

MOVING BEYOND THE QUICK FIX: MEDICAL MALPRACTICE NON-ECONOMIC DAMAGE CAPS A POOR SOLUTION TO THE GROWING HEALTHCARE CRISIS

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I. INTRODUCTION

There is no doubt that the United States is facing a healthcare crisis.¹ The United States has the most expensive healthcare system in the world, spending billions more than any industrialized nation.² Despite the astronomical cost of our healthcare system, Americans continue to go without access to affordable and quality healthcare and affordable prescription medication.³ For example, nearly forty-two million Americans were uninsured in 2013.⁴ One in four working-age Americans did not have insurance at some point in 2013.⁵ Over sixty percent of all bankruptcies are a result of unpaid medical bills.⁶ The United States ranks highest in medical cost per capita, but ranks twenty-sixth in the world for average life

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¹ See, e.g., Eric Lindenfeld & Jasper L. Tran, *Beyond Preemption of Generic Drug Claims*, 45 SW. L. REV. 241 (2015) (discussing generic drugs); Eric Lindenfeld & Jasper L. Tran, *Prescription Drugs and Design Defect Liability: Blanket Immunity Approach to the Increased Costs and Unavailability of Prescription Medication*, 64 DRAKE L. REV. 111 (2016) (discussing prescription drugs); Jasper L. Tran & Derek Tri Tran, *(De)Regulating Neuroenhancement*, 37 U. LA VERNE L. REV. 179, 186–90 (2015) (discussing neuroenhancing drugs).

² Lenny Bernstein, *Once Again, U.S. has the Most Expensive, Least Effective Health Care System in Survey*, THE WASHINGTON POST (June 16, 2014), <http://www.washingtonpost.com/news/to-your-health/wp/2014/06/16/once-again-u-s-has-most-expensive-least-effective-health-care-system-in-survey>.

³ David Morgan, *One in Four Americans without Health Coverage: Study*, REUTERS (Apr. 19, 2012, 2:04 PM), <http://www.reuters.com/article/2012/04/19/us-usa-healthcare-insurance-idUSBRE83117420120419>.

⁴ Jessica C. Smith & Carla Medalia, U.S. CENSUS BUREAU, P60-250, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2013 (2014).

⁵ *Id.*

⁶ Joan McCarter, *Medical Bills Cause 62 Percent of Bankruptcies*, PARTNERS HEALTHCARE (Jan. 5, 2012, 11:12 AM), <http://www.dailykos.com/story/2012/01/05/1051848/-Medical-bills-cause-62-percent-of-nbsp-bankruptcies>.

expectancy.⁷ Over the past decade, there has been a growing movement among the medical community and state legislatures to address the healthcare crisis through the capping of non-economic damages for medical malpractice lawsuits.⁸ The focus of these caps is to limit damages that relate to pain and suffering, emotional distress, loss of companionship and punitive damages, but does not limit damages based on any economic losses.⁹ Proponents of caps point to the success of caps implemented in several states as proof that the caps are a viable solution. However, their data is grossly inflated and misleading. Moreover, caps are likely to breed more malpractice, are unconstitutional, and are likely to punish those who suffer the most—women, children, and the elderly.

This paper proceeds in five Parts. Part I provides the background and evolution of medical malpractice lawsuits in general. Part II introduces the beginning stages of medical malpractice tort reform and some of the theoretical arguments put forth by its proponents and opponents. Part III of this note analyzes the argument put forth by proponents of non-economic damage caps as the most viable solution for the growing healthcare crisis. It also analyzes the accuracy of medical and financial data put forth and argues that caps are likely to cause more medical error to the same class that it is meant to protect. In addition, this part discusses the disproportionately disparate effect non-economic damage caps would have on low-income individuals, women, children and the elderly. Lastly, Part III analyzes the troublesome constitutional issues that non-economic damage caps in medical malpractice suits pose.

