying text.

11. *See infra* notes 20–25 and accompanying text.

12. *See* Carson v. Maurer, 424 A.2d 825, 839 (N.H. 1980) (holding that New Hampshire's sliding scale limitation on contingency fees in medical malpractice claims violated the equal protection clause); Heller v. Frankston, 464 A.2d 581, 586 (Pa. Commw. Ct. 1983) (holding that Pennsylvania's sliding scale limitation on contingency fees violated the separation of powers clause), *aff'd on other grounds*, 475 A.2d 1291, 1296–97 (Pa. 1984).

ineffective at reducing costs.[13] Strikingly, although efficacy seems to determine whether a state statute passes constitutional review, and although legal decisions in these states have purported to determine whether reform measures are effective, none of the courts have given substantial empirical support for their findings.

This Note analyzes the available empirical evidence to determine the efficacy, and thus constitutionality, of contingency fee limiting statutes in reducing the medical malpractice payouts and medical malpractice insurance premiums. Part I of this Note reviews the current status of contingency fee limitations in state and national legislatures and at the ballot box. Part II analyzes the equal protection argument against contingency fee limitations. Part III examines theoretical arguments and existing empirical studies regarding how contingency fee limitations influence the cost of the medical liability system. Part IV provides new empirical data to determine how contingency fee limitations influence medical malpractice premiums. This Note concludes that although the efficacy of contingency fee limitations in limiting health care costs is not entirely clear, there is sufficient support for contingency fee statutes to pass rational basis review, which is the controlling standard under an equal protection analysis.

I. THE STATUS OF CONTINGENCY FEE LIMITATIONS IN THE LEGISLATURES AND AT THE BALLOT BOX

National medical malpractice reform, including contingency fee limitations, continues to draw attention from President Bush and his supporters in Congress. In May of 2004, the House of Representatives passed a comprehensive medical liability reform bill known as the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2004.[14] The HEALTH Act, modeled after California's medical malpractice reform,[15] contains a sliding scale maximum on

13. *See, e.g.*, Roa v. Lodi Med. Group, Inc., 695 P.2d 164, 170–71 (Cal. 1985) (finding that contingency fee limitations do not violate the equal protection clause because, among other things, these limitations increase the chances that a plaintiff will accept a lower settlement and decrease the amount of "marginal" malpractice claims brought), *appeal dismissed*, 474 U.S. 990, 990 (1985); *Carson*, 424 A.2d at 839 (finding the relationship between the contingency fee limiting statute and the containment of medical malpractice costs questionable).

14. Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2004, H.R. 4280, 108th Cong. § 5 (2004).

15. CAL. BUS. & PROF. CODE § 6146 (West 2003).

contingency fees in medical malpractice actions ranging from 40 percent for the first $50,000 recovered to 15 percent for any amount exceeding $600,000.[16] The bill, however, failed to make it through the Senate.[17] The House of Representatives also passed a comparable bill in 2003, but similarly failed to obtain the sixty votes necessary to end a potential filibuster.[18] Representative Rahm Emmanuel, a Democrat from Illinois, compared the congressional attempts at medical malpractice reform to the movie Groundhog Day. "[I]n the movie Bill Murray's character relived the same day over and over again, and here in Congress we are doing the same. . . . We took [medical malpractice reform] up in March of 2003. Nothing happened, but we took it up again."[19] Although medical malpractice reform has the support of President Bush and stronger support in the 109th Congress, it is still unlikely that such sweeping medical malpractice reform will pass at the national level, leaving medical malpractice reform in the province of the states.

Currently, twenty-four states place some form of statutory or regulatory limit on the contingency fee a lawyer can collect in medical malpractice cases. The most common type of this statute places a maximum on the percentage of allowable attorneys' fees based on a sliding scale that decreases the percentage as the award gets higher.[20]

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16. *See id.* (limiting an attorney's contingent fee in medical malpractice actions to 40 percent of the first $50,000 recovered, 33 percent of the next $50,000, 25 percent of the next $500,000, and 15 percent of any amount exceeding $600,000).

17. *See* Sander, *supra* note 2, at 8 (noting that after the failure of the 2004 bill to pass the Senate, President Bush "urged Congress to send him a 'meaningful, real medical liability bill' to sign in 2005").

18. Dr. William P. Gunnar, *Is There an Acceptable Answer to Rising Medical Malpractice Premiums?*, 13 ANNALS HEALTH L. 465, 465–66 (2004).

19. 150 CONG. REC. H4141 (daily ed. June 15, 2004) (statement of Rep. Emmanuel).

20. *See* CAL. BUS. & PROF. CODE § 6146 (West 2003) (limiting attorney's contingent fee in medical malpractice actions to 40 percent of the first $50,000 recovered, 33 percent of the next $50,000, 25 percent of the next $500,000, and 15 percent of any amount exceeding $600,000); CONN. GEN. STAT. ANN. § 52-251c (West 2004) (limiting attorney's contingent fees in "personal injury, wrongful death or damage to property" claims to 33 percent of the first $300,000 recovered, 25 percent of the next $300,000, 20 percent of the next $300,000, 15 percent of the next $300,000 and 10 percent of any amount exceeding $1.2 million); DEL. CODE ANN. tit. 18, § 6865 (2004) (limiting attorney's contingent fee in medical malpractice actions to 35 percent of the first $100,000 recovered, 25 percent of the next $100,000, and 10 percent of any amount exceeding $200,000); 735 ILL. COMP. STAT. ANN. 5/2-1114 (West 2003) (limiting attorney's contingent fees in medical malpractice actions to 33 percent of the first $150,000 recovered , 25 percent of the next $850,000, and 20 percent of any amount exceeding $1 million); ME. REV. STAT. ANN. tit. 24, § 2961 (2003) (limiting attorney's contingent fee in professional negligence actions to 33 percent of the first $100,000 recovered, 25 percent of the next $100,000, and 20

In 2004, Nevada imposed a statutory sliding scale limitation on contingency fees, doing so not by legislative action but by a 2004 voter initiative entitled "Keep Our Doctors in Nevada."[21] A few states have rejected the sliding scale model and imposed a fixed maximum contingency fee, varying from a lenient 50 percent to a more stringent 15 percent.[22] Still other states have decided against set limits on contingent fees and instead subject fee arrangements to judicial review for reasonableness; these statutes usually contain guidelines for determining reasonableness such as the time and labor required, the result obtained, and the experience and ability of the lawyer.[23]

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percent of any amount exceeding $200,000); MASS. GEN. LAWS ANN. ch. 231, § 60I (West 2003) (limiting attorney's contingent fee in medical negligence actions to 40 percent of the first $150,000 recovered, 33 percent of the next $150,000, 30 percent of the next $200,000, 25 percent of any amount exceeding $500,000, and further restrictions if claimant's recovery minus attorney fees does not cover claimant's past and future medical expenses); N.J. CT. R. § 1:21-7 (West 2003) (limiting attorney's contingent fee in tort actions to 33 percent of the first $500,000 recovered, 30 percent of the next $500,000, 25 percent of the next $500,000, 20 percent of the next $500,000, and a reasonable percentage approved by the court for any amount exceeding $2 million); N.Y. JUD. CT. ACTS LAW § 474-a (McKinney 2003) (limiting attorney's contingent fee in medical, dental or podiatric malpractice actions to 30 percent of the first $250,000 recovered, 25 percent of the next $250,000, 20 percent of the next $500,000, 15 percent of the next $250,000, and 10 percent of any amount exceeding $1.25 million); WIS. STAT. ANN. § 655.013 (West 2003) (limiting attorney's contingent fees in malpractice cases to 33 percent or 25 percent of the first $1 million recovered, depending on when liability is stipulated, and 20 percent of any amount exceeding $1 million).

21. *See* NEV. REV. STAT. § 7.095 (Supp. 2006) (limiting attorney's contingent fee in medical malpractice actions to 40 percent of the first $50,000 recovered, 33 percent of the next $50,000, 25 percent of the next $500,000, and 15 percent of any amount exceeding $600,000); Michael Bradford & Judy Greenwald, *Voters Repeal California 'Play or Pay' Benefit Mandate*, BUS. INS., Nov. 8, 2004, at 16 (noting that Nevada voters passed contingency fee caps and also rejected an amendment that would have "eliminated limits to malpractice awards and prohibited caps on attorney fees").

