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Addressing the Medical Malpractice Insurance Crisis: Alternatives to Damage Caps

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TABLE OF CONTENTS

I. INTRODUCTION ................................................................. 413
II. TORT REFORM VIA DAMAGE CAPS ........................................ 415
   A. EFFECT OF DAMAGE CAPS ................................................. 416
   B. CALIFORNIA'S EXPERIENCE WITH DAMAGE CAP REFORM ...... 417
   C. NECESSITY OF INSURANCE REFORM ...................................... 419
III. THE CONNECTION BETWEEN THE ECONOMY AND MEDICAL MALPRACTICE CRISIS ...................................................... 420
IV. VIABLE TORT REFORM OPTIONS ............................................. 423
   A. REDUCING THE COMBINED RATIO ........................................ 423
      1. Certificate of Merit ....................................................... 425
      2. Merit Rating .................................................................. 427
   B. DAMAGE CAPS USING AUSTRALIA'S "MOST EXTREME CASE MODEL" ...................................................... 433
V. CONCLUSION ........................................................................ 437

I. INTRODUCTION

In recent years there has been a dramatic increase in the premiums charged for medical malpractice insurance. Many claim that premiums in some areas have become prohibitive, forcing many physicians to restrict the type of procedures they perform, others to move to lower cost regions, and some to leave the medical field all together. The ultimate effect of these

2. William P. Gunnar, Is There an Acceptable Answer to Rising Medical Malpractice Premiums?, 13 ANNALS HEALTH L. 465, 473-75 (2004); see also Rachel Zimmerman &
increasing premiums is a reduction in the public’s access to healthcare and an increase in patient costs for the services received.3 This progression of increasing premiums leading to reduced access to healthcare has been referred to as the “medical malpractice crisis.”4 However, there is significant debate about whether such a “crisis” exists.5 For example, some evidence indicates that, on average, doctors perceive the risk of a medical malpractice suit to be three times greater than the actual risk.6 Despite the arguments for and against the existence of medical malpractice insurance crises, there has been enough public outcry to lead the legislatures of all fifty states to attempt reform.7

Tort reform in the area of medical malpractice is a highly controversial topic. Legislatures have taken numerous approaches to tort reform, including limiting the amount of recovery available, attempting to limit the number of suits filed, decreasing the likelihood of a plaintiff verdict, and insurance reform.8 The most common method of tort reform is to limit the non-economic damages awarded to the plaintiff.9 This type of reform, often called a damage cap, is the oldest type of tort reform and was first enacted in the 19th century.10 This comment addresses the reasons that damage caps, as currently implemented in the United States, are an ineffective means of resolving the medical malpractice crises that repeatedly plague the insurance system. Part I begins with the background and history of damage caps, examines California’s unique experience with damage cap reform, and concludes with a discussion of the necessity of insurance reform. Part II examines the relationship between medical malpractice insurance “cri-


4. Id. at 166.


7. GAO Report, supra note 1, at 41.


10. Id.
II. TORT REFORM VIA DAMAGE CAPS

Proponents of damage caps cite increasingly prohibitive malpractice insurance costs as evidence that reform is necessary. These supporters blame rising insurance costs on excessive damage awards and an increase in frivolous claims, and argue that damage caps would both reduce plaintiff windfalls and discourage frivolous lawsuits. Opponents to damage caps cite statistics that indicate that relatively few medical malpractice claims are filed, and that plaintiffs in such cases have a low probability of obtaining a favorable verdict. Those who oppose damage caps also claim that such caps impose the burden of the insurance problem on the most severely injured plaintiffs.

The constitutionality of damage caps has been challenged in several states. Of the twenty states with damage caps, courts in eighteen of those states have specifically ruled such caps constitutional. However, of the thirty states that do not have caps, eight have ruled such damage caps unconstitutional, including both Illinois and Texas. Illinois recently enacted new tort reform, including damage caps on non-economic damages. Because it appears to directly conflict with the Illinois Supreme Court's

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13. Id. at 779-80.
15. Gfell, supra note 12, at 782-83. Note that the Wisconsin Supreme Court found damage caps to be unconstitutional in 2005, bringing the number of states finding caps unconstitutional to eighteen. See Ferdon v. Wis. Patients Comp. Fund, 701 N.W.2d 440 (Wis. 2005).
ruling in Best v. Taylor Machine Works which disallowed damage caps, this new legislation is likely to face constitutional challenge. Texas, on the other hand, has recently circumvented the judicial strike on damage caps by passing Proposition 12, an amendment to the state constitution that specifically gives the legislature the power to limit non-economic damages.

A. EFFECT OF DAMAGE CAPS

Many supporters cheer the passing of Texas' Proposition 12 as a triumph for tort reform, predicting continued instability and uncertainty regarding medical malpractice insurance rates for states that fail to pass similar constitutional amendments. However, limiting non-economic damage awards is a "quick-fix," not a long-term solution. Damage caps alone are insufficient to effect medical malpractice insurance stability. In a recent congressional hearing regarding a federal proposal to curb medical malpractice insurance premiums, evidence was presented that the five states with the highest medical malpractice insurance rates, Florida, Michigan, Nevada, Ohio, and West Virginia, respectively, also have damage caps, whereas the state with the lowest premiums, Oklahoma, does not. In addition, Weiss Ratings, an independent insurance-rating agency, recently concluded that damage caps are likely to increase rather than decrease medical malpractice insurance rates. In fact, between 1991 and 2002 the median annual medical malpractice insurance premiums rose 35.9 percent in states that did not cap damages, compared to a 48.2 percent increase in states where damages were capped. Only eight states exhibited static or declining medical malpractice insurance rates. Of those eight states, only two