Next, Part IV of this note discusses the viability of other solutions to the healthcare crisis and the potential to remedy the crisis without compromising societal fairness or our constitutional freedoms. Subpart A of this section addresses the possibility of limiting the amount of frivolous claims through a “certification of merit requirement.” Subpart B advocates for patient safety and the prevention of medical negligence before it arises. Subpart C offers an alternative to the way in which insurance companies calculate their medical malpractice premium rates. Finally, this note concludes, stating that non-economic damage caps is an undesirable approach to both the healthcare and medical malpractice insurance crisis because of their inequitable and constitutional implications and the availability of other viable alternatives.

⁷ Allan Detsky, *Why America is Losing the Health Race*, THE NEW YORKER (June 11, 2014), <http://www.newyorker.com/tech/elements/why-america-is-losing-the-health-race>.

⁸ David A. Hyman et. al., *Does Tort Reform Affect Physician Supply? Evidence from Texas*, 42 INT'L REV. L. & ECON. 203, 204 (2015).

⁹ Zachary J. Cloutier, *What Watts Forgot to Mention: Equal Protection Analysis of Missouri's Noneconomic Damage Cap*, 83 UMKC L. REV. 403, 403 (2014).

II. THE EVOLUTION OF MEDICAL MALPRACTICE

The first known account of medical malpractice litigation in the world occurred in 1375 in England in *Stanton v. Cavendish*.¹⁰ There, a surgeon was alleged to have been liable of performing a hand surgery negligently.¹¹ While the court eventually dismissed the suit on procedural technicalities, it suggested that surgeons are liable for failure to treat in a competent manner.¹² Throughout the medieval period, physicians continued to be held responsible for professional misconduct, although the term “malpractice” did not evolve until the early nineteenth century.¹³ By the fifteenth century, medical malpractice lawsuits were relatively common in England, and medical professionals were often subpoenaed to testify in medical malpractice lawsuits.¹⁴ Many doctors even began taking out individual insurance policies prior to performance of surgeries that may lead to death.¹⁵

The first recorded case of medical malpractice in the United States however, occurred nearly three hundred and fifty years later in 1794, in *Cross v. Guthery*.¹⁶ In that case, a plaintiff was successful in his negligence case against a doctor who inexpertly amputated his wife's breast, causing her death.¹⁷ From 1794 until 1861, claims made against physicians in the United States were relatively minimal, with only twenty-seven recorded malpractice lawsuits in that period.¹⁸ While there was a slight increase in medical malpractice litigation after that period, allowing for the creation a somewhat substantial body of law, medical malpractice, as a distinct body of law, did not develop until the beginning of the twentieth-century.¹⁹ During the period of 1935-1955, the number of medical malpractice lawsuits suddenly increased twentyfold, fueled by advents such as antibiotics, diagnostic imaging, and laboratory equipment.²⁰ These advents

¹⁰ Kaycee Hopwood, “*For It's One, Two, Three Strikes, You're Out...*”, 39 J. MARSHALL L. REV. 493, 496 (2006).

¹¹ *Id.*

¹² *See id.* at 495; *see also*, Theodore Silver, *One Hundred years of Harmful Error: The Historical Jurisprudence of Medical Malpractice*, 1992 WIS. L. REV. 1196 n.13 (1992) (Explaining that the plaintiff failed to plead the case under ‘vi et armis’).

¹³ Silver, *supra* note 11, at 1195-96.

¹⁴ Robert J. Flemma, M.D, *Medical Malpractice: A Dilemma in the Search for Justice*, 68 MARQ. L. REV. 237, 239 (1985).

¹⁵ *Id.* at 237.

¹⁶ *Cross v. Guthery*, 2 Root 90, 1794 WL 198, at *90 (Conn. Super. Ct. 1794).

¹⁷ *Id.*

¹⁸ Flemma, *supra* note 14, at 240.

¹⁹ *Id.* at 240-41.