22. *See* IND. CODE ANN. § 34-18-18-1 (West 1999) (limiting attorney's contingent fee to 15 percent of the amount recovered in medical malpractice actions in which defendant is represented by patient's compensation fund); MICH. CT. R. 8.121 (West Supp. 2004) (limiting attorney's contingent fee to 33 percent of damages in personal injury and wrongful death actions); OKLA. STAT. ANN. tit. 5, § 7 (West 2003) (limiting attorney's contingent fee to 50 percent of the net recovery in all actions); OR. REV. STAT. § 31.735 (2004) (limiting attorney's share of punitive damage award to 20 percent in all actions); TENN. CODE ANN. § 29-26-120 (West 2002) (limiting attorney's contingent fee to 33 percent of damages in malpractice actions); UTAH CODE ANN. § 78-14-7.5 (West 2002) (limiting attorney's contingent fee to 33 percent of amount recovered in medical malpractice actions).

23. *See* ARIZ. REV. STAT. ANN. § 12-568 (2002) (allowing judicial review of attorney's fees on the request of either party in health care actions); HAW. REV. STAT. ANN. § 607-15.5 (LexisNexis 2003) (requiring attorney fee arrangements to be approved by the court in all tort actions); IOWA CODE ANN. § 147.138 (West 1997) (requiring court to determine reasonableness of plaintiff's attorney fee in medical malpractice actions); KAN. STAT. ANN. § 7-121b (2004) (requiring judicial approval of attorney compensation in medical malpractice actions); MD.

Discouraged by the Florida state legislature's failed attempts at medical malpractice reform, voters in that state resorted to constitutional, as opposed to statutory or regulatory, measures to limit contingency fees, and passed a constitutional amendment strictly limiting the fees.[24] Florida's constitutional amendment is unique in that it was not passed as part of a comprehensive medical malpractice reform plan but as a stand-alone limitation on medical malpractice contingency fees.[25] The Florida amendment thus clearly demonstrates the importance of the contingency fee issue and attention that it is receiving in medical malpractice reform.

II. THE EQUAL PROTECTION CHALLENGES TO CONTINGENCY FEE LIMITATIONS

Medical malpractice reform statutes emerged in the 1970's and were immediately attacked as violating various state and federal constitutional provisions. Contingency fee limitations have been challenged under numerous theories: separation of powers,[26] the right to counsel,[27] due process,[28] and most notably, equal protection.[29] The

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CODE ANN., CTS. & JUD. PROC. § 3-2A-07(b) (West 1999) (requiring approval of disputed attorney fees by court or arbitration panel in medical malpractice actions); NEB. REV. STAT. § 44-2834 (2004) (allowing judicial review of reasonableness of attorney's fees at the request of either party in medical malpractice actions); WASH. REV. CODE ANN. § 4.24.005 (West 2005) (allowing judicial review of reasonableness of attorney's fees at the request of either party in any tort action); WYO. CONTINGENT FEES CT. R. 5(f) (2005) (allowing for petition of reasonableness of contingent fee arrangement and providing presumptively reasonable sliding scale arrangement dependent on whether the case lasts more or less than sixty days from the filing date).

24. *See* FLA. CONST. art. I, § 26 (limiting attorney's contingent fee in medical liability actions to 30 percent of the first $250,000 recovered and 10 percent of any amount exceeding $250,000). *But see* Chris Grier, *Florida Medical-Malpractice Amendment Might Be Circumvented*, BESTWIRE, Nov. 30, 2004, *available at* LEXIS News & Business Library (reporting that Florida lawyers are considering asking clients to waive their rights to capped attorney's fees as a condition of representation).

25. Prior to the 2004 amendment, Florida already had in place extensive statutory regulations covering medical malpractice litigation. *See generally* FLA. STAT. ANN. § 768 (West 2001).

26. *See, e.g.*, Roa v. Lodi Med. Group, Inc., 695 P.2d 164, 172 (Cal. 1985) (rejecting plaintiff's argument that "in light of this court's inherent power to review attorney fee contracts and to prevent overreaching and unfairness, the question of the appropriateness of attorney fees is a matter committed solely to the judicial branch") (citation omitted), *appeal dismissed*, 474 U.S. 990, 990 (1985). *But see* Heller v. Frankston, 464 A.2d 581, 586 (Pa. Commw. Ct. 1983) (holding Pennsylvania's sliding scale limitation on contingency fees violated the separation of powers clause), *aff'd on other grounds*, 475 A.2d 1291, 1296–97 (Pa. 1984).

27. *See Roa*, 695 P.2d at 169 ("The sliding scale schedule [of contingency fees] certainly does not unconstitutionally impinge on a malpractice victim's right to counsel.").

Fourteenth Amendment's equal protection clause, as well as similar clauses contained in most state constitutions, guarantees that "all persons similarly circumstanced shall be treated alike."[30] Those who oppose fee limitations directed specifically at medical malpractice actions may argue that such statutes violate the equal protection clause by imposing inferior treatment on several parties: medical malpractice victims as compared to other tort victims; plaintiffs' lawyers as compared to defense lawyers; more severely injured plaintiffs as compared to less severely injured plaintiffs;[31] and poor plaintiffs as compared to those with the financial means necessary to hire lawyers on an hourly basis.

In evaluating an equal protection challenge, the courts first must determine which of the three levels of review to apply. In general, courts apply rational basis review—the most lenient form of review—unless a suspect or quasi-suspect class is implicated or a fundamental right is impacted.[32] None of the numerous courts to consider the issue have found that medical malpractice claimants or their lawyers constitute a suspect class,[33] and it is well established that heightened scrutiny does not apply to laws discriminating against the poor.[34]

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28. *See id.* at 166 (rejecting the argument that contingency fee limitations violate due process by "impermissibly infring[ing] on the right of medical malpractice victims to retain counsel in malpractice actions").

29. Some plaintiffs have tried more novel attacks, but these have garnered little attention by courts. In California, for example, challengers to the state's limitation on contingency fee statutes in medical malpractice cases claimed the statute violated the First Amendment right to petition. *Id.* at 167 n.5. Calling the argument "creative," the court nonetheless dismissed it with a footnote. *Id.* ("Although the argument is creative, its logic clearly proves too much, for it would preclude a state from imposing *any* limitation on attorney fees, no matter how unconscionably high such fees might be . . . .").

30. F. S. Royster Guano Co. v. Virginia, 253 U.S. 412, 415 (1920).

31. Arguably, contingency fee limitations, especially sliding scale limitations, have a greater effect on claimants and counsel with more severe injuries, because their damage awards will be higher. Thus, in these cases, the lawyers' fees will be more severely limited than in cases with lower damage awards.

32. *See, e.g.*, Romer v. Evans, 517 U.S. 620, 631 (1996) ("[I]f a law neither burdens a fundamental right nor targets a suspect class, we will uphold the legislative classification so long as it bears a rational relation to some legitimate end.").

33. *See* DiFilippo v. Beck, 520 F. Supp. 1009, 1016 (D. Del. 1981) ("Parties to a malpractice action, whether plaintiffs or defendants, have never been held to be a suspect or a quasi-suspect class for the purpose of equal protection analysis and indeed they do not possess any of the characteristics . . . .").

34. *See* San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 28 (1973) (holding that economic status does not constitute a suspect classification); *see also* Maher v. Roe, 432 U.S. 464, 471 (1977) (noting that the Supreme Court "has never held that financial need alone identifies a suspect class for purposes of equal protection analysis").

Furthermore, although contingency fee limiting statutes implicate certain rights, such as the right to contract and the right to be compensated for injury, no court has found that such statutes impact any fundamental rights.[35] Thus, the majority of courts have applied rational basis review to challenges to medical malpractice reform statutes in general, and to contingency fee limitations specifically.

A few courts, however, have applied intermediate scrutiny in evaluating equal protection claims against medical malpractice reform statutes. In *Arneson v. Olson*,[36] the Supreme Court of North Dakota applied intermediate scrutiny to hold that North Dakota's medical malpractice reform statute violated the equal protection clause of the federal and state constitutions.[37] The court stated that for the medical malpractice reform statute to be constitutional, there must be a "close correspondence between statutory classifications and legislative goals."[38] Similarly, the New Hampshire Supreme Court in *Carson v. Maurer*[39] applied intermediate scrutiny to an equal protection challenge of New Hampshire's medical malpractice reform statute, finding that the rights involved were "sufficiently important to require that the restrictions imposed on those rights be subjected to a more rigorous judicial scrutiny than allowed under the rational basis test."[40] The court in *Carson* recognized that such a heightened form of scrutiny was not required by the federal Constitution,[41] but opted to use its power in interpreting the state Constitution "to grant individuals more rights than the Federal Constitution requires."[42]

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35. *See, e.g.*, Carson v. Maurer, 424 A.2d 825, 830 (N.H. 1980) (finding the "right to recover for personal injuries" is not fundamental); Newton v. Cox, 878 S.W.2d 105, 109 (Tenn. 1994) (holding that the right to contract is "not a fundamental right which would trigger strict scrutiny analysis").

