Northern Illinois University Law Review

Volume 26 | Issue 3 Article 8

7-1-2006

Why Medical Malpractice Caps are Wrong

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I. INTRODUCTION

When Jane Smith[1] was admitted to a local hospital with a treatable illness, she expected the medical staff to treat her according to the appropriate standard of care. Her husband and daughter expected the same. Unfortunately, her treating physician ordered the administration of intravenous (IV) fluids that were incompatible with other medication she was receiving. Jane died just a few minutes after the fluids were injected into her body. Because Jane worked as a volunteer at her daughter's school, her family incurred little economic loss as a result of her death. Under the new Illinois cap on damages, Jane's family would have been able to recover only $500,000 in noneconomic damages for the doctor's negligence.

Like economic damages, noneconomic damages are compensatory – they are meant to reimburse Jane's family for losses they incurred as a

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1. I have decided to use a fictitious name in order to respect the confidentiality of the client, the client's family, and their settlement agreement. The medical facts, however, are those of a real case.

result of the doctor's fault. Damage caps stifle the compensatory nature of noneconomic damages. No matter how grave the injury, how severe the loss, the reimbursement in Illinois is now limited to $500,000. The result is that, if Jane's death had occurred today, her family would be inadequately and unfairly compensated for the losses they suffered as a result of the doctor's negligence. This system places the burden of "tort reform" on the most severely injured plaintiffs.

Although trial lawyers may realize the inequities of damage caps, a recent poll conducted by the Kaiser Family Foundation found that most Americans do not.[2] Approximately 63% of the people polled favored caps on noneconomic damages in medical malpractice cases.[3] This preference is based on the belief that capping noneconomic damages will somehow lead to a decrease in medical costs. Nearly 70% of the people questioned said they believed that limiting pain-and-suffering would help "a lot" (32%) or "some" (37%) in reducing overall health costs.[4]

However, these opinions indicate the public's misunderstanding of the negligible effect damage caps have on malpractice premiums, access to health care, and health care costs, compared with the catastrophic effect caps impose on victims of medical malpractice.

II. FACTS ABOUT CAPS

Damage caps do not reduce medical malpractice insurance premiums. The ineffectiveness of damage caps was recently presented in a congressional hearing.[5] Testimony demonstrated that of the five states with the highest medical malpractice insurance premiums, Florida, Michigan, Nevada, Ohio, and West Virginia, all have damage caps.[6] In contrast, the state with the lowest medical malpractice insurance premiums, Oklahoma, does not have a damage cap.[7] A recent study shows that medical malpractice payouts in Oklahoma have actually decreased 16.4%, after adjusting for

2. Kaiser Family Foundation/Harvard School of Public Health Survey, *Health Care Agenda for the New Congress* (January 2005), *available at* http://www.kff.org/kaiserpolls/upload/Health-Care-Agenda-for-the-New-Congress-Survey-Toplines.pdf.

3. *Id.* at 19.

4. *Id.* at 20.

5. *Assessing the Need to Enact Medical Liability Reform: Hearing Before the Subcomm. on Health of the Comm. on Energy and Commerce House of Representatives*, 108th Cong. 13 (2003), *available at* http://energycommerce.house.gov/108/action/108-2.pdf.

6. *Id.* at 14.

7. *Id.*

inflation.[8] Nonetheless, there has been a recent push to pass legislation in Oklahoma which would limit noneconomic damages to $300,000.[9]

Not only are damage caps ineffective in reducing premiums, they are also unable to avoid significant premium increases. For example, soon after Texas passed a state constitutional amendment authorizing damage caps, some insurers requested rate hikes as high as 35% for doctors and 60% for hospitals.[10] Similarly, in Florida insurers requested premium increases of up to 45% immediately after damage cap legislation was passed.[11] In fact, a recent study by Weiss Ratings, Inc, an independent insurance rating agency, concluded that damage caps were likely to *increase* rather than decrease medical malpractice insurance rates.[12] The study examined median premium costs from 1991 to 2002. During the period of the study, premiums rose 48.2% in states that had damage caps, but only 35.9% in states without caps.[13] This statistic is particularly compelling in light of the fact that the median claim payout was higher in states without damage caps.[14] The results of this study led Weiss Ratings, Inc. to conclude that there are "other, far more significant factors driving premium rates higher."[15]

In addition to this statistical evidence, the insurance industry itself has demonstrated that damage caps are ineffective in reducing medical malpractice premiums. In response to an unfavorable report on "tort reform," the American Insurance Association admitted that insurers "never promised that tort reform will achieve specific savings," and that there are "other state-specific factors that affect premium levels, such as taxes, fees, and the degree of market competition."[16] The Medical Assurance Company

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8. Congress Watch Public Citizen, *Medical Misdiagnosis in Oklahoma: Challenging the Medical Malpractice Claims of the Doctors' Lobby*, 9 (2004), *available at* http://www.citizen.org/documents/Oklahoma_Report_Final_4.21.pdf.