²⁰ *Id.* at 241.

caused the science of medicine to become more objective.²¹ Lawyers could now review the same objective data as the physician to determine if the physician conformed to minimal standards.²²

The frequency of medical malpractice lawsuits continued to rise into the latter half of the twentieth century with many doctors slowly beginning to minimize invasive surgical procedures, or closing their doors altogether.²³ A study performed by the American Medical Association determined that by 1957, one out of seven physicians practicing at that time had experienced a medical malpractice suit during his or her career.²⁴ The number and size of claims continued to increase into the 1970's and by 1975, as many as 14,000 malpractice suits were being filed against physicians yearly,²⁵ with the average jury award at \$171,000.²⁶ The increase in the frequency and severity of the claims soon caused many insurance companies to drastically raise premiums, and many others refused to issue medical malpractice insurance altogether.²⁷ In fact, malpractice premiums in 1975 were at 1 billion dollars per year, up from 60 million in 1960.²⁸ The rise in costs and the increased unavailability of insurance premiums also began to force doctors to leave specific practice areas, raise their prices for services, or to leave the practice of medicine entirely.²⁹ The healthcare

²¹ Cf. Jasper L. Tran, *Press Clause and 3D Printing*, 14 NW. J. TECH. & INTELL. PROP. 75, 77 (2016) ("Technology is progressing at an extraordinary speed. New disruptive technologies are emerging every year."). For a discussion of emerging technologies that would affect the science of medicine, see generally Jasper L. Tran, *The Law and 3D Printing*, 31 J. MARSHALL J. INFO. TECH. & PRIVACY L. 505, 507–09 (2015) (discussing 3D printing); Jasper L. Tran, *To Bioprint or Not To Bioprint*, 17 N.C. J.L. & TECH. 123, 137–40 (2015) (discussing bioprinting); Jasper L. Tran, *Patenting Bioprinting*, HARV. J.L. & TECH. DIG. (2015), <http://jolt.law.harvard.edu/digest/patent/patenting-bioprinting> (discussing the patentability of bioprinting); Jasper L. Tran, *3D-Printed Food*, 17 MINN. J.L. SCI. & TECH. (2016) (discussing 3D-printed food).

²² Flemma, *supra* note 13, at 241.

²³ IRA RUTKOW, *SEEKING THE CURE: A HISTORY OF MEDICINE IN AMERICA* 298 (2010).

²⁴ American Medical Association, *Opinion Survey on Medical Malpractice*, 164 JAMA 1583, 1583 (1957).

²⁵ Bus. Week, Jan. 12, 1976, at 60; see also Daniel W. Meek, *Nuclear Power and the Price-Anderson Act: Promotion over Public Protection*, 30 STAN. L. REV. 393, 468 n.190 (1978).

²⁵ Imrana Manzanara, *Capping Statutes and their Constitutionality*, 37 THE ADVOC. (TEXAS) 103, 103 (2006).

²⁶ Bus. Week, Jan. 12, 1976, at 60; see also Daniel W. Meek, *Nuclear Power and the Price-Anderson Act: Promotion over Public Protection*, 30 STAN. L. REV. 393, 468 n.190 (1978).

²⁷ Imrana Manzanara, *Capping Statutes and their Constitutionality*, 37 THE ADVOC. (TEXAS) 103, 103 (2006).

²⁸ TARKY LOMBARDI, *MEDICAL MALPRACTICE INSURANCE: A LEGISLATORS VIEW* 1 (1978).

²⁹ Orrin Hatch, *The Medical Malpractice Crisis: Physicians' Concern Over Future Liability Costs is Adversely Affecting Access to Health Care for All Americans. What Can We Do to Solve the Problem?*, ROLL CALL (Mar. 26, 1990), at [source unavailable]; Daniel J. Sheffner,

consumer was also forced to shoulder the burden in the form of rising health insurance premiums and the unavailability of competent healthcare professionals willing to perform high-risk procedures.³⁰ These factors soon prompted cries from practitioners, hospitals and the general public to address the growing crisis at the state and federal level.³¹ Modern medical malpractice tort reform was thus born.