36. 270 N.W.2d 125 (N.D. 1978).

37. *Id.* at 136.

38. *Id.* at 134.

39. 424 A.2d 825 (N.H. 1980).

40. *Id.* at 830.

41. *Id.* at 831 (acknowledging that the United States Supreme Court has reserved intermediate scrutiny for classifications based on gender and illegitimacy).

42. *Id.* (noting that the court had previously applied intermediate scrutiny to "economic and social legislation and ordinances which did not involve distinctions based upon gender or illegitimacy"). Despite the express statement of the court in *Carson*, however, it is questionable whether a heightened form of scrutiny was in fact applied. *See* David L. Bearman, Case Comment, *Constitutional Law*—Newton v. Cox*: The Rationality of Tennessee's Medical Malpractice Contingency Fee Statute*, 25 U. MEM. L. REV. 1555, 1575 (1995) (arguing that much of the court's language in *Carson* points to the fact that rational basis review, not intermediate scrutiny, was actually used).

These two decisions, however, have received little support from courts or commentators.[43] Given that no suspect class or fundamental right is in question, the consensus is that rational basis review should be applied to contingency fee limitations in medical malpractice actions.[44]

Under the rational basis test, a statute will be upheld if "the legislative classification . . . is rationally related to achievement of the [legitimate] statutory purposes."[45] Employing this deferential test, it is rare for courts to invalidate a statute. The party opposing the statute has the extremely difficult task of proving that "the legislative facts on which the classification is apparently based could not reasonably be conceived to be true by the governmental decisionmaker."[46] As long as the relationship between the legislative classification and a conceivable purpose of the statute is "debatable," the statute will be found constitutional under an equal protection challenge.[47]

Although it is rare for a statute to be found unconstitutional using the rational basis test, several different types of medical malpractice reforms have succumbed to equal protection challenges under this test.[48] All contingency fee limitations on medical malpractice actions that have thus far been reviewed under the

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43. *But see* R. Scott Jenkins & Wm. C. Schweinfurth, *California's Medical Injury Compensation Reform Act: An Equal Protection Challenge*, 52 S. CAL. L. REV. 829, 868–80 (1979) (discussing cases in which courts arguably applied a stricter form of review to medical malpractice reforms through a balancing of interests).

44. *See, e.g.*, Newton v. Cox, 878 S.W.2d 105, 109–10 (Tenn. 1994) ("[T]he rational basis test is the appropriate analysis to be employed when determining the constitutionality of medical malpractice statutes."); Jean A. Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills*, 58 GEO. WASH. L. REV. 181, 199–206 (1990) (arguing that rational basis review is the correct level of scrutiny for medical malpractice reform legislation); Richard M. Birnholz, Comment, *The Validity and Propriety of Contingent Fee Controls*, 37 UCLA L. REV. 949, 973 (1990) ("[C]ourts are correct to apply the rational basis test in evaluating whether future limits on contingent fees violate equal protection."). *But see* Jenkins & Schweinfurth, *supra* note 43, at 872 (stating that "medical malpractice legislation, because of its tenuous effect and the interests affected, may demand a higher level of judicial scrutiny than other social and economic legislation").

45. Minnesota v. Clover Leaf Creamery Co., 449 U.S. 456, 463 (1981).

46. Vance v. Bradley, 440 U.S. 93, 111 (1979).

47. United States v. Carolene Prods. Co., 304 U.S. 144, 154 (1938).

48. *See, e.g.*, Boucher v. Sayeed, 459 A.2d 87, 94 (R.I. 1983) (finding Rhode Island's medical malpractice reform unconstitutional under rational basis review because no medical malpractice crisis existed); *see also* Robert W. George, Comment, *Prognosis Questionable: An Examination of the Constitutional Health of the Arkansas Medical Malpractice Statute of Repose*, 50 ARK. L. REV. 691, 716 n.131 (1998) (listing examples of cases in which courts found medical malpractice reform statutes unconstitutional using rational basis review).

rational basis test, however, have been upheld against equal protection challenges. Generally, the stated purpose for most medical malpractice reform legislation is to reduce the costs involved with medical malpractice litigation in order to lower medical malpractice insurance premiums, thus decreasing the cost of health care and increasing the availability of physicians.[49] Importantly, to pass the rational basis test, contingency fee limitations need not be the *most* effective means of combating rising medical malpractice insurance premiums, but only a *possible* means.[50] Courts have therefore held that limiting the attorneys' fees collected in medical malpractice actions, as opposed to all tort actions, is a rational use of the legislative power to curtail rising medical malpractice insurance premiums.[51] All of these courts' holdings are made as conclusory statements without reference to evidence supporting or denying the efficacy of contingency fee limitations in stabilizing medical malpractice insurance premiums. Although the rational basis test

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49. For example, the purpose of the California contingency fee limiting statute was explained as follows:

> The Legislature finds and declares that there is a major health care crisis in the State of California attributable to skyrocketing malpractice premium costs and resulting in a potential breakdown of the health delivery system, severe hardships for the medically indigent, a denial of access for the economically marginal, and depletion of physicians such as to substantially worsen the quality of health care available to citizens of this state. The Legislature, acting within the scope of its police powers, finds the statutory remedy herein provided is intended to provide an adequate and reasonable remedy . . . .

CAL. BUS. & PROF. CODE § 6146 note (West 2003).

50. *See* Bernier v. Burris, 497 N.E.2d 763, 779 (Ill. 1986) ("[T]he legislature is not limited to choosing the single, most effective remedy against the problem but rather may decide to attack it along several fronts simultaneously.").

51. *See, e.g.*, DiFilippo v. Beck, 520 F. Supp. 1009, 1016 (D. Del. 1981) ("[I]t is rational to limit attorney's fees which may be collected in malpractice suits and not in other actions because the limitation is also related to reducing malpractice insurance costs and, consequently, medical costs."); Roa v. Lodi Med. Group, Inc., 695 P.2d 164, 170 (Cal. 1985) ("[T]he Legislature could reasonably have determined that the provision would serve to reduce malpractice insurance costs."), *appeal dismissed*, 474 U.S. 990 (1985); *Bernier*, 497 N.E.2d at 779 ("The legislature may have reasonably believed that the limits on fees would expedite the resolution of disputes, act as a disincentive for filing frivolous suits, and preserve to a plaintiff a greater part of his recovery, and in those ways help reduce the malpractice crisis."); Johnson v. St. Vincent Hosp., Inc., 404 N.E.2d 585, 602–03 (Ind. 1980) ("The disparate treatment accorded plaintiffs and counsel in medical malpractice cases is the natural consequent of the fact that the Legislature sought in this Act to protect the public interest adversely being affected by a curtailment of malpractice insurance for health care providers."); Newton v. Cox, 878 S.W.2d 105, 110 (Tenn. 1994) ("It is conceivable that the General Assembly concluded that the contingency fee cap . . . would further the purposes of the Medical Malpractice Act by reducing malpractice insurance costs and, therefore, reduce the cost of health care to the public.").

does not require state legislatures to produce evidence to support a challenged statute's purpose,[52] empirical evidence regarding the effects of contingency fee limitations on the costs of medical malpractice litigation and insurance premiums would nonetheless be useful for meaningful judicial review.

III. THE EFFECT OF FEE LIMITATIONS ON MEDICAL MALPRACTICE LIABILITY COSTS

There are two main ways that contingency fee limitations could affect medical malpractice litigation costs: first, by decreasing the overall claim rate and second, by increasing the settlement rate.[53] Contingency fee limitation statutes may decrease the overall claim rate by discouraging plaintiff's' lawyers from bringing frivolous suits. Although it is unknown exactly how many frivolous medical malpractice suits are filed, one small study of medical malpractice claims filed in New York found that only 17 percent of the claims reviewed contained negligent treatment.[54] Furthermore, over half of the claims in the study lacked not only health care provider negligence, but were void of medical injury altogether.[55] More recent and widespread data also support the inference that the number of frivolous medical malpractice suits is higher than in other categories of torts.[56] Typically, tort plaintiffs are successful in approximately half of trials, whereas medical malpractice plaintiffs are only successful in approximately one quarter of trials.[57] Although the lower percentage

52. *See, e.g.*, Minnesota v. Clover Leaf Co., 449 U.S. 456, 464 (1980) ("States are not required to convince the courts of the correctness of their legislative judgments.").