20. TEX. CONST. art. III, § 66.
21. See Cetra, supra note 11, at 537-38.
22. See id. at 555.
26. Id.
27. The eight states and their percentage change in premiums from 1991 to 2002 are as follows: Maine (-16.0%), Iowa (-12.0%), Alabama (-8.3%), Wisconsin (-5.0%), Arizona (+2.6%), Michigan (+3.5%), New York (+6.1%), and Georgia (+7.5%). Id.
had damage caps, while the other six did not. 28 Thus, according to Weiss Ratings, these statistics indicate that, "on average, doctors in states with caps actually suffered a significantly larger increase than doctors in states without caps." 29 Overall, the Weiss Ratings study revealed that

[j]nsurers in states with caps raised their premiums at a significantly faster pace than those in states without caps. Even with the imposition of caps, insurers in nearly nine out of ten states continued to raise rates, while insurers in states without caps were actually more likely to hold or cut their premium rates. In states with caps, insurers are more likely to charge [medical malpractice] premiums exceeding the national median than those in states without caps. 30

Thus, caps on damages do not successfully stall rising medical malpractice premiums. 31

B. CALIFORNIA'S EXPERIENCE WITH DAMAGE CAP REFORM

One specific example of the insufficiency of damage caps to effect a reduction in medical malpractice insurance costs is seen in California. California was one of the pioneers in tort reform, passing the Medical Injury Compensation Reform Act (MICRA) in 1975, which included a non-economic damage cap of $250,000. 32 However, twelve years after the legislature passed MICRA, the medical malpractice insurance rates in California were 190 percent higher than before MICRA was enacted. 33 A study by the U.S. General Accounting Office (GAO) found that malpractice premiums for physicians in California increased anywhere from 16 percent to 337 percent between 1980 and 1986. 34 According to the GAO study, four other

28. Michigan and Wisconsin have caps, Alabama, Arizona, Georgia, Iowa, Maine, and New York do not. Id.
29. Id.
30. Id.
32. CAL. CIV. CODE § 3333.2(b) (Deering 2004).
states reported that tort reform had had "little effect" on insurance premiums. After evaluating the failure of MICRA to reduce medical malpractice insurance premiums, the California State Assembly Committee on the Judiciary reported that Californian medical malpractice insurance companies had a 20.6 percent average rate of return, compared to 13 percent for property and casualty insurance, and 6.8 percent for private automobile insurers. These return rates indicate that, in the absence of insurance reform, any economic benefit of damage caps goes to the insurance companies rather than to the policy holders. In 2003, the Weiss Ratings published a similar conclusion, reporting that the insurance providers were profiting from the damage caps and not lowering premiums, despite the reduced amount paid in claims.

The only type of legislation proven to lower medical malpractice insurance premiums is that which effects insurance reform. Twelve years after passing MICRA, California passed Proposition 103 to reform medical malpractice insurance. The insurance reform initially required a 20 percent reduction in premium rates, followed by stringent regulation of the industry. As a result of Proposition 103, the insurance industry in California issued $1.2 billion in rate refunds, of which $135 million went to physicians. Among other provisions, Proposition 103 fixed insurance rates for one year, and required the insurance providers to submit any subsequent rate increases to the California Department of Insurance for approval. In addition, Proposition 103 repealed the anti-competitive laws that had been in place favoring the insurance industry. It also gave banks and other financial institutions the ability to provide insurance policies, and consumers the right to join together to bargain for lower group policy rates. Thus, Proposition 103 encouraged competitive, market pricing in the insurance industry.

Unlike Texas' Proposition 12, California's Proposition 103 passed by a large majority. The popularity of Proposition 103 is particularly remarkable in light of the opposition it faced from the insurance industry, which spent $80 million opposing the proposal, more than six times the

35. Id. at 2.
38. Hearing on Medical Insurance Crisis, supra note 33, at 131.
39. Id.
40. Id.
41. Id. at 133-34.
42. Id. at 134.
43. Id.
44. Hearing on Medical Insurance Crisis, supra note 33, at 134.
combined campaign costs for Texas' Proposition 12. In addition, the California insurance industry proposed alternative legislation, to compete with Proposition 103, that would effect additional tort reform rather than insurance reform. However, voters recognized that tort reform had not resulted in the desired change in the medical malpractice insurance prices, and elected to support insurance reform instead.

Through insurance reform, Proposition 103 accomplished what MICRA was unable to do through tort reform. In the three years following the insurance reform, medical malpractice insurance premiums dropped in price by over 20 percent, which is nearly 31 percent after adjusting for inflation. In the years following the passage of Proposition 103, insurance rates have risen only in proportion to inflation.

C. NECESSITY OF INSURANCE REFORM

In addition to rising, unstable premiums, several other characteristics of the medical malpractice insurance industry indicate that reform is necessary. For example, under the current system, a particular physician's history as to medical malpractice claims has little effect on the malpractice rates that physician is charged. Approximately 5 percent of physicians account for 54 percent of medical malpractice judgments and settlements. However, rather than recapturing these payment costs from the doctors responsible for the claims, insurers spread the risk across all the physicians of similar specialties. This practice is detrimental to both physicians and patients. By spreading the high costs originating from a few policy holders across all policy holders, insurance companies force lower-risk physicians to pay higher premiums to sustain the costs incurred by a few high-risk physicians. If, instead, premiums were based on claim history and payments made to claimants on behalf of the individual policy owner, each physician's premiums would more accurately reflect the liability risk assumed by the insurer in issuing a policy to that particular physician.

46. Hearing on Medical Insurance Crisis, supra note 33, at 134.
47. Id. at 136.
48. Id. at 139.
49. Gunnar, supra note 2, at 471.
51. Gunnar, supra note 2, at 472.
52. Id. at 471-72.
The practice of spreading payments originating from claims against a few doctors among all the policy holders is also detrimental to patients.\(^{53}\) When a few doctors are responsible for a disproportionate percentage of payments, there is cause for concern. On average, these doctors pose a higher risk to the patient than a doctor with no history of claims, or a history of claims settled in the doctor's favor.\(^{54}\)

California's history of rising medical malpractice insurance premiums despite tort reform legislation indicates that damage caps alone cannot effect tort reform sufficient to address the medical malpractice insurance "crisis". However, with the addition of insurance reform, the malpractice insurance rates stabilized.\(^{55}\) States in crisis should begin with insurance reform as a means of reducing medical malpractice insurance rates. Although the effect of the insurance reforms, absent the tort reform, is unknown, any successful effort to reduce medical malpractice premiums is likely to require insurance reform, such reform is a reasonable legislative beginning. Once the insurance reform legislation is in place, the status of medical malpractice insurance can be re-evaluated to determine whether or not additional reform is still necessary. The current options for tort reform will remain possible. In addition, there is a possibility that federal tort reform legislation will preempt any state action, or will provide alternative methods for effecting tort reform that are not currently being considered.