9. *Id.* at 1.

10. Darrin Schlegel, *Some Malpractice Rates to Rise Despite Prop. 12*, HOUS. CHRON., Nov. 19, 2003 at A1, *available at* www.chron.com/CDA/archives/archive.mpl?id=2003_3709161.

11. Julie Kay, *Medical Malpractice: Surprise Hikes Despite Legislation that Promised to Reign in Physicians' Premiums, Three Firms File for Big Rate Increases*, PALM BEACH DAILY BUS. REV., Nov 20, 2003.

12. Martide D. Weiss, Melissa Gannon, and Stephanie Eakins, *Medical Malpractice Caps The Impact of Non-Economic Damage Caps on Physician Premiums, Claims Payout Levels, and Availability of Coverage* (2003), *available at* http://www.weissratings.com/malpractice.asp (last visited March 27, 2006).

13. *Id.* at 3.

14. *Id.*

15. *Id.*

16. American Insurance Association, *AIA Cites Fatal Flaws in Critic's Report on Tort Reform*, (March 13, 2002), *available at* http://www.aiadc.org/DocFrame.asp?DocID=7027.

of Mississippi, a "crisis" state that actually *has* a cap, stated that tort reform does "not provide a magical 'silver-bullet' that will immediately affect medical malpractice insurance rates."[17] Additionally, St. Paul Insurance Company stated that Florida's non-economic cap "will produce little or no savings to the tort system as it pertains to medical malpractice."[18] Donald Zuk, Chief Executive of SCPIE Holdings, a leading malpractice insurer in California, said, "I don't like to hear insurance-company executives say it's the tort system—it's self-inflicted."[19]

But perhaps the strongest indictment against tort "reform" came from the nation's largest medical malpractice insurer, G.E. Medical Protective. In 2004, G.E. admitted that damage caps will *not* lower physicians' premiums.[20] G.E. has pushed for higher physician premiums in states that already have caps, seeking a 29.2% rate hike in California and a 19% rate hike in Texas.[21] As Douglas Heller, the executive director of the Foundation for Taxpayer and Consumer Rights in Santa Monica, California stated, "[w]hen the largest malpractice insurer in the nation tells a regulator that caps on damages don't work, every legislator, regulator and voter in the nation should listen."[22]

III. FACTS ABOUT ACCESS TO MEDICAL CARE

One common argument advanced by damage cap proponents is that, as a result of prohibitively high malpractice premiums, doctors will cease practicing medicine in states without caps, and as a result patients in those states will experience reduced access to health care. For example, in Florida, hospital associations reported that access to newborn delivery services had been reduced due to the closure of five hospital obstetrics units.[23] However, as the United States General Accounting Office (GAO) reported, each hospital had been experiencing low demand, which ultimately led to the closings. In addition, the closings were in separate

17. Julie Goodman, *Premiums Rise by 45%*, CLARION-LEDGER, Sep. 22, 2002, at 2.

18. The Foundation for Taxpayer and Consumer Rights, *Nation's Largest Medical Malpractice Insurer Declares Caps on Damages Don't Work, Raises Docs' Premiums: Smoking Gun Document Exposes Insurance Industry Lies*, Oct. 26, 2004, *available at* http://www.consumerwatchdog.net/insurance/pr/pr0048698.php3.

19. Rachel Zimmerman & Christopher Oster, *Insurers' Missteps Helped Provoke Malpractice "Crisis,"* WALL ST. J., Jun. 24, 2002, *available at* http://pqsab.pqarchiver.com/wsj/access/12803182.html?.

20. The Foundation for Taxpayer and Consumer Rights, *supra* note 18.

21. *Id.*

22. *Id.*

23. U.S. Gen. Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care* (2003), *available at* www.gao.gov/new.items/d03836.pdf.

locations in the state, and in each case nearby obstetrics units were available in each situation.[24]

Similarly, one report claimed that twenty-four ob/gyns had left Pennsylvania because of concerns regarding malpractice premiums.[25] However, during the time period in question, the population of women between the ages of 18 and 40 decreased by 18,000, suggesting that a decrease in demand for ob/gyn services, rather than concerns about malpractice, may have been behind the decision of those doctors to leave the state.[26]