53. A third important indicator of medical liability costs, the amount paid per award, is likely to be influenced relatively little by contingency fee limitations because evidence does not show that nonmeritorious cases are awarded any less damages than meritorious cases.

54. *See, e.g.*, A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245, 245–51(1991).

55. *Id.*

56. *See generally* THOMAS H. COHEN, BUREAU OF JUSTICE STATISTICS, MEDICAL MALPRACTICE TRIALS AND VERDICTS IN LARGE COUNTIES, 2001 (Apr. 2004), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/mmtvlc01.pdf (comparing the success rates of medical malpractice claims and other tort claims).

57. *Id.* ("The overall win rate for medical malpractice plaintiffs (27 percent) was about half of that found among plaintiffs in all tort trials (52 percent)."); *see also* NICHOLAS M. PACE ET AL., RAND INST. FOR CIVIL JUSTICE, CAPPING NON-ECONOMIC AWARDS IN MEDICAL MALPRACTICE TRIALS: JURY VERDICTS UNDER MICRA 19 (2004) ("About 22 percent of California medical malpractice trials during our study period resulted in a verdict in favor of one

of plaintiff victories could be explained by a multitude of factors—for example, complexity of cases, reluctance of juries to hold doctors accountable, or difficulty in obtaining expert witnesses to testify against defendant doctors—it does not change the fact that plaintiffs' attorneys bring unsuccessful medical malpractice cases at a higher rate than other tort cases.

Reducing the payoff for frivolous medical malpractice cases will deter attorneys from bringing such cases. The effect of the most common type of contingency fee statute—a sliding scale limitation on fees—on the net recovery by attorneys is dramatic. In a study of California medical malpractice lawsuits, researchers found that California's statutory limit on contingency fees reduced the average attorneys' fees between 1995 and 1999 by 46 percent.[58] When California's cap on damages was combined with a sliding scale limitation, attorneys' fees were reduced by a total of 60 percent.[59] It is possible that California's dramatic decrease in fees can be replicated in other states by implementing a sliding scale fee limitation. Such a drastic reduction in attorneys' fees changes the economics for the plaintiffs' attorneys who bring medical malpractice suits, forcing them to reexamine the risk they are willing to take. With less to gain from successful suits, plaintiffs' lawyers will be unable to file a multitude of lawsuits of questionable merit while relying on one or two "windfall" awards to offset the costs of unsuccessful suits. This means that to stay profitable, plaintiffs' lawyers will expectedly raise the threshold for likelihood of success in determining which cases they choose to file.

In a 2004 report denouncing the spread of contingency fee limitations, the American Bar Association's Task Force on Contingent Fees (Task Force) disputed the claim that contingent fee limitations prevent frivolous medical malpractice lawsuits.[60] The ABA study undertook to "study the interaction of contingent fees and medical malpractice litigation and determine whether changes in current rules and practices might serve the interests of the public and

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or more plaintiffs in the case (compared with 53 percent for all other types of trials in California during this same period).").

58. *See* PACE ET AL., *supra* note 57, at 36 (comparing what an attorney would have received under a 33 percent flat fee with what the attorney would receive under California's sliding scale limitation in 257 medical malpractice trials between 1995 and 1999).

59. *Id.* Taking into account only the cap on damages and not the contingency fee limitations, attorneys' fees were reduced by 30 percent. *Id.*

60. *See* A.B.A. TORT TRIAL & INS. PRACTICE SECTION TASK FORCE ON CONTINGENT FEES, *supra* note 4, at 20 ("Logic suggests that contingent fees actually prevent frivolous suits.").

of individual victims of medical malpractice."[61] The study concluded that states should not enact contingency fee limitations because such limitations "risk compromising access to justice by medical malpractice victims."[62] Instead of limiting contingency fees, the Task Force suggested that states provide bar-supported public information services to help potential clients find lawyers and negotiate fee contracts, mandate a standardized disclosure by lawyers seeking to represent medical malpractice plaintiffs, improve the enforcement of existing procedural and ethical rules, and encourage the use of alternative dispute resolution.[63] The Task Force concluded that adopting these measures would "not only improve client access to justice but also enhance the ability of clients to establish fair and informed terms of legal representation, including reasonable contingent fee arrangements."[64]

The ABA report's logic, however, is flawed. In an effort to prove that contingent fees have not produced an "explosion in medical malpractice litigation" and that frivolous malpractice suits are not an issue, the report describes state studies that show the number of new tort lawsuits filed is stable or even declining in the first part of the twenty-first century and that medical malpractice suits only make up a small percentage of overall tort litigation.[65] Considering that contingency fees have been the primary payment method for plaintiffs' lawyers in most tort litigation for decades,[66] it would not be expected that such fee arrangements would have produced a jump in the number of suits filed. Also, the fact that medical malpractice suits make up a small percentage of overall tort claims is irrelevant to the question of whether or not frivolous medical malpractice claims are filed. There is no suggestion that medical malpractice attorneys are more likely to use contingency fee arrangements than other tort attorneys, so the more relevant question is whether the number of medical malpractice suits filed per incident of medical malpractice is equivalent to the rate of suit to rate of incident for other torts; this question is not addressed by the ABA report.

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61. *Id.* at 10.

62. *Id.* at 11.

63. *Id.* at 43–45.

64. *Id.* at 45.

65. *Id.* at 17.

66. For a historical background of the contingency fee arrangement, see Lester Brickman, *Contingent Fees Without Contingencies:* Hamlet *Without the Prince of Denmark?*, 37 UCLA L. REV. 29, 35–39 (1989).

A more plausible criticism of the effect of contingency fee limitations on the rate of medical malpractice claims is that such limitations will not only prevent frivolous malpractice suits but meritorious ones as well.[67] Past studies show that only 2[68] to 12[69] percent of actual medical malpractice incidents result in a lawsuit. This low filing rate may be the result of patients' failure to detect malpractice, patients' reluctance to sue doctors, and the high cost of investigation and litigation. In theory, sliding scale contingency fee limitations could increase the number of meritorious suits that lawyers bring. A lawyer who is able to charge an unlimited fixed rate will gravitate toward cases in which the expected damages are high, because the marginal time and cost to present a case would decrease with higher awards. However, a lawyer who is subject to a sliding scale rate that has a maximum award fixed below the normal fixed contingency rate will find cases with lower expected damages more appealing.[70] Consequently, logic suggests that a meaningful reform of contingency fees in medical malpractice cases would reduce the amount of frivolous suits brought by decreasing the incentive for lawyers to bring a multitude of suits regardless of the merits. It may be the case, however, that as overall claim rates decrease, the number of meritorious suits brought will actually increase.

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67. *See* A.B.A. TORT TRIAL & INS. PRACTICE SECTION TASK FORCE ON CONTINGENT FEES, *supra* note 4, at 32 ("Elimination of, or significant constraints on, contingent fees would make legal assistance available only to those injured persons who are wealthy. The poor, the retired, African Americans, and women especially will suffer because they are often unable to afford hourly fees." (quoting Florida Senator Walter Campbell)).

68. A New York study found that one medical malpractice claim was brought for every 7.6 incidents of medical malpractice; but due to the frivolous claims included in this ratio, the actual percentage of medical malpractice incidents that resulted in lawsuits was only 1.53 percent. *See* Localio et al., *supra* note 54.

69. *See* PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 13 (1991) (finding only one out of eight valid medical malpractice claims are ever filed).

70. For example, if two cases with the same probability of success are presented to a lawyer, one having an expected award of $1 million and the other an expected award of $250,000, the lawyer would receive $250,000 more in fees under a flat contingency fee of 33 percent from the $1 million case than the $250,000 case upon success of the case. If, however, the lawyer was forced to use a sliding scale contingency rate such as the one in force in California, the lawyer would earn only $147,500 more in fees from the $1 million case than the $250,000 case. *See* CAL. BUS. & PROF. CODE § 6146 (West 2003) (limiting attorney's contingent fee in medical malpractice actions to 40 percent of the first $50,000 recovered, 33 percent of the next $50,000, 25 percent of the next $500,000, and 15 percent of any amount exceeding $600,000). This reduction in fee more accurately reflects the decreasing marginal costs in terms of time and effort by the lawyer, and makes the attorney more likely to accept the lower award cases.