### III. THE CONNECTION BETWEEN THE ECONOMY AND MEDICAL MALPRACTICE CRISSES

The first recognized medical malpractice insurance crisis occurred in the 1970s.\(^{56}\) In response, forty-nine states enacted legislation intended to reduce the cost of medical malpractice litigation.\(^{57}\) Although there was wide variation in the approaches taken, none were effective as evidenced by the increasingly severe medical malpractice insurance crises that followed.

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54. See generally Ellis et al., supra note 53; Nye & Hofflander, supra note 53.

55. Hearing on Medical Insurance Crisis, supra note 33, at 139.


in the 1980s and the early 2000s. One explanation for the failure of these reform measures is that the state legislatures neglected to accurately identify and address the source of the crises. Traditionally, the crises catalyst has been identified as an increase in the number of medical malpractice claims. As the number of claims rose, insurance carriers were forced to raise premiums to compensate for their increased defense costs. In addition, the crises were exacerbated when some insurers left the market, decreasing the supply of medical malpractice insurance policies available. Although this traditional explanation would explain a single crisis, increasing in severity with time, it cannot explain the observed pattern of three, separately occurring crises, beginning in the 1970s and followed by increasingly severe crises in the 1980s and the 2000s. Instead, recent studies have shown that the timing and severity of the crises is better explained by fluctuations in the bond market. In fact, studies performed by Americans for Insurance Reform (AIR), a coalition of consumer groups around the country, conclude that, historically, there has been no relation between the premiums charged and the payments made on malpractice claims. These studies indicate that in the past thirty years the payments made by insurers on medical malpractice claims, including both verdicts and settlements, has risen only in relation to inflation. In contrast, the premiums charged for medical malpractice insurance were found to correlate with the economy, rising when interest rates fell. Despite the reforms enacted in response to each medical malpractice insurance crisis, the crises in the past have only dissipated when the interest rates rose in response to the recovering economy.

This correlation between medical malpractice insurance crisis and the economy makes sense in light of the insurance industry investment scheme. Insurance companies make most of their profit from market investments during the 1980s and the early 2000s.

59. Id. at 1078 n.3.
61. See generally id.
62. Id.; Insurance Information Institute, supra note 57.
63. Trimble, supra note 60, at 894.
65. Nathanson, supra note 58, at 1078.
66. Stable Losses, supra note 64.
67. Id.
68. Id.
69. Id.
rather than from premiums. In most states, insurers are statutorily required to place at least eighty percent of their investments in low-risk markets, such as government or corporate backed bonds in order to protect insureds from liability exposure should the insurer lose in a high-risk market. Therefore, when the market is high, insurers are able to keep premium rates low, often dropping premium rates below cost in order to gain access to more investment capital. However, when the market crashes, as it did in the mid-1970s, mid-1980s and the early 2000s, insurers raise premium rates to compensate for investment losses. Under this view, each medical malpractice crisis results from a predictable response to the cyclical nature of the market, and is not caused by an increase in litigation or an increase in jury verdicts in malpractice cases.

The insurance industry's reliance on investments for income has led some in opposition of tort reform to claim that the medical malpractice crises are caused by mismanagement on the part of insurance companies. This is unlikely because of the statutory restrictions meant to ensure the overall security of the invested funds. Even if the losses were a result of mismanagement, the fault would lie in the statutory restrictions rather than with the management decisions of the insurance companies. In addition, if market fluctuations and mismanagement of investments were solely responsible for the rising premium costs associated with medical malpractice insurance crises, then similar crises would be expected to occur in other lines of insurance. Yet recurrent insurance crises have historically only been seen in the areas of medical malpractice and product liability. Therefore, the key to identifying the cause of the medical malpractice insurance crises, in order to develop effective reform, is to pinpoint the reason that medical malpractice insurance exhibits a high sensitivity to the bond

70. Id.
71. Nathanson, supra note 58, at 1084.
72. Josh Goldstein, Collapse Spreads Misery, PHILA. ENQUIRER, March 2, 2003, at E1; Stable Losses, supra note 64.
73. Harvey Rosenfield, Auto Insurance: Crisis and Reform, 29 U. MEM. L. REV. 69, 75-77 (1998). See also GAO Report, supra note 1, at 27 (Table 2); Stable Losses, supra note 64.
74. Stable Losses, supra note 64.
75. Id.
76. Nathanson, supra note 58, at 1084.
77. Id. at 1084 (citing Steve Kanigher, Medical Malpractice: The Costs of Coverage, LAS VEGAS SUN WEEKEND ED., June 21, 2002).
78. Nathanson, supra note 58, at 1086.
market, whereas other lines of insurance are able to maintain profitability despite bond market fluctuations.80

IV. VIABLE TORT REFORM OPTIONS

A. REDUCING THE COMBINED RATIO

One significant difference between medical malpractice insurance and other lines of insurance is the combined ratio. The combined ratio is a statistic used by insurance companies to measure profitability.81 The combined ratio represents the profitability of a particular line of insurance without regard to investment income.82 The ratio corresponds to the percentage of each dollar collected in premiums that is spent on claims, defense costs, or underwriting costs.83 Thus, combined ratios greater than 100 represent a net loss, absent investment income, whereas combined ratios below 100 represent a net gain, absent investment income.84 For example, a combined ratio of 90 indicates that for every dollar generated in premiums, the insurer spends 90 cents on payouts, making a 10 cent profit. A combined ratio of 110, on the other hand, indicates a loss of 10 cents per dollar, since the insurer spends $1.10 in payouts for each dollar received in premiums.85 One result of a high combined ratio is an increased sensitivity to the market.86 When the market is strong, investment profits can make up for moderate losses relating to the combined ratio.87 When the market weakens those insurance lines with the highest combined ratios are the first to lose profitability.88 This increased sensitivity results from an inability of investment income to account for the net losses in premiums compared to payouts.89 If the market crashes, insurance lines with the highest combined ratios are affected the most severely.90