III. MODERN MEDICAL MALPRACTICE TORT REFORM

Medical malpractice reform in the United States is not a new concept. In 1875, leading physician Dr. Frank Hamilton warned that medical malpractice lawsuits threatened the vitality of the medical profession:

[T]here is at this time a general feeling of uneasiness, and a conviction that the business is at best very dangerous, so far as property and reputation is concerned. The result is that some of the most thoroughly qualified men utterly refuse to attend surgical cases, confining their practice to that of medicine alone.³²

While Dr. Hamilton's words mirror the concerns of the modern day medical community, he places the blame on the crisis upon the physicians themselves:

In my early days I was disposed to lay most of the blame upon lawyers. I supposed that a certain class of pettifogging lawyers hunted up these cases and incited the people to prosecutions. But I have changed my mind upon this point. Perhaps they are in some degree responsible; but I am convinced that the responsibility rests mostly with ourselves. Many writers upon surgery, and most practical surgeons, have claimed too much. They declared that they could do many things which they could not; and their patients have simply taken them at their word, and required of them damages when they have fallen short of their own claims and promises.³³

Fatal Medical Negligence and Missouri's Perverse Incentive, 7 ST. LOUIS U.J. HEALTH L. & POL'Y 147, 152 (2013).

³⁰ *Id.*

³¹ W. John Thomas, *The Medical Malpractice "Crisis": A Critical Examination of A Public Debate*, 65 TEMP. L. REV. 459, 461 (1992).

³² *Id.* at 462.

³³ *Id.* at 465.

Dr. Hamilton's rhetoric differs markedly from modern day physicians, hospitals and insurance lobbyists who place blame on an out-of-control legal system, rather than the medical profession, or insurance companies. Rather, the current medical community asserts that huge jury awards and the associated costs of defending frivolous lawsuits are the primary causes of the health care crisis.³⁴ They contend that the soaring costs of medical malpractice premium rates are forcing physicians to charge higher costs for services, or to leave the market altogether.³⁵ They further contended that health insurance companies are raising their rates in order to offset these higher costs, making health insurance unaffordable to a large class of Americans.³⁶ In support of their contention, the medical community points to the excessive damages awarded in medical malpractice lawsuits, skyrocketing costs of liability insurance and health insurance, as well as the dwindling number of qualified professionals entering "high-risk" specialties such as neurosurgery and obstetrics and gynecology.³⁷

While there have been relatively minimal efforts at the federal level to address the rising costs of medical malpractice premium rates,³⁸ state legislators have primarily sought to address the medical malpractice insurance crisis through the capping of non-economic damages in tort lawsuits against physicians and hospitals.³⁹ Proponents of the damage caps assert that caps on non-economic damages will dissuade lawyers from bringing costly and unmeritorious lawsuits, decreasing much of the defense costs to insurers.⁴⁰ Most importantly, proponents argue that non-economic damage caps would shield insurance companies from large and unpredictable jury verdicts, which usually come in the form of punitive damage awards.⁴¹ To date, over half of U.S. states have instituted some type of limitation of non-economic damages in medical malpractice cases in an attempt to reduce insurance premiums, increase the affordability and

³⁴ Hatch, *supra* note 29.

³⁵ *Id.*

³⁶ Kevin J. Gfell, *The Constitutional and Economic Implications of A National Cap on Non-Economic Damages in Medical Malpractice Actions*, 37 *IND. L. REV.* 773, 775 (2004).

³⁷ Emily Chow, *Health Courts: An Extreme Makeover of Medical Malpractice with Potentially Fatal Complications*, 7 *YALE J. HEALTH POL'Y, L. & ETHICS* 387, 387 (2007).

³⁸ Barry Furrow & David Hyman, *The Medical Malpractice Crisis: Federal Efforts, States' Roles and Private Responses* Session 1: Federal Efforts and State Approaches to the Crisis, 13 *ANNALS HEALTH L.* 521, 534 (2004).