The second way in which contingency fee limitations may reduce medical liability litigation costs is by increasing the rate of settlement. Approximately 85 percent of medical malpractice claims that are not dropped or dismissed result in settlement.[71] Fifteen percent of cases result in trial with approximately one-quarter of those resulting in verdicts for the plaintiff.[72] These numbers show that insurance companies are generally willing to settle meritorious claims for amounts that plaintiffs and their attorneys find reasonable. By decreasing the amount that the plaintiff's attorney may charge in fees, contingency fee limitation statutes consequently increase the amount of a proposed settlement a plaintiff will retain. In determining whether or not to accept a settlement offer, plaintiffs may look to both the amount of the proposed settlement and the amount of the settlement they, as plaintiffs, will take home. Contingency fee limiting statutes will decrease the percentage of the settlement retained by the lawyer and thus lower the threshold settlement offer necessary for insurance companies to induce plaintiffs to settle. Attorneys will also have a greater incentive under sliding scale contingency fee limitations to accept a lower settlement offer. Because the attorney receives a lower percentage of higher awards under such a system, attorneys will have less incentive to risk sure money for the opportunity of a large jury verdict. Whether plaintiffs' or attorneys' interests control the settlement decision, contingency fee limitations will likely increase the number of cases insurance companies are able to settle, and may even decrease the average settlement cost. Even if the average amount of settlements is not affected, increasing the settlement rate would save insurance companies tens of thousands of dollars per settlement by avoiding costly litigation.[73]

Given the amount of attention contingency fee limitations have received in the legislatures, courts, and literature, it is surprising that there is relatively little empirical research on such statutes. This dearth of empirical research may be due to the difficulty in studying

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71. *See* Christopher H. Schmitt, *A Medical Mistake*, U.S. NEWS & WORLD REP., June 30, 2003, at 24–27 (reporting 2002 data from the Physician Insurers Association of America that showed 67.7 percent of medical malpractice claims are dropped or dismissed, 27.4 percent result in settlement, and 4.9 percent result in trial).

72. *See id.* (showing 18.4 percent chance of plaintiff receiving a verdict); *supra* note 57 and accompanying text (citing statistics that show 27 percent of medical malpractice lawsuits result in plaintiff verdict).

73. *See supra* note 7 and accompanying text (citing April 2002 study that attributed 7 percent of the increase in health insurance premiums to litigation).

the impact of medical malpractice reforms generally.[74] Another contributing factor, however, may be the undue obsession with determining who is to blame for rising medical malpractice premiums and a lack of concern with facts to support such positions. The studies that have attempted to determine the effect of contingency fee limitations on medical malpractice liability have produced inconsistent results. One early study by Patricia Danzon looking at the effect of various tort reforms on frequency of claims and the average severity of claims found that contingency fee limitations reduce claim frequency and severity overall, as well as increase the settlement rate of claims filed.[75] Conversely, a study published three years later by the same author concluded that contingency fee limitations did not have "any systematic impact on claim frequency or severity."[76] One major flaw in these studies, however, is that they grouped all contingency fee limiting statutes together.[77] Although all types of medical malpractice reform statutes vary from state to state, the variations in contingency fee limitation statutes are especially great. For example, it is hardly informative to put Oklahoma's statute limiting contingency fees to 50 percent of the plaintiff's net recovery[78] on the same plane as Delaware's sliding scale contingency fee statute which limits contingency fees to 35 percent of the first $100,000 recovered, 25 percent of the next $100,000, and 10 percent of any amount exceeding $200,000.[79] The Oklahoma statute would rarely constrain lawyers,[80] whereas almost all lawyers in Delaware will be

74. *See, e.g.*, CONG. BUDGET OFFICE, *supra* note 6, at 8–9 (noting the difficulties in calculating the impact of tort reform, including the variety of tort reform statutes, the lack of availability of data on tort cases, the enactment of tort reforms in groups instead of individually, the lag in implementation of reforms due to constitutional challenges, and the difficulty in determining the status of state tort reform).

75. Patricia M. Danzon & Lee A. Lillard, *Settlement Out of Court: The Disposition of Medical Malpractice Claims*, 12 J. LEGAL STUD. 345 (1983).

76. Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 LAW & CONTEMP. PROBS. 57, 78 (Spring 1986).

77. *See* Patricia M. Danzon, Symposium, *The Effects of Tort Reforms on the Frequency and Severity of Medical Malpractice Claims*, 48 OHIO ST. L.J. 413, 414 (Spring 1987) (noting a flaw of the author's medical malpractice reform impact studies is the inability to "measure separately the effects of each variant of each law").

78. OKLA. STAT. ANN. tit. 5, § 7 (West 2003).

79. DEL. CODE ANN. tit. 18, § 6865 (2004).

80. Note, however, that ethical and competitive restrictions limit the contingency an attorney may charge. *See, e.g.*, MODEL RULES OF PROF'L CONDUCT R. 1.5 (1983) (requiring attorneys' fees to be "reasonable"); MODEL CODE OF PROF'L RESPONSIBILITY DR 2-106 (1981) (prohibiting attorneys' fees which are "clearly excessive").

constrained by that state's statute. Even if the Oklahoma statute did constrain lawyers, the overall amount a lawyer could collect in fees, and thus his ability to subsidize frivolous suits, would be substantially greater in that state. For instance on a one million dollar award, a lawyer following the Oklahoma statue would collect over three and a half times as much as a lawyer constrained by the Delaware statute. Thus, it is not surprising that a study grouping all contingency fee limitations together would find that the reforms had no statistically significant effect on medical liability costs.

Another study designed to examine the effectiveness of contingency fee limitations, as well as other medical malpractice reforms, measured the effects of the limitations on the probability a claim would be paid, the amount paid, and the time taken to resolve the claim.[81] This study found that contingency fee limitations increased the time to filing and decreased the time from filing to closing.[82] The author attributes these changes in timing to reduced efforts by the attorneys.[83] Although this is possible, the delay in time to filing suits could also mean that plaintiffs' attorneys are conducting a more thorough review of incoming claims to weed out cases with little chance of success. Additionally, the decreased time from filing to closing could be reflective of an increased settlement rate. Neither of these factors is considered in this study. The variables measured in this study are not the variables that contingency limitation statutes are likely to effect—claim frequency and settlement rate. Furthermore, the study suffers from the same flaw as the Danzon study, because it groups all contingency fee limitations into a single category.[84]

Later studies suffer from the same inconsistencies and flaws. In a study of insurance company payouts between 1993 and 2001, a researcher found that caps on contingent fees resulted in lower claims

81. Frank A. Sloan et al., *Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis*, 14 J. HEALTH POL. POL'Y & L. 663, 663 (1989).

82. *Id.* at 677.

83. *See id.* ("The results for placing a limit on plaintiff attorneys' fees are consistent with the view that such regulation reduces lawyers' efforts on malpractice cases.").

84. The Sloan study includes all statutes that create "some type of numerical limit for attorneys' fees in malpractice cases." *Id.* at 673 tbl.I. Thus, as in the Danzon study, both the Oklahoma and Delaware statutes would be categorized the same. *See supra* notes 75–77 and accompanying text.

payments by insurers.[85] In a study published less than one year later, however, the same researcher found contingency fee limitations had no effect on medical malpractice liability.[86] Overall, there are few empirical studies involving limitations on contingency fees in medical malpractice cases; the studies that exist contain inconsistencies and flaws, and as a result, very little can be said about the true effect of fee limitations on medical malpractice liability costs.

IV. THE EFFECT OF FEE LIMITATIONS ON MEDICAL MALPRACTICE INSURANCE PREMIUMS

The studies examined in Part III illustrate some of the difficulties of determining the effects of contingency fee limitations on medical liability costs. Although data on the effect of fee limitations on settlement rates and claim frequency would be extremely informative, what matters to the constitutional analysis is whether or not such statutes affect insurance premiums. It is undeniable that medical malpractice premiums have been sharply increasing since 1999.[87] The cause of this increase, however, is less certain. Opponents of medical malpractice reform argue that the source of the increase is not medical malpractice litigation at all, but rather economic cycles and insurance companies' mismanagement of investments.[88] Thus, they argue that insurance reform, not tort reform, is the answer to rising insurance premiums.[89] This viewpoint is held only by a small minority.[90] The majority of commentators recognize that declining

85. *See* CONG. BUDGET OFFICE, *supra* note 6, at 18 n.47 (citing Kenneth E. Thorpe, Remarks on Medical Malpractice in Crisis: Health Care Policy Options at the Council on Health Care Economics and Policy (Mar. 3, 2003)).

86. *See* Thorpe, *supra* note 5, at 26 (finding damage caps were the only tort reform measure that effectively reduced medical malpractice insurance premiums).

87. *See infra* Tables 1–5.

88. *See* Mitchell J. Nathanson, *It's the Economy (and Combined Ratio), Stupid: Examining the Medical Malpractice Litigation Crisis Myth and the Factors Critical to Reform*, 108 PENN ST. L. REV. 1077, 1081 (2004) (explaining the minority viewpoint that "the insurance industry is at fault for these malpractice crises due to investment mismanagement").