Medical malpractice insurance differs from other lines of insurance in that it exhibits particularly high combined ratios.91 In 2001 the nationwide combined ratio for medical malpractice insurers was 140, compared to na-

80. Nathanson, supra note 58, at 1086-87.
81. Id. at 1087.
83. Id.
84. Id.
85. Nathanson, supra note 58, at 1088.
86. Id. at 1089.
87. Id.
88. Id. at 1088.
89. Id.
90. Id.
91. Nathanson, supra note 58, at 1088-89.
tionwide combined ratios of 99.9 and 108.8 for property and casualty insurance, respectively.\footnote{92} While a medical malpractice combined ratio of 140 may be tolerated in a strong market where investment profits can offset combined ratio losses, such a high combined ratio cannot be sustained in a weak market where there is little investment income and premiums must therefore correspond closely to payouts.\footnote{93} Thus, in order to stabilize the medical malpractice industry against market fluctuations, any reform must lower the combined ratio for medical malpractice insurers.\footnote{94} In addition, stabilizing the medical malpractice insurance field against market fluctuations will provide a greater incentive for insurers that had previously abandoned or avoided medical malpractice to offer this line of insurance.\footnote{95} Such an increase in supply should also have a favorable effect on premium rates.

The goal of decreasing the combined ratio in medical malpractice insurance can be achieved in a combination of ways. Since the combined ratio is the balance between premium income and costs, including payouts on claims and defense costs, the combined ratio may be reduced by either reducing payouts, defense costs or both.\footnote{96} One easy way for insurance companies to decrease the ratio is to increase premiums. This is one response by the insurance industry that leads to medical malpractice insurance crises. However, the combined ratio may also be decreased by reducing the amount paid out on claims, through verdicts and through settlements.\footnote{97} This attempt to decrease payouts is the approach taken by the majority of tort reform efforts.\footnote{98}

When considering the medical malpractice crisis in terms of the combined ratio, it becomes clear why damage caps are insufficient to effect satisfactory reduction in medical malpractice premiums. On average, only 1.3 percent of medical malpractice claims filed ultimately result in a plaintiff’s verdict at trial.\footnote{99} But these are the only types of cases on which damage caps have an effect. Damage caps have no effect on the costs defending cases that do not go to verdict, nor do they reduce costs in successfully defending cases at trial. In other words, damage caps have no impact on nearly ninety-nine percent of cases filed.\footnote{100} In addition, of the 1.3 percent of cases that do result in a plaintiff’s verdict, many are below the established statutory caps. Thus the damage caps actually affect even fewer

\footnotesize{92. Id. at 1088.}
\footnotesize{93. Id.}
\footnotesize{94. Id. at 1089.}
\footnotesize{95. Id. at 1089-90.}
\footnotesize{96. Id. at 1090.}
\footnotesize{97. Nathanson, supra note 58, at 1090}
\footnotesize{98. Id.}
\footnotesize{99. Insurance Information Institute, supra note 57.}
\footnotesize{100. Id.}
cases. When viewed in light of how few cases damage caps actually affect, it is clear why damage caps do not substantially reduce the combined ratio and therefore do not have a substantial effect on the medical malpractice insurance crisis.

However, a third way to lower the combined ratio has been largely overlooked. This method involves measures that attempt to lower the insurer’s defense costs on claims that do not result in other payouts. These defense costs on claims that are ultimately resolved in favor of the defendants are the source of the majority of the wasteful spending in medical malpractice litigation. For example, of each dollar paid out by medical malpractice insurers, approximately forty cents is spent on defense, rather than in payment of settlements or verdicts. In contrast, the average amount spent on defense costs over all types of insurance was only twelve to thirteen cents per dollar. This discrepancy indicates that medical malpractice insurers spend over three times as much on defense costs when compared to other lines of insurance. In addition, although the increase in the number of medical malpractice claims filed has not had a significant effect on the amounts paid on claims, it has significantly affected the amount paid in defense costs.

In order to be successful in stabilizing the medical malpractice insurance field, reform must be directed at an area in which there is wasteful spending that can effectively be eliminated. Thus effective medical malpractice insurance reform should target this source of wasted expenses.

1. Certificate of Merit

Another suggested method of tort reform that targets the wasted defense costs is requiring the plaintiff to file a certificate of merit with the complaint. In general, a certificate of merit is an affidavit, signed by a medical expert, attesting to the validity of the claim. In many cases, if the plaintiff fails to file the affidavit of merit, or if the court finds the affidavit and accompanying report insufficient to establish the likelihood of

101. Nathanson, supra note 58, at 1108.
102. Id. at 1091.
103. Id.
104. Id.
105. Fact Book, supra note 82, at 83.
106. Id. at 74.
107. Nathanson, supra note 58, at 1090.
108. Id. at 1091.
negligence, the case will be dismissed, often with prejudice.\textsuperscript{110} In addition, some states limit the type of medical expert that can make the affidavit, requiring that the expert be in the same practice area or specialty as the defendant in the case.\textsuperscript{111} The purpose of these certificates is to shelter defendants and insurers from the costs, both economic and professional, of defending against frivolous claims.\textsuperscript{112} The requirement is intended to limit the number of meritless cases filed, as well as to provide defendants with a means of quickly and inexpensively disposing of those that are filed but lack an adequate showing of merit.\textsuperscript{113}

Unlike mandatory arbitration hearings and damage caps, there is some evidence that certificates of merit do have a positive effect on the medical malpractice insurance crisis. For example, the number of medical malpractice cases filed in the year after Maryland enacted a certificate of merit requirement dropped 36 percent.\textsuperscript{114} Proponents claim that certificates of merit positively affect the combined ratio by reducing the area of greatest economic waste, namely defense costs in cases that are ultimately resolved in favor of the defense.\textsuperscript{115} Approximately 62 percent of all medical malpractice cases filed are resolved in favor of the defense, with the case being either dismissed or dropped without payment.\textsuperscript{116} In addition, one study showed that nearly half of one major medical malpractice insurer's legal costs went to defense of cases that were ultimately resolved without payment to the plaintiff.\textsuperscript{117} Thus, certificate proponents argue that requiring some showing of merit will reduce these costs, thereby reducing the combined ratio,\textsuperscript{118} and ultimately stabilizing the medical malpractice insurance industry.