³⁹ *Id.*

⁴⁰ Kyle Miller, Note, *Putting the Caps on Caps: Reconciling the Goal of Medical Malpractice Reform with the Twin Objectives of Tort Law*, 59 *VAND. L. REV.* 1457, 1478 (2006).

⁴¹ *Id.*

access to healthcare, and keep qualified professionals within their borders.⁴² Wisconsin, for example, instituted a cap of \$350,000 for non-economic damages for medical malpractice in 1995, although it was eventually increased to \$750,000 in 2005.⁴³ Michigan has also instituted sweeping changes, passing legislation that limits the award of non-economic damages in medical malpractice cases to \$280,000 for regular occurrences, and \$500,000 in cases of serious brain, spinal, or reproductive organ injuries.⁴⁴

IV. NON-ECONOMIC DAMAGED CAPS ARE A POOR SOLUTION TO THE HEALTHCARE CRISIS

However well intentioned proponents of the cap are, limits on recovery are likely to harm the general public more than the benefits they offer. First, the medical and financial data put forth by proponents is often inflated and misleading. Second, caps are likely to cause more medical error to the same class that they are meant to protect. Third, non-economic damage caps disproportionately affect women, children and the elderly and the most seriously injured. Finally, damage caps violate multiple constitutional protections.

A. Statistical Data Suggests That Non-Economic Damage Caps do not Help Alleviate the Healthcare Crisis

While proponents of damage caps contend that medical malpractice is a driving factor of the modern health crisis, the majority of statistical data suggest otherwise. For example, a 2009 Congressional Budget Office estimate suggests that “caps on damages would [barely] reduce national healthcare spending by 0.5 percent.”⁴⁵ Another 2009 study agreed with the CBO report after investigating over 25 years of Medicare data, stating that direct reforms, including damage caps, did not significantly affect

⁴² David Goguen, *Which States Don't Have a Damage Cap For Medical Malpractice Cases?*, NOLO, <http://www.nolo.com/legal-encyclopedia/which-states-don-t-damage-cap-medical-malpractice-cases.html>.

⁴³ Michael S. Kenitz, *Wisconsin's Caps on Noneconomic Damages in Medical Malpractice Cases: Where Wisconsin Stands (and Should Stand) on "Tort Reform"*, 89 MARQ. L. REV. 601, 609 (2006).

⁴⁴ David M. Ottenwess, Meagan A. Lamberti, Stephanie P. Ottenwess & Adrienne D. Dresevic, *Medical Malpractice Tort Reform*, THE HEALTH L. PARTNERS 30, 32 (Mar. 2011), http://www.thehealthlawpartners.com/files/rm332_p30-36_features.pdf.

⁴⁵ Scott Baltic, *Who Benefits from Tort Reform?*, MED. ECON. (Aug. 9, 2013), <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/alice-gosfield/who-benefits-tort-reform?page=full>.

healthcare expenditures.⁴⁶ In a 2003 congressional hearing before the Health of the House Committee on Energy and Commerce, testimony demonstrated that the states with the five highest liability premiums also had damage caps, while the states with the lowest premiums did not.⁴⁷ Some have attributed this phenomenon to insurance companies “pocketing profits generated by the damage caps” rather than lowering premiums.⁴⁸ In fact, studies have suggested that caps actually *raise* insurance premiums, rather than decrease them. According to a study done by Weiss ratings over a twelve-year period, states that implemented damage caps experienced a 48.2% increase in the median premiums, while states without caps experienced only a 35.9% increase.⁴⁹ Some have attributed this phenomenon to higher cumulative total jury verdict amounts, spawned by a juror’s perception that a cap generally represents a fair reward.⁵⁰ For example, a jury may initially decide to award \$75,000 in non-economic damages for a particular injury, but when advised on a \$100,000 non-economic damage cap, decide to award the cap limit instead.