89. *See id.* at 1083 ("Commentators adhering to this position conclude that because it is the economy which dictates premium rates, tort reform is not only unnecessary but irrelevant to the problem.").

90. *See, e.g.*, Office of the Assistant Sec'y for Planning & Evaluation, U.S. Dep't of Health and Human Servs., *Update on the Medical Litigation Crisis: Not the Result of the "Insurance Cycle"* (Sept. 25, 2002), *available at* http://heal-fl-health-care-pdf.netcomsus.com/resources_update_report.doc (presenting evidence that the medical liability crisis is caused by an out of control litigation system and not insurance company mismanagement).

returns on investment and other factors have an impact on the rising medical malpractice insurance premiums, but emphasizes that the data shows that medical malpractice litigation payouts are the greatest contributor to increasing premiums.[91]

To determine what, if any, effect contingency fee limitation statutes have on medical malpractice insurance premiums, this Note separates states into four groups based on the status of their contingency fee limitations between 1999 and 2004: (1) states with "strict" contingency fee limitations, (2) states with "weak" contingency fee limitations, (3) states with judicial review of contingency fees, and (4) states with no restrictions on contingency fee limits. For the purpose of this analysis, states were determined to have "strict" or "weak" contingency fee limitations based on whether their limitations would result in attorneys' fees on the median medical malpractice award less than the traditional 33 percent[92] contingency fee.[93] States were further divided based on the existence of a cap on noneconomic damages in an attempt to isolate the effect of the contingency fee limitation statute alone. It is impossible, however, to fully separate out the effect of contingency fee limitations, as many factors influence insurance premiums. First, tort reform measures such as modifications to the collateral source rule, restrictions on punitive damages restrictions on joint and several liability, expert witness limitations, periodic payment allowances, statute of limitations modifications, restrictions on the use of *res ipsa loquitur*, and prescreening requirements may affect premium rates.[94] Second,

91. *See, e.g.*, U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 15 (Oct. 2003), *available at* http://www.gao.gov/new.items/d04128t.pdf ("[M]ultiple factors, including falling investment income and rising reinsurance costs, have contributed to recent increases in premium rates . . . . [but] losses on medical malpractice claims—which make up the largest part of insurers' costs—appear to be the primary driver of rate increases in the long run.").

92. *See* U.S. CONG. OFFICE OF TECH. ASSESSMENT, IMPACT OF LEGAL REFORMS ON MEDICAL MALPRACTICE COSTS 29 (Sept. 1993), *available at* http://www.wws.princeton.edu/ota/disk1/1993/9329/9329.PDF (stating that the average plaintiffs' lawyers in medical malpractice cases collects one third of the recovery).

93. *See* Cohen, *supra* note 56 (finding that the median award in medical malpractice trials is $425,000).

94. *See* U.S. CONG. OFFICE OF TECH. ASSESSMENT, *supra* note 92, at 2–3 (explaining that although studies on tort reform show that only damage caps and mandatory collateral source offsets reduce medical malpractice costs, this is likely because of insufficient or inaccurate study of other reforms); *see also* CONG. BUDGET OFFICE, *supra* note 6, at x–xi (summarizing the findings of recent empirical studies on the effects of tort reform on overall tort liability).

varying state insurance regulations may affect premium rates.[95] Third, the level of competition among medical malpractice insurers in a state could also affect premium rates.[96] Fourth, demographic variables such as the percentage of the population living in urban areas,[97] rate of surgery,[98] age of the population, and even the density of attorneys could affect insurance premiums.[99]

For each state, the median insurance premium for three specialties—internal medicine, general surgery, and obstetrics and gynecology (OB/Gyn)—was calculated for the year 2004.[100] In addition, the percent change in premiums from 1999 to 2004 was calculated to assess the intrastate stability of premiums. This intrastate stability measure is important as it helps take into account the effect of the individualized state factors discussed above, besides damage caps and contingency fee limitations, on insurance premiums. This is especially important because states likely to enact medical malpractice reform are those already facing the pressures of high insurance premiums or those with a high underlying propensity for malpractice litigation. To begin, the data for the twenty-eight states without any contingency fee limitations is shown below in Table 1.[101]

95. For an analysis of the effect of state insurance regulations on medical malpractice premiums, see generally John A. Rizzo, *The Impact of Medical Malpractice Rate Regulation*, 3 J. RISK & UNCERTAINTY 482 (1989).

96. For state-by-state data concerning competition in the medical liability insurance market, see ERIC NORDMAN ET AL., NAT'L ASS'N FOR INS. COMM'RS, MEDICAL MALPRACTICE INSURANCE REPORT: A STUDY OF MARKET CONDITIONS AND POTENTIAL SOLUTIONS TO THE RECENT CRISIS 35–37 (2004).

97. *See* Danzon, *supra* note 77, at 415 ("States that have a higher percentage of the population in urban areas tend to have a higher frequency of claims per physician and higher awards.").

98. *See id.* (finding that the number of surgeries per capita was positively correlated to the amount of claims filed per physician and the claim severity).

99. *See* Frank A. Sloan, *State Responses to the Malpractice Insurance "Crisis" of the 1970's: An Empirical Assessment*, 9 J. HEALTH POL. POL'Y & L. 629, 643 (1985) ("[T]he notion that a ten percent increase in a state's lawyer / population ratio leads to almost a like percentage increase in premiums . . . is a distinct possibility.").

100. These three specialties were chosen because of data availability. The categories reflect the wide range of rates among specialties.

101. Data for all tables is drawn from *2004 Annual Rate Survey*, MED. LIABILITY MONITOR, Oct. 2004; *1999 Annual Rate Survey*, MED. LIABILITY MONITOR, Oct. 1999. The Medical Liability Monitor is an independent newsletter covering professional liability insurance and risk management. It is consistently cited by the United States General Accountability Office, the Department of Health and Human Services, and numerous newspapers and trade journals.

Table 1a. Medical Malpractice Insurance Premiums and Stability in States without Contingency Fee Restrictions—States with No Cap on Noneconomic Damages

State	2004 Insurance Premiums (Percent Change, 1999–2004)		
	Internal Medicine	**General Surgery**	**OB/Gyn**
Alabama	$7,484 (23.34%)	$30,515 (32.53%)	$41,737 (13.55%)
Arkansas	6,936 (134.80)	22,471 (153.78)	41,072 (186.89)
Florida	41,092 (133.33)	155,370 (174.61)	180,171 (94.43)
Georgia	12,916 (105.60)	46,215 (204.91)	57,515 (66.43)
Kentucky	10,802 (76.55)	45,230 (67.89)	59,280 (48.77)
Minnesota	4,283 (-2.37)	12,848 (37.36)	22,950 (28.90)
Mississippi	12,667 (197.58)	57,266 (249.02)	80,120 (137.49)
Nevada	14,062 (22.34)	49,650 (26.42)	62,854 (-0.34)
New Hampshire	9,051 (63.25)	34,304 (47.00)	53,936 (50.07)
North Carolina	10,394 (92.91)	48,417 (127.28)	72,445 (96.77)
Pennsylvania	25,020 (264.12)	92,772 (407.77)	119,113 (308.74)
Rhode Island	10,552 (85.15)	39,145 (62.44)	87,952 (52.40)
South Carolina	9,094 (520.50)	40,950 (541.93)	47,739 (528.14)
Texas	24,728 (131.12)	72,460 (186.35)	95,677 (149.92)
Vermont	6,422 (34.97)	20,177 (41.14)	43,729 (78.13)
Wyoming	16,137 (47.40)	52,272 (70.90)	66,727 (40.66)
Average	13,852 (120.66)	51,254 (151.96)	70,813 (117.56)
Median	10,677 (89.03)	45,723 (99.09)	61,067 (72.28)
Std. Deviation	9,329 (126.84)	34,022 (146.09)	37,643 (133.80)

Table 1b. $500,000 or Greater Cap on Noneconomic Damages

State	2004 Insurance Premiums (Percent Change, 1999–2004)		
	Internal Medicine	**General Surgery**	**OB/Gyn**
Alaska	$10,619 (23.98%)	$40,882 (40.96%)	$54,420 (11.36%)
Louisiana	16,092 (113.51)	51,377 (117.05)	80,089 (98.10)
Missouri	19,140 (118.74)	65,131 (87.58)	93,625 (85.76)
New Mexico	12,586 (182.38)	56,639 (81.86)	70,808 (106.80)
North Dakota	8,294 (75.76)	24,588 (95.40)	32,037 (48.13)