Although the requirement of certificates of merit may have some beneficial effect on the medical malpractice insurance crisis, it is not, on its own, a satisfactory means of stabilizing the medical malpractice insurance field. The situation in Illinois is a clear example of the insufficiency of certificates of merit to defeat the medical malpractice insurance crises. Illinois has required certificates of merit to be filed in all medical malpractice cases

\textsuperscript{110} See, e.g., 735 ILL. COMP. STAT. 5/2-622 (2004); MD. CODE ANN., [CTS. & JUD. Proc.] § 3-2A-04(b) (2003).
\textsuperscript{111} See, e.g., 735 ILL. COMP. STAT. 5/2-622 (2004).
\textsuperscript{112} Parness & Leonetti, supra note 109, at 538.
\textsuperscript{113} See, e.g., DeLuna v. St. Elizabeth's Hosp., 588 N.E.2d 1139, 1142 (ILL. 1992) (stating that the statute requiring a certificate of merit "is designed to reduce the number of frivolous suits that are filed and to eliminate such actions at an early stage, before the expenses of litigation have mounted").
\textsuperscript{114} Trimble, supra note 60, at 907.
\textsuperscript{115} Nathanson, supra note 58, at 1119.
\textsuperscript{116} Insurance Information Institute, supra note 57.
\textsuperscript{117} Trimble, supra note 60, at 910.
\textsuperscript{118} Nathanson, supra note 58, at 1119.
since 1989. In fact, Illinois' requirement is stricter than many certificate of merit statutes in that it requires that the consulting medical expert be in the area of health care or medicine that is at issue in the case. In particular, Illinois requires that the consulting medical professional must either be practicing or have practiced within the last six years, or be teaching or have taught within the last six years, in the same area at issue in the case. If the defendant is a physician licensed only to treat patients without drugs, medicines, surgery, or if the defendant is a dentist, podiatrist, psychologist or naprapath, then the consultant must be a "health professional licensed in the same profession, with the same class of license, as the defendant." For all other types of defendants, the consulting health professional must be "a physician licensed to practice medicine in all its branches." Despite these strict requirements for certificates of merit, Illinois faces a severe medical malpractice insurance crisis. Thus it is necessary to find some other method, in addition to the certificate of merit requirement, that effectively stabilizes the medical malpractice insurance rates, without exacting harsh social costs as do damage caps.

2. Merit Rating

One alternative is to apply experience or merit rating to premium assessments. Merit rating refers to using a policyholder's past claim or payout history to assess premium rates. Under the current system of medical malpractice insurance, policy holders are classified according to factors which, theoretically, estimate the policy holder's risk of being named in a medical malpractice suit. These factors may include physician specialty, services and procedures performed, and geographical location. However, in most cases prior claim or payout history does not affect premium rates even though such past history has been shown to be extraordinarily useful.

119. See 735 ILL. COMP. STAT. 5/2-622 (2004) (The "Healing Art Malpractice" was enacted by P.A. 86-646 and became effective September 1, 1989. Note that a portion of this section of the Illinois Compiled Statutes was amended by the Civil Justice Reform Amendments of 1995 (P.A. 89-7), which were subsequently found unconstitutional by Best v. Taylor Mach. Works, 689 N.E.2d 1057 (Ill. 1997). However, those parts not affected by the Amendments remain good law.).
120. 735 ILL. COMP. STAT. 5/2-622 (2004).
121. Id.
122. Id.
123. Id.
126. Id. at 261.
127. Ellis et al., supra note 53, at 67.
in setting accurate premium rates. In addition, if a physician switches insurance companies, the new company rarely receives information regarding past claims. However, in light of the fact that prior history does predict the risk of future claims, failing to use this information is both inefficient and irrational.

Experience rating is based on the premise that not all policy holders have the same risk of incurring a medical malpractice claim. Some classes of doctors experience a higher risk of claims. In addition, some doctors within a given specialty face a higher probability of experiencing future claims. For example, one study examined medical malpractice claims in Pennsylvania. In that study, only 3.5 percent of physicians practicing in internal medicine experienced any medical malpractice claims during the study’s eight year period. In contrast, nearly 20 percent of orthopedic surgeons experienced at least one medical malpractice claim during the eight year study. Another study examined claims in New York State over a four year period. The New York study similarly found that nearly 30 percent of general practitioners experienced at least one claim during the study period, whereas only 1.2 percent of psychiatrists were named in a medical malpractice case over the same time period. The idea behind experience rating is that those physicians that have experienced a recent claim, who constitute a minority of insureds, have a higher risk of experiencing another claim in the near future. The medical malpractice claim experience of a given classification group, for example a particular practice specialty in a certain geographical area, is used to calculate a gamma parameter based on a Poisson distribution. The gamma parameter provides an estimate of the expected number of claims for the classification group (i.e. the practice area or specialization). This parameter can be viewed as the relative baseline for each classification group.