IV. FACTS ABOUT HEALTH CARE COSTS

Another popular argument put forth by cap proponents is that, without damage caps, high malpractice judgments will drive health care costs, which are already high, to prohibitive levels. However, according to the Congressional Budget Office (CBO), malpractice costs account for less than 2% of all health care spending in the United States.[27] Even assuming, as the CBO does, that damage caps will reduce malpractice costs by 25% to 30%, and that 100% of the saving are passed on to consumers, the savings will only be a miniscule 0.4 to 0.5% for the entire population.[28] In reality, consumers are likely to experience an even lower percentage in savings after the insurance and health care industries take their cuts from any savings. In addition, the CBO found "no statistical difference in per capita health care spending between states with and without limits on malpractice torts."[29] This fact indicates that damage caps do not decrease health care costs.

Similarly, cap proponents argue that fear of malpractice litigation leads physicians to practice "defense medicine," ordering more diagnostic tests and issuing more specialist referrals than they believe are necessary. These extra tests and specialist visits, proponents argue, will unnecessarily increase overall health care costs for the patients. Not only are such "defensive medicine" practices uncommon, but where they do exist they may have nothing to do with the presence or lack of damage caps. For example, the CBO stated that "some so-called defensive medicine may be motivated less by liability concerns than by the income it generates for physicians or by the positive (albeit small) benefits to patients. . . . CBO believes that savings from reducing defensive medicine would be very

24. *Id.*
25. *Id.* at 17, tbl. 1.
26. *Id.* at 18.
27. Cong. Budget Office, *Limiting Tort Liability for Medical Malpractice* (2004), *available at* www.cbo.gov/showdoc.cfm?index=4968&sequence=0.
28. *Id.*
29. *Id.*

small."[30] Thus, according to the CBO, defensive medicine practices cannot be attributed to fears of medical malpractice claims, nor do these practices significantly increase health care costs.

V. FACTS ABOUT MALPRACTICE LITIGATION

Some cap proponents claim that, in addition to increasing medical malpractice premiums, physicians are forced to leave the practice of medicine because of a fear of frivolous litigation. Despite alarming assertions by proponents of "tort reform," victims of medical malpractice are not overly litigious. In fact, relatively few medical malpractice cases are filed. In the Harvard Medical Malpractice Study III, investigators determined that less than 2% of malpractice victims file a lawsuit against their doctors.[31] The results of a recent *Wall Street Journal* study reported that both payouts in medical malpractice suits and the number of filings per capita have remained steady in recent years.[32] In addition, claims paid by ISMIE, Illinois' largest medical malpractice insurer, decreased each year from 1999 to 2003.[33]

In addition to relatively few medical malpractice cases being filed, those that are filed are difficult to win. St. Clair County, in southern Illinois, has been labeled a "judicial hellhole" by the American Tort Reform Foundation (ATR Foundation), based on allegations of excessive litigation and verdicts.[34] However, of the 295 medical malpractice claims filed between 1999 and 2004 in St. Clair county, only ten cases proceeded to a verdict at trial.[35] Of those ten cases, only *two* resulted in verdicts for the plaintiffs.[36] According to this statistical history, Illinois' new damage cap will affect less than 1% of medical malpractice cases filed in St. Clair County.

On a national level, the U.S. Department of Justice found that only approximately 27% of medical malpractice claims that proceed to trial

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30. *Id.*

31. Kelly K. Meadows, Note: *Resolving Medical Malpractice Disputes in Massachusetts: Statutory and Judicial Initiatives in Alternative Dispute Resolution*, 4 SUFFOLK J. TRIAL & APP. ADVOC. 165, 169 (1999).

32. *Malpractice Awards Stay Flat*, WALL ST. J., Apr. 1, 2004.

33. Coalition for Consumer Rights, *Opening ISMIE's Books: An Inside Look at Illinois' Largest Medical Malpractice Insurer* (June 2004).

34. American Tort Reform Foundation, *Judicial Hellholes 2004, available at* http://www.atra.org/reports/hellholes/2004.

35. Laninya A. Cason, *Senate Bill 475 – Cause for Concern or Self-Generated Crisis?*, THE CATALYST (Ill. Bar Ass'n), Jan. 2006, at 3.

36. *Id.*

prevail, about half the rate of success of other tort claims.[37] In addition, relatively few medical malpractice cases proceed to trial. According to the Insurance Information Institute, only 1.3% of medical malpractice cases filed result in a verdict in favor of the plaintiff at trial.[38] Damage caps affect even fewer cases, since many of the 1.3% that prevail in trial will have verdicts below the capped amount. In light of the small percentage of medical malpractice cases on which damage caps act, it is easy to see why damage caps are ineffective in lowering medical malpractice premiums. Yet these caps have a catastrophic effect on the individual plaintiffs who receive inadequate and unfair compensation for life-changing losses.