South Dakota	3,848 (52.28)	12,569 (86.57)	21,072 (81.97)
Virginia	11,184 (182.46)	40,851 (157.94)	62,205 (131.11)
West Virginia	23,323 (80.63)	77,915 (66.33)	113,966 (42.43)
Average	13,136 (103.72)	46,244 (91.71)	66,028 (75.71)
Median	11,885 (97.07)	46,130 (87.07)	66,506 (83.87)
Std. Deviation	6,196 (57.36)	21,230 (34.65)	30,720 (39.07)

Table 1c. Less than $500,000 Cap on Noneconomic Damages

	2004 Insurance Premiums (Percent Change, 1999–2004)		
State	**Internal Medicine**	**General Surgery**	**OB/Gyn**
Colorado	$12,706 (52.69%)	$44,927 (65.18%)	$51,074 (65.83%)
Idaho	5,176 (44.44)	19,224 (36.29)	31,048 (37.31)
Montana	11,306 (70.45)	48,249 (146.58)	80,199 (130.30)
Ohio	20,202 (113.12)	68,436 (117.64)	94,513 (101.57)
Average	12,348 (70.18)	45,209 (91.42)	64,209 (83.75)
Median	12,006 (61.57)	46,588 (91.41)	65,637 (83.70)
Std. Deviation	6,174 (30.62)	20,199 (49.86)	28,555 (40.67)

Table 1d. Summary

	2004 Insurance Premiums (Percent Change, 1999–2004)		
	Internal Medicine	**General Surgery**	**OB/Gyn**
Average	$13,433 (108.61%)	$48,959 (126.10%)	$68,502 (100.77%)
Median	11,245 (82.89)	45,723 (87.08)	62,530 (80.05)
Std. Deviation	7,928 (101.03)	28,507 (115.63)	33,618 (104.51)

Tables 1a–d show that doctors in unregulated states, especially specialists, are facing extremely high and ever-increasing malpractice premiums. Table 1d demonstrates that on average, rates have more than doubled for all three specialties. The large standard deviations, however, show that broad generalizations based on these data are not warranted. Table 2 examines the effect of statutes allowing judicial review of contingency fees on malpractice premiums.

Table 2a. 2004 Medical Malpractice Insurance Premiums and Stability in States with Judicial Review of Contingency Fees—States with No Cap on Noneconomic Damages

State	2004 Insurance Premiums (Percent Change, 1999–2004)		
	Internal Medicine	**General Surgery**	**OB/Gyn**
Arizona	$19,991 (122.81%)	$69,917 (131.62%)	$83,515 (79.02%)
Iowa	6,400 (53.29)	25,820 (79.43)	43,407 (51.92)
Average	13,195 (88.05)	47,719 (105.53)	63,461 (65.47)
Median	13,195 (88.05)	47,719 (105.53)	63,461 (65.47)
Std. Deviation	9,610 (49.16)	30,969 (36.90)	28,361 (19.16)

Table 2b. $500,000 or Greater Cap on Noneconomic Damages

State	2004 Insurance Premiums (Percent Change, 1999–2004)		
	Internal Medicine	**General Surgery**	**OB/Gyn**
Hawaii	$10,284 (50.88%)	$37,012 (50.90%)	$61,684 (50.89%)
Maryland	14,171 (113.45)	52,288 (80.55)	102,587 (53.39)
Nebraska	3,286 (23.84)	11,948 (5.73)	19,713 (13.96)
Washington	14,096 (73.38)	45,416 (54.96)	65,252 (55.78)
Average	10,459 (65.39)	36,666 (48.03)	62,309 (43.51)
Median	12,190 (62.13)	41,214 (52.93)	63,468 (52.14)
Std. Deviation	5,115 (37.91)	17,623 (31.11)	33,891 (19.80)

Table 2c. Less than $500,000 Cap on Noneconomic Damages

State	2004 Insurance Premiums (Percent Change, 1999–2004)		
	Internal Medicine	**General Surgery**	**OB/Gyn**
Kansas	$8,803 (90.98%)	$32,304 (69.33%)	$44,447 (47.17%)

Table 2d. Summary

	2004 Insurance Premiums (Percent Change, 1999–2004)		
	Internal Medicine	**General Surgery**	**OB/Gyn**
Average	$11,004 (75.52%)	$39,201 (67.50%)	$60,086 (50.30%)
Median	10,284 (73.38)	37,012 (69.33)	61,684 (51.92)
Std. Deviation	5,575 (35.80)	18,749 (38.03)	27,499 (19.14)

Surprisingly, Tables 2a–d show that the seven states with statutes authorizing judicial review of contingency fee arrangements fared the best out of the four groups of states. Many of these states, however, have small urban populations, and as noted above this plays a significant role in insurance premiums.[102]

Table 3a. 2004 Medical Malpractice Insurance Premiums and Stability in States with Weak Restrictions on Contingency Fees—States with No Cap on Noneconomic Damages

	2004 Insurance Premiums (Percent Change, 1999–2004)		
State	**Internal Medicine**	**General Surgery**	**OB/Gyn**
New Jersey	$19,135 (127.42%)	$54,761 (145.26%)	$96,732 (114.17%)
Tennessee	8,566 (93.31)	32,544 (79.86)	48,841 (82.50)
Oklahoma	9,227 (189.32)	31,975 (160.48)	39,473 (137.67)
Oregon	8,552 (105.02)	31,610 (129.67)	43,535 (100.81)
Average	11,370 (128.77)	37,722 (128.82)	57,145 (108.79)
Median	8,896 (116.22)	32,259 (137.47)	46,188 (107.49)
Std. Deviation	5,186 (42.78)	11,365 (34.98)	26,668 (23.22)

Table 3b. $500,000 or Greater Cap on Noneconomic Damages

	2004 Insurance Premiums (Percent Change, 1999–2004)		
State	**Internal Medicine**	**General Surgery**	**OB/Gyn**
Massachusetts	$12,908 (91.48%)	$39,474 (80.88%)	$105,006 (72.38%)

102. *See supra* note 97 and accompanying text (noting urban areas on average have higher awards and higher rates of filing).

Table 3c. Less than $500,000 Cap on Noneconomic Damages

State	2004 Insurance Premiums (Percent Change, 1999–2004)		
	Internal Medicine	**General Surgery**	**OB/Gyn**
Utah	$10,209 (80.21%)	$56,791 (127.22%)	$80,180 (90.24%)
Michigan	23,234 (125.77)	82,930 (198.86)	82,930 (66.57)
Average	16,722 (102.99)	69,861 (163.04)	81,555 (78.41)
Median	16,722 (102.99)	69,861 (163.04)	81,555 (78.41)
Std. Deviation	9,210 (32.22)	18,483 (50.66)	1,945 (16.74)

Table 3d. Summary

	2004 Insurance Premiums (Percent Change, 1999–2004)		
	Internal Medicine	**General Surgery**	**OB/Gyn**
Average	$13,119 (116.08%)	$47,155 (131.75%)	$70,957 (94.91%)
Median	10,209 (105.02)	39,474 (129.67)	80,180 (90.24)
Std. Deviation	5,827 (36.79)	19,040 (42.46)	26,722 (24.90)

Tables 3a–d show that "weak" contingency fee limitations have no effect on medical malpractice premiums. This is to be expected, as such restrictions mandate the status quo, setting contingency fee limitations at or above the average percentage of the award that attorneys retain.[103]

Table 4a. 2004 Medical Malpractice Insurance Premiums and Stability in States with Strict Restrictions on Contingency Fees—States with No Cap on Noneconomic Damages

State	2004 Insurance Premiums (Percent Change, 1999–2004)		
	Internal Medicine	**General Surgery**	**OB/Gyn**
Connecticut	$20,557 (177.07%)	$61,209 (115.31%)	$126,766 (185.85%)
Delaware	11,137 (159.83)	33,515 (119.09)	52,468 (53.82)
Illinois	29,080 (81.01)	78,164 (69.76)	122,889 (70.06)
New York	12,971 (-32.44)	55,623 (-0.03)	78,774 (-23.05)

103. *See supra* notes 92–93 and accompanying text.