129. Id. at 150.
130. Id. at 154 (citing John E. Rolph, Some Statistical Evidence on Merit Rating in Medical Malpractice Insurance, 48 J. Risk & Ins. 247 (1981)).
131. Id. at 150.
132. Ellis et al., supra note 53, at 66.
133. Id. at 68.
134. Id. at 66.
135. See Nye & Hofflander, supra note 53.
136. Nye & Hofflander, supra note 53, at 151 (Table 1).
137. Id.
138. Ellis et al., supra note 53.
139. Id. at 69.
140. See Ellis et al., supra note 53; Nye & Hofflander, supra note 53.
141. Nye & Hofflander, supra note 53, at 152-54.
142. Id. at 154 (Table 2).
Physicians in a classification group with a higher baseline have a higher risk of experiencing future medical malpractice claims, even in the absence of past claims.\textsuperscript{143} Subsequently, physicians in these classification groups will have higher baseline premiums.\textsuperscript{144} This result is consistent with the current premium system, in which higher risk specialties pay higher premiums.\textsuperscript{145} The shape of the gamma distribution for each classification also provides information about the relative importance of claims experience in predicting future claims.\textsuperscript{146} For example, in the Pennsylvania study the claim numbers varied more among the orthopedic surgeons than it did among the internists.\textsuperscript{147} The New York study had similar results, with orthopedic surgeons constituting only five percent of the physicians included in the study, but accounting for twenty-six percent of the physicians experiencing more than four paid claims during the study period.\textsuperscript{148} This increased variation indicates that an internist with a high number of claims is more likely explained by "bad luck" than an orthopedic surgeon with a high number of claims.\textsuperscript{149} In other words, past claims are more predictive in a classification with a higher variation in the number of claims than in a classification with relatively little variation in claim experience among members.

In an experience rating system, the insurer using the distribution for the appropriate classification, would base premium rates on the mean expected claims per year.\textsuperscript{150} Physicians with no prior claims would pay the baseline premium rate, which would incorporate the risk associated with the physician's specialty, geography, etc.\textsuperscript{151} In every specialty examined in the Pennsylvania study, the majority of doctors had no prior claims.\textsuperscript{152} Thus the majority of doctors would pay the baseline rate in premiums for their practice area. The minority of doctors that did have prior claims would pay a surcharge in premiums, based on their mean expected claims per year, given their previous claim history.\textsuperscript{153} In other words, experience rating provides a way for insurance companies to individualize the premiums charged.\textsuperscript{154} This individualization of premiums appeals to a sense of fair-
ness, which dictates that physicians that are repeatedly negligent should bear the costs of the increased risk to insurers. 155

Data has shown that physicians differ in terms of their risk of future medical malpractice claims,156 and that experience rating does effectively predict future losses based on past claim history.157 In addition, experience rating is desirable for several reasons. First, it works to reduce the combined ratio from both sides, raising premiums for doctors with a greater than average number of claims and reducing defense costs by decreasing the number of claims by creating cost-prohibitive premiums for the physicians with the greatest number of prior claims.158 Second, experience rating acts as a deterrent against medical negligence.159 Third, experience rating provides a more equitable distribution of the risks, translated into premium rates, for doctors within a given practice area.160

Experience rating is appealing as a means of stabilizing the medical malpractice insurance industry because it will reduce the combined ratio from both directions. Using an experience rating scheme allows insurers to add a surcharge to the premium rates of doctors with a prior recent history of paid claims.161 This surcharge is proportional to the number, and ideally the severity, of the claims experienced.162 To the extent that insurers retain physicians with prior history of paid claims, the combined ratio should decrease because of the increase in premiums. Conversely, it is foreseeable that the physicians with the most frequent and severe claims will experience increasingly prohibitive premium costs. To the extent that the physicians with the highest frequency and severity of claims are unable to retain affordable insurance, experience rating will reduce the combined ratio by decreasing defense costs from claims exiting or existing physicians would have incurred under the current system. In essence the increasing surcharges will serve to drive out the physicians who incur the highest risks.

Statistical Evidence on Merit Rating in Medical Malpractice Insurance, 48 J. RISK & INS. 247, 255-56 (1981)).

155. Id. at 272 (citing Schwartz & Komesar, Doctors, Damages, and Deterrence, 298 NEW ENG. J. MED. 1282, 1282-83, 1287, 1289 (1978) and PATRICK M. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY, 86-87, 250, n 5 (1985)).


160. Darling, supra note 125, at 264.

161. Id.

162. See Ellis et al., supra note 53; Nye & Hofflander, supra note 53; see also Sloan, supra note 159, at 132.
For example, one study found that 6 percent of anesthesiologists and obstetrician-gynecologists incurred 87 percent of the costs in those categories. These are the physicians that will incur the highest surcharges and those that are most likely to be unable to afford to maintain their policies.

In the past, medical malpractice insurance companies that have attempted to use experience rating have not been enthusiastic about its effects. One complaint is that physicians with the highest surcharges cancelled their policies. There are several reasons why this response should not hinder the expansion of experience rating into the medical malpractice insurance area. In previous attempts to use experience rating, claim histories were not shared among insurers. Thus if a physician had too many claims with one insurer, he could change carriers and begin with a clean claim history. In order for experience rating to be effective on the overall medical malpractice insurance crisis, claim history must follow the physician. More importantly, however, insurers should not object to losing these physicians as policy holders since, absent the surcharge, they pay less in premiums than their expected loss predicts they should. In addition, these physicians are primarily responsible for the high defense costs, which contribute to the high combined ratio. Experience rating will have the effect of making malpractice insurance cost-prohibitive to the physicians with excessive malpractice claims. Forcing out these high-risk doctors will result in a decrease in claims, which will translate to a decrease in the combined ratio. In fact, other lines of insurance that use experience rating have demonstrated a reduction in claim frequency.

Another benefit to experience rating is that it functions as a deterrent against medical negligence. One of the fundamental goals of the tort system is to deter negligent conduct. Evidence from other lines of insurance indicates that experience rating does decrease the frequency of claims. In addition, evidence from other lines of insurance, although limited, indicates that insureds do behave differently when their premium rates are determined by past conduct. Under the current system, the deterrent effect of the tort system is blunted by malpractice insurance.