VI. SOLUTIONS

A. INSURANCE REFORM

Proponents of damage caps often point to California as an example of the effectiveness of caps in reducing medical malpractice premiums. In the mid 1970's, California passed the Injury Compensation Reform Act (or "MICRA"), "tort reform" which included a $250,000 cap on noneconomic damages.[39] Despite this cap, malpractice premiums increased 450% over the thirteen years following the "tort reform."[40] It wasn't until California passed *insurance reform* through Proposition 103 that malpractice premiums stabilized.[41] This insurance reform froze insurance premium rates, required insurers to obtain approval from the government for rate increases greater than 15%, and repealed insurance antitrust exemptions.[42]

Following the insurance reform, premium rates dropped 31% in just three years, after adjusting for inflation, and since then rates have risen only in proportion to inflation.[43] Thus, California's *insurance reform*, not "tort reform," is responsible for the decrease in malpractice premiums.

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37. U.S. Dep't of Justice, *Medical Malpractice Trials and Verdicts in Large Counties* (2001), *available at* http://www.ojp.usdoj.gov/bjs/abstract/mmtvlc01.htm.

38. Insurance Information Institute, *Medical Malpractice*, *available at* http://www.iii.org/media/hottopics/insurance/medicalmal/ (last visited April 25, 2006).

39. CAL. CIV. CODE § 3333.2(b) (Deering 2004).

40. Foundation for Taxpayer and Consumer Rights, *False Accounting: How Medical Malpractice Insurance Companies Inflate Losses to Justify Sudden Surges in Rates and Tort Reform* (Dec. 2005), *available at* http://www.consumerwatchdog.org/malpractice/rp/1008.pdf.

41. *The Medical Liability Insurance Crisis: A Review of the Situation in Pennsylvania: Hearing Before the Subcomm. on Oversight and Investigations of the House Comm. on Energy and Commerce*, 108th Cong. 130 (2003) (statement of Harvey Rosenfield, President, Foundation for Taxpayer and Consumer Rights), *available at* http://energycommerce.house.gov/108/action/108-4.pdf.

42. *Id.* at 133-34.

43. *Id.* at 136, 139.

Insurers make most of their profits not from premiums, but from investments made using the capital generated by premiums.[44] Thus, insurers can afford to offer lower rates when the market is strong and their investments are turning profits. However, when interest rates are low or the stock market is sluggish (as has generally been the case the last few years), insurers must make up for this lost income through higher premiums.[45] In fact, recent studies have shown that the timing and severity of malpractice "crises" are strongly correlated with fluctuations in the market, rather than with changes in litigation patterns or verdict amounts.[46] Further evidence indicates that past "crises" have only receded when the market has recovered.[47]

Market competition also affects the insurance industry just as it does any other business. The experience of St. Paul Company, once one of the largest medical malpractice insurance companies in the United States, illustrates this point. After St. Paul released about $1.1 billion in reserves (which looked like profit), many new insurance carriers entered the market. Intense competition led to premium rates so low that premiums could no longer cover malpractice claims. As a result, St. Paul pulled out of the malpractice insurance market, causing a huge supply and demand problem for physicians in some states.[48] These facts demonstrate that, contrary to cap proponents' arguments, insurance premiums are dictated by market fluctuations and supply and demand in the insurance industry, not malpractice litigation. Therefore, in order to reduce malpractice premiums, lawmakers should advocate changes to the insurance industry.

B. MERIT RATING

One primary cause of increasing medical malpractice premiums is an increase in medical malpractice. In the United States, more people are killed each year as a result of medical malpractice than die in car accidents

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44. Americans for Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates in Illinois* (Feb. 2003), *available at* http://www.insurance-reform.org/StableLossesIL.pdf.

45. Center for Justice and Democracy, *A Short Guide to Understanding Today's Medical Malpractice Insurance "Crisis" (and Useful Questions to Ask)* (Sept. 25, 2002), *available at* http://www.centerjd.org/MediaGuide.pdf.

46. 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, 1081-82 (2004).

47. *See* Americans for Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates 2004* (Oct. 2004), *available at* http://www.insurance-reform.org/StableLosses04.pdf.