Maine	7,004 (13.11)	22,456 (18.35)	37,361 (17.33)
Average	16,150 (79.72)	50,193 (64.50)	83,651 (60.80)
Median	12,971 (81.01)	55,623 (69.76)	78,774 (53.82)
Std. Deviation	8,739 (90.71)	22,253 (54.51)	40,427 (78.57)

Table 4b. $500,000 or Greater Cap on Noneconomic Damages

	2004 Insurance Premiums (Percent Change, 1999–2004)		
State	**Internal Medicine**	**General Surgery**	**OB/Gyn**
None	N/A	N/A	N/A

Table 4c. Less than $500,000 Cap on Noneconomic Damages

	2004 Insurance Premiums (Percent Change, 1999–2004)		
State	**Internal Medicine**	**General Surgery**	**OB/Gyn**
California	$11,220 (25.78%)	$35,880 (48.77%)	$58,608 (30.12%)
Indiana	8,704 (209.29)	33,506 (111.03)	52,729 (106.42)
Wisconsin	6,505 (24.74)	21,504 (31.08)	31,504 (16.11)
Average	8,810 (86.60)	30,297 (63.63)	47,614 (50.88)
Median	8,704 (25.78)	33,506 (48.77)	52,729 (30.12)
Std. Deviation	2,359 (106.25)	7,707 (41.99)	14,258 (48.60)

Table 4d. Summary

	2004 Insurance Premiums (Percent Change, 1999–2004)		
	Internal Medicine	**General Surgery**	**OB/Gyn**
Average	$13,397 (82.30%)	$42,732 (64.17%)	$70,137 (57.08%)
Median	11,179 (53.40)	34,698 (59.27)	55,669 (41.97)
Std. Deviation	7,724 (89.11)	20,149 (46.92)	36,604 (65.03)

Table 4d, however, shows that strict contingency fee limitations do tend to have an effect on malpractice premiums. On average, states that enacted "strict" fee restrictions had approximately half the rate increase from 1999–2004 in general surgery and OB/Gyn premiums than states with weak restrictions or no restrictions at all. Although not as drastic, the states with strict fee restrictions also saw much slower increases in internal medicine premiums. Such stability,

however, was not seen by all states with strict fee restrictions. Connecticut, Delaware, and Indiana all saw premiums double between 1999 and 2004. Finally, Table 5 looks at overall national averages for medical malpractice premiums.

Table 5. Medical Malpractice Insurance Premiums and Stability

	2004 Insurance Premiums (Percent Change, 1999–2004)		
	Internal Medicine	**General Surgery**	**OB/Gyn**
Average	$13,043 (100.81%)	$46,344 (108.78%)	$67,929 (85.90%)
Median	11,160 (88.06)	42,939 (81.37)	61,944 (68.32)
Std. Deviation	7,199 (85.42)	24,630 (94.31)	31,706 (84.84)

Overall, the tables show one clear trend—medical malpractice insurance premiums are exorbitantly high and are continuing to increase at alarming rates. Every state but one has seen double-digit percentage increases in premiums since 1999.[104] Further, twenty-four states have seen insurance premiums double since 1999 in at least one of the specialties examined. In fact, the *average* national rate increase in both internal medicine and general surgery is over 100 percent. States that have enacted caps on damages appear to fare slightly better both in terms of the amount of premiums and the stability of premiums.

104. Table 4a shows New York has actually seen a significant reduction in medical malpractice premiums since 1999. A large reason for this is that New York's 1999 premiums were the highest in the nation ($19,200 for internal medicine, $55,638 for general surgery, and $102,373 for OB/Gyn). *See 1999 Annual Rate Survey*, *supra* note 101. Also, despite the decrease in premiums, New York is still among the twenty-one states the American Medical Association has identified as in medical liability crisis. *See* Am. Med. Ass'n, Medical Liability Crisis Map, http://www.ama-assn.org/ama/noindex/category/11871.html (last visited Nov. 5, 2006) (defining a state in crisis as one where patients are losing access to medical care). The other states identified as crisis states are Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Massachusetts, Mississippi, Missouri, Nevada, New Jersey, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Texas, Washington, West Virginia, and Wyoming. *Id.*

Table 6a. Comparison of Medical Malpractice Insurance Premiums and Stability—States with Noneconomic Damages Caps

	2004 Insurance Premiums (Percent Change, 1999–2004)		
	Internal Medicine	**General Surgery**	**OB/Gyn**
No Cap on Noneconomic Damages (27 States)	$13,861 (111.86%)	$48,791 (128.89%)	$70,621 (101.89%)
$500,000 or Greater Cap on Noneconomic Damages (13 States)	12,295 (90.98)	42,776 (77.44)	67,882 (65.54)
Less than $500,000 Cap on Noneconomic Damages (10 States)	11,807 (83.75)	44,375 (95.20)	60,723 (69.16)

The amount of the caps appears to have a slight effect on the amount of the insurance premiums, but no effect on their stability.

Contingency fee statutes seem to produce even greater stabilizing effects than statutory caps, but have no apparent effect on the actual amount of premiums.

Table 6b. Comparison of Medical Malpractice Insurance Premiums and Stability—States with Contingency Fee Restrictions

	2004 Insurance Premiums (Percent Change, 1999–2004)		
	Internal Medicine	**General Surgery**	**OB/Gyn**
Strict Fee Restrictions (8 States)	$13,397 (82.30%)	$42,732 (64.17%)	$70,137 (57.08%)
Weak Fee Restrictions (7 States)	13,119 (116.08)	47,155 (131.75)	70,957 (94.90)
Judicial Review of Fees (7 States)	11,004 (75.52)	39,201 (67.50)	60,086 (50.31)
No Fee Restriction (28 States)	13,433 (108.61)	48,959 (126.10)	68,502 (100.77)

It is clear, however, that not all contingency fee statutes are created equally. Those characterized as "weak" show no effect on insurance premiums, whereas those characterized as "strict" show a noticeable effect. Finally, the combination of caps on noneconomic damages and contingency fee limitations appears to be effective in limiting malpractice premiums and growth of premiums. Although only three states have such a combination, the data can still be instructive. Looking at the data from California, it is understandable why Congress may want to model national medical malpractice reform on California's statute. California ranks in the top twelve for stability of premiums in all three specialties.[105] This is especially impressive given California's demographics—its many urban centers,[106] its propensity for litigation,[107] and numerous other factors.

Given that the foregoing data fails to take into account many key factors, it is important not to overgeneralize its conclusions. The main purpose of this Note is to encourage legislatures, courts, and commentators to conduct further research into the efficacy of contingency fee limitations. The data augments the argument that fee limitations reduce medical malpractice insurance premiums and offers support for courts, under the extremely lenient rational basis review, to hold that such statutes do not violate the equal protection clause. As noted in Part II, to declare a statute unconstitutional under the equal protection clause, the challenger must show that "the legislative facts on which the classification is apparently based could not reasonably be conceived to be true by the governmental decisionmaker."[108] It is clear from the data that a reasonable legislature could determine that contingency fee limitations are an appropriate way to curb rising medical malpractice costs.

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105. California ranks ninth lowest in increase in internal medicine premiums, twelfth lowest in general surgery premium increases, and ninth lowest in Ob / Gyn premium increases.

106. For example, the eight states with a lower percentage increase on internal medicine premiums were New York, Nevada, Alaska, Alabama, Nebraska, Wisconsin, Maine, and Minnesota. Besides New York, discussed *supra* note 104, all of these states have much smaller urban populations than California.

107. *See* Christine McCarthy, *Exemplary and Aggravated Damages in Medical Negligence Litigation*, 6 J.L. & MED. 187, 187 (1998) (reporting that California is the most litigious jurisdiction in the United States).

108. Vance v. Bradley, 440 U.S. 93, 111 (1970).

CONCLUSION

The problem is clear. Medical malpractice insurance rates are rising at astronomical rates across the country. Physicians facing skyrocketing premiums are being forced to stop performing high-risk procedures or to enter an early retirement.[109] Some states are in better shape than others, but it appears that none are safe from the potential deadly consequences of pricing both doctors and patients out of the healthcare market. Unfortunately, the solution is not nearly as clear as the problem. The data presented in this Note show that contingency fee limitations may stabilize medical malpractice insurance premiums, but cannot reduce premiums in states that are already facing a severe crisis. Even the highly touted cap on noneconomic damages does not appear to solve the problem without being paired with other reforms.

Although both measures will probably survive lenient judicial scrutiny, this does not mean legislators need not delve more deeply into the problem. The first decade of the twenty-first century placed medical malpractice reform in the spotlight, making it crucial to examine the efficiency of the proposed reforms. Given the magnitude of the crisis, the healthcare system cannot afford ineffective or stop gap reform measures. Empirical research is needed to determine what effects various medical malpractice reforms have on medical liability costs, insurance premiums, and patient care.

109. *See* Thorpe, *supra* note 5, at 8 (noting the dire consequences rising malpractice premiums are having on doctor livelihood and patient care).