163. Sloan, supra note 159, at 129.
164. Id.
165. Id.
166. See id.
167. Id. at 129, n.1.
169. Sloan, supra note 159, at 129.
171. Sloan, supra note 159, at 128.
172. Id. at 129.
173. Id. at 132.
174. Id.
though there is some deterrent effect in the loss of reputation associated with a malpractice claim, the majority of the deterrence, primarily economic cost, is absorbed by the insurance company.\textsuperscript{175} The deterrent effect is even less effective when premium prices are not correlated with claim history.\textsuperscript{176} Experience rating, on the other hand, allows the full economic deterrence of the tort system to be experienced by the policy holder, since negligent conduct results in higher costs for the physician.\textsuperscript{177}

Experience rating rewards low-risk physicians, those who are least likely to incur future claims, by ensuring that these physicians pay the lowest premiums for their particular classification.\textsuperscript{178} Thus experience rating is likely to appeal to low-risk physicians.\textsuperscript{179} In contrast, because experience rating charges high-risk physicians for the increased risk of malpractice claims, it is likely to be disfavored by physicians with multiple prior claims.\textsuperscript{180} This disfavor from high-risk physicians is to be expected, particularly in light of the current system, in which the risk and corresponding increase in premiums that is created by the few physicians with multiple claims is spread among all the physicians in the particular classification.\textsuperscript{181}

The implementation of an experience rating system is most likely going to require legislative intervention.\textsuperscript{182} Without government mandate, there will most likely not be enough claim history to provide accurate risk estimates, which are necessary to successful correlation between premiums and risks insured against.\textsuperscript{183} In addition, an appropriate time period during which claim history will be considered in assessing current premiums must be established.\textsuperscript{184} It must be determined whether only paid claims will be considered, or whether pending claims will also impact the premium assessment.\textsuperscript{185} One drawback in the case of medical malpractice claims is that there is generally a period of several years between the time of the alleged negligence and the time when the claim is ultimately resolved. If only paid claims are considered, there may be a significant lag between the occurrence of negligence and the adjustment of premium rates. In addition, considering only paid claims may create a disincentive for physicians to settle.\textsuperscript{186} This effect could increase litigation defense costs and have an

\begin{flushleft}
\textsuperscript{175.} Id.
\textsuperscript{176.} Id.
\textsuperscript{177.} Nye & Hofflander, supra note 53, at 151.
\textsuperscript{178.} Ellis et al., supra note 53, at 73.
\textsuperscript{179.} Id. at 75.
\textsuperscript{180.} Id.
\textsuperscript{181.} Id.
\textsuperscript{182.} Sloan, supra note 159, at 130.
\textsuperscript{183.} Id.
\textsuperscript{184.} Id.
\textsuperscript{185.} Darling, supra note 125, at 264.
\textsuperscript{186.} Sloan, supra note 159, at 130.
\end{flushleft}
adverse effect on the combined ratio. On the other hand, if open claims are considered, physicians may experience increased premiums based on claims that are ultimately resolved in the physician's favor, without payout to the patient.\textsuperscript{187} One potential solution to these problems is to have a peer review of claims.\textsuperscript{188} If such a review were considered in determining when to add a surcharge to a given physician's premium, it would remove the physician's reluctance to settle open claims,\textsuperscript{189} and may be able to alleviate the lag in premium assessments based on paid claims resulting from the gap in time between a claim being filed and a claim being ultimately paid to the plaintiff.

B. DAMAGE CAPS USING AUSTRALIA'S "MOST EXTREME CASE MODEL"

Although the type of damage caps used in the United States have been relatively ineffective in resolving the medical malpractice crisis in the United States, a different application of a damage cap may be more successful in reducing the combined ratio and thereby resolving the medical malpractice crisis. Currently in the United States, damage caps establish a bright-line limit on the amount of non-economic damages that a plaintiff may recover.\textsuperscript{190} Though the jury may award any amount for non-economic damages, any award exceeding the statutory cap is subsequently reduced to the statutory maximum by the judge.\textsuperscript{191} One problem with this type of damage cap is that any plaintiff, even one with a relatively minor injury, may receive the maximum non-economic award.\textsuperscript{192} Thus, a plaintiff with catastrophic injuries may receive the same amount of compensation for pain and suffering, loss of quality of life, etc. as a plaintiff with comparatively minor suffering. In addition, juries are not generally given any guidance as to the calculation of non-economic damages.\textsuperscript{193} For example, one such instruction states:

The damages for pain and suffering should include such amounts as you find, by the greater weight of the evidence,

\textsuperscript{187} Id.
\textsuperscript{188} Id. at 131.
\textsuperscript{189} Id.
\textsuperscript{190} Masada, supra note 3, at 188.
\textsuperscript{191} Poisson, supra note 56, at 771-72. See also Salgado v. County of Los Angeles, 967 P.2d 585, 594 (Cal. 1998) (implementing judicial reduction of jury award); Schiernbeck v. Haight, 9 Cal. Rptr. 2d 716, 724 (Cal. Ct. App. 1992) (recommending that the jury not be informed of the statutory cap on non-economic damages).
\textsuperscript{192} Masada, supra note 3, at 189.
is fair compensation for the actual physical pain and mental suffering which were the immediate and necessary consequences of the injury. There is no fixed formula for evaluating pain and suffering. You will determine what is fair compensation by applying logic and common sense to the evidence.194

Because jurors are inexperienced in calculating non-economic damages and are given virtually no guidance in determining the appropriate compensation for non-economic damages, jury awards are erratic and unpredictable.195 Given comparable plaintiffs with comparable injuries, two different juries are unlikely to award similar amounts for non-economic damages.196 Similarly, an equitable system would award greater compensation for a debilitating injury experienced by a young person compared to a similarly debilitating injury experienced by an older person, since the younger person has a longer life expectancy and therefore a longer period of suffering with the injury.197 Patients' rights advocates object to these inequitable results of damage caps.198 A pre-established limit on the amount of compensation one may receive for pain and suffering directly contradicts the notion that pain and suffering awards are a necessary component of total compensation, and thereby required to make the plaintiff "whole."199 An indiscriminate limit on this type of compensation necessarily results in some plaintiffs being inadequately compensated, and yet does nothing to prevent against the potential for over-compensation which is claimed to be the cause of the medical malpractice crisis. In addition, the unpredictability of damage awards hinders the ability of insurers to establish appropriate premiums, which in turn contributes to the medical malpractice insurance crisis.200