48. Center for Justice and Democracy, *supra* note 45.

and workplace accidents combined.[49] A study published by The Wall Street Journal in 2004 estimated that medical errors contributed to almost 600,000 patient deaths over just three years.[50] Even more people are otherwise injured as a result of medical negligence. In many instances, a very small percentage of doctors are responsible for a disproportionately high percentage of the malpractice payouts. For example, about 54% of medical malpractice settlements and judgments can be attributed to about 5% of all doctors.[51] Oftentimes, these doctors are the ones that have numerous sizeable payouts. And yet, a doctor's history of medical malpractice payouts does not affect his or her malpractice premiums.

When a driver negligently causes an auto accident, his or her insurance premiums are increased to reflect the increased risk the insurance company incurs. This system is referred to as "merit" or "experience" rating. This system is premised on the fact that not all insured have the same risk of incurring future negligence claims. Experience rating is a way of allocating the risk of future negligence claims according to each insured's individual risk of incurring a claim in the future. Consider two drivers, similar in all respects except that Driver A has had numerous car accidents and Driver B has not had any. Statistically, Driver A poses a higher risk of incurring a future claim than does Driver B. Consequently, in a merit rating system, Driver A's insurance premiums would be higher than Driver B's, to reflect Driver A's increased risk of future claims.

Unfortunately, medical malpractice insurance is not merit rated. This means that a doctor who has numerous malpractice payouts pays the same insurance premiums as other doctors in the same specialty and geographical area. Essentially, all the doctors in the same specialty, regardless of claim history, share the risk of future lawsuits. This system is particularly troubling in light of statistics indicating that a small proportion of doctors contribute to the majority of medical malpractice payouts. For example, one study found that 6% of anesthesiologists and obstetrician-gynecologists were responsible for 87% of malpractice payouts in those specialties.[52] Under the current system, the anesthesiologists and obstetrician-gynecologists who have not had any malpractice payouts are assessed the same premiums as those who have had numerous payouts. This system

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49. TOM BAKER, THE MEDICAL MALPRACTICE MYTH, 1-13 (2005) *available at* http://www.press.uchicago.edu/Misc/Chicago/036480.html.

50. Paul Davies, *Fatal Medical Errors Said to be More Widespread*, WALL ST. J., July 27, 2004, *available at* http://online.wsj.com/article-print/0,,SB109088045221774311,00.html.

51. *Dissenting Views to H.R. 5, The House Comm. on the Judiciary*, 108th Cong. 2, *available at* http://www.house.gov/judiciary_democrats/hr5dissenting108cong.pdf.

52. Frank A. Sloan, *Experience Rating: Does it Make Sense for Medical Malpractice Insurance?*, 80 AM. ECON. REV. 128, 129 (1990).

forces lower-risk physicians to pay higher premiums in order to cover the costs incurred by higher-risk physicians in the same specialty. When such a small percentage of doctors are responsible for numerous payouts and errors, there is cause for concern regarding those few doctors. Failing to assess premiums based on claim history is unfair to the lower-risk physicians, who represent the majority of practicing physicians, and must consequently pay higher premiums than their individual risk requires. Even worse, this system is unfair to patients who are treated by high-risk physicians with a pattern of malpractice payouts, but who are sheltered by the ability to spread the risk they incur across the less negligent-prone doctors in their specialty.

Skeptics often claim that merit rating is unfair to doctors who experience numerous claims because of "bad luck" rather than negligence. However, experience rating uses sophisticated statistical analyses to assess the likelihood of a future claim based on past claims.[53] The statistics account for the increased risk of claims based on high risk specialties, procedures, and services, and assess the probability that past claims increase the likelihood of future claims.[54] It is important to point out that the more payouts an individual doctor has in comparison to the average number of payouts for his or her specialty, the more likely it is that the doctor will incur future payouts. Studies have clearly shown that, despite claims of "bad luck," a history with significantly more payouts than the average for the specialty is an important predictor of future claims.[55]

VII. CONCLUSION

Capping damages does not lower malpractice premiums, decrease health care costs, or increase access to health care. In order to effect these changes, lawmakers should focus on regulating the insurance industry and reforming malpractice insurance policies. In addition, reforms should focus on reducing the incidence of malpractice, and allocating the risk of future malpractice payouts equitably such that individual physicians are assessed premiums based on their individual risk of future malpractice payouts. Not only do arbitrary damage caps deprive patients who experience severe, life-changing losses and injuries of fair compensation, but they do so without affecting any of the benefits their proponents promise. Such caps do not resolve the medical malpractice "crisis" – they only punish innocent victims.

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53. For a detailed discussion of the statistical methods, see Carrie Lynn Vine, Comment, *Addressing the Medical Malpractice Insurance Crisis: Alternatives to Damage Caps*, 26 N. ILL. U. L. REV. 413 (2006).

54. *See* Sloan, *supra* note 52.

55. *Id.*