After experiencing a medical malpractice insurance crisis similar to those experienced in the United States,201 Australia began implementing a different kind of damage cap system, based on the “most extreme case.”202 The system was developed in the state of New South Wales, with the intent

194. Id.
195. Id. at 7. See also Poisson, supra note 56, at 766.
196. VIDMAR, supra note 193, at 191-193.
197. See Poisson, supra note 56, at 782-83.
201. Id. at 165.
202. Id. at 182.
to "facilitate fair and sustainable compensation for persons suffering severe injuries, to keep costs of medical indemnity premiums at reasonable levels, and to maintain a full range of medical services for the community." The "most extreme case" system attempts to provide an objective method of calculating non-economic damages by statutorily creating (1) a maximum for non-economic damages, (2) a compensation scheme based on comparison to a "most extreme case," and (3) an injury threshold, below which no non-economic damages may be recovered. Under this system, non-economic damages are calculated using two steps. First, the judge must determine the severity of the plaintiff's non-economic damages in comparison to a "most extreme case." For example, the judge may compare a knee injury resulting in a reduced range of motion to the "most extreme case" injury in which the leg is completely incapacitated, and find that the reduced motion is x% of the most extreme case. Second, the judge uses the statute to calculate the actual amount of non-economic damages. The statute contains both a maximum amount recoverable for non-economic damages (a damage cap) and a conversion table which is used to convert the percentage of injury compared to the most extreme case into the percentage of the statutory maximum to which the plaintiff is entitled. For example, injuries that are determined to be less than 15% of a most extreme case are not entitled to any non-economic damages. Injuries determined to be 20% of a most extreme case are entitled to receive 3.5% of the statutory maximum in non-economic damages, while injuries that are 30% of the most extreme case receive 23% of the maximum. Thus, if the statutory maximum is AU$500,000 then an injury that is 20% of the most extreme case would result in the plaintiff receiving a non-economic damage award of AU$17,500, whereas an injury that is deemed 30% of the most extreme case would be entitled an award of AU$115,000. Injuries that are 33-100% of most extreme cases receive their respective percentages of the maximum non-economic damage award.

The Australian most extreme case system has several advantages over the United States bright line system. First, the most extreme case system

203. Id. at 182-83.
204. Id. at 183 (citing Civil Liability Act, 2002, pt. 2, div. 3, 16(1), 16(3) (N.S.W.).
205. Id. at 185.
206. Note that under the Australian judicial system judges assign fault and assess damages, not injuries. Masada, supra note 3, at 180-181.
207. Id. at 185.
208. Id. at 189-90.
209. Id. at 185.
211. Id.
212. Id.
213. Id.
decreases the variability in damage awards for similar injuries, thereby making it easier for insurers to set appropriate premiums. Insurers are able to rely on the fact that less severe injuries will receive lower non-economic damage awards. Second, under the Australian system the amount of damages received is proportional to the severity of the loss experienced. Thus, unlike the United States system, the maximum award is reserved for those plaintiffs who are most seriously injured. Since relatively few plaintiffs are awarded the maximum, overall liability is reduced. Third, the Australian system provides a minimum threshold to recovery of non-economic damages, which further reduces overall liability. This minimum reduces litigation costs, since it removes some of the incentive to pursue frivolous or speculative cases. Fourth, the Australian system focuses on determining non-economic damages based on the injury rather than the malfeasance of the defendant. Evidence indicates that American juries often improperly consider the nature of the wrongful act in assessing damages for pain and suffering. The result is a punitive element within the non-economic damage assessment, which leads to an inflated award. Because non-economic damages are intended to be compensatory, the nature of the defendant’s conduct is irrelevant to assessing the amount of suffering. The Australian system redirects the focus of damage assessment to the nature of the injury, and away from the nature of the malfeasance, eliminating the hidden punitive aspect of the damage award. Fifth, the Australian system can support a higher maximum damage award than can the U.S. bright line system. Under the bright line system, virtually any claim can result in the maximum non-economic damage award. Therefore, the amount of the bright-line cap must be conservative in order to be effective. Because the Australian system reserves the maximum award for the relatively few “most extreme cases,” the sys-

214. Masada, supra note 3, at 188.
215. Id. at 191.
216. Id. at 189.
217. Id.
218. Id. at 188.
219. Id. at 190.
220. Masada, supra note 3, at 190.
221. Id. at 194.
223. Schwartz & Lorber, supra note 222.
224. Poisson, supra note 56, at 764.
225. Masada, supra note 3, at 194.
226. Id. at 196.
227. Id.
228. Id.
tem can sustain a greater maximum while still ensuring an overall reduction in insurer payouts. 229

V. CONCLUSION

Damage caps, as currently implemented in the United States, are insufficient to effect substantial resolution of the medical malpractice insurance crisis. 230 The complex causation of the medical malpractice insurance crisis requires a multi-faceted solution. 231 Although many factors, working in concert, have led to the current medical malpractice insurance crisis, 232 the clear connection between fluctuations in the market economy and medical malpractice crises indicates that the medical malpractice industry can be stabilized by reducing the combined ratio. 233 Because many factors contribute to the combined ratio, there are several ways to approach its reduction. One viable option is to implement a merit rating system for the assessment of medical malpractice insurance premiums. 234 A merit-based system will reduce the combined ratio by increasing premiums from doctors with a history of being sued for medical malpractice, and reducing claim frequency by setting increasingly prohibitive premiums to those doctors who are the most often sued. 235 Another viable option is to implement a damage cap system based on Australia’s “most extreme case” model. The most extreme case model will reduce the combined ratio by reducing the overall liability in payouts, and discouraging meritless or speculative claims, while retaining an equitable distribution of non-economic damage awards.

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