Contrary to what many proponents of cap damages claim, there is also evidence that suggests that damage-caps, or the lack thereof, do not correlate with the decisions of doctors on whether to practice within that state. For example, Texas instituted damage caps of \$250,000 in 2003, but an independent study suggested “that caps did not increase the supply of doctors.”⁵¹ In fact, “[f]rom 2003-2010, Texas’s physician to population ratio increased by 3.4%.”⁵² In 2003, Texas was ranked as the 42nd worst physician to population ratio in the nation, and by 2010, they had dropped to 44th.⁵³ Most notably, after of a year of studying the issue, West Virginia’s Legislative Committee concluded that damage caps have no meaningful impact “on the cost of liability insurance” or the decisions of

⁴⁶ Frank A. Sloan & John H. Shadle, *Is There Empirical Evidence for “Defensive Medicine”?* A Reassessment, 28 J. HEALTH ECON. 481, 488 (2009).

⁴⁷ *Assessing the Need to Enact Medical Liability Reform: Hearing on H.R. 5 Before the Subcomm. on Health of the House Comm. on Energy and Commerce*, 108th Cong. 13-14 (2003), <http://www.gpo.gov/fdsys/pkg/CHRG-108hhrg86049/pdf/CHRG-108hhrg86049.pdf>.

⁴⁸ Nicholas T. Timm, *From Damages Caps to Health Courts: Continuing Progress in Medical Malpractice Reform*, 2010 MICH. ST. L. REV. 1209, 1217 (2010).

⁴⁹ Patrick A. Salvi, *Why Medical Malpractice Caps Are Wrong*, 26 N. ILL. U. L. REV. 553, 555 (2006).

⁵⁰ Kathryn Zeiler, *Turning from Damages Caps to Information Disclosure: An Alternative to Tort Reform*, 5 YALE J. HEALTH POL’Y L. & ETHICS 385, 387-88 (2005).

⁵¹ Alan H. Figman, *The Fallacies of Medical “Tort Reform”*, CARDOZO LAW WEBSITE 1, 5 (2003),

<https://cardozo.yu.edu/sites/default/files/Figman.FallaciesOfMedMalTortReform.pdf>.

⁵² *Id.*

⁵³ *Id.* at 5-6.

physicians to practice within a particular state.⁵⁴ Similarly, a study conducted in Illinois prior to an implementation of damage caps indicates that the number of doctors licensed within the state was steadily increasing, not decreasing, even in high-risk specialty fields.⁵⁵

B. Non-Economic Damage Caps Are Likely to Breed More Malpractice

Damage caps are also likely to harm the very same class of people it is supposedly meant to benefit. Concurrent to the rise in cost of medical malpractice premiums, there is another, more devastating medical crisis: medical error. A 1999 study conducted by the Institute of Medicine calculated that almost 100,000 patients die every year, and “over a million more are injured” from preventable medical errors.⁵⁶ That same study estimated medical error wastes 17 to 29 billion dollars every year to “lost income, lost household production, disability, and healthcare expenses.”⁵⁷ “[M]edical error is either the eighth-leading, sixth-leading, or third-leading cause of death in the United States, depending on the source.”⁵⁸

The threat of medical malpractice and associated heavy payouts in cases of medical error ensure that doctors take every precaution to minimize the threat of harm. A Harvard Medical Practice study conducted over the course of several years found that the threat of tort liability exerts significant pressure on physicians to use reasonable care.⁵⁹ The study also found that the threat of liability “made [doctors] twice as likely to take more time in explaining the risks of treatment to their patients.”⁶⁰ It concluded that negligent deaths and injuries would rise if the threat of significant liability were removed.⁶¹ Similarly, the reluctance of insurance providers to offer affordable rates to physicians with a history of malfeasance assures that these less competent doctors are unable to practice. In this sense, the threat of unlimited liability functions as it should: limiting the frequency of medical negligence by competent doctors, and the amount of incompetent doctors in practice.

⁵⁴ Gfell, *supra* note 36, at 803.

⁵⁵ Kenitz *supra* note 43, at 622.

⁵⁶ Joanna C. Schwartz, *A Dose of Reality for Medical Malpractice Reform*, 88 N.Y.U. L. REV. 1224, 1225 (2013).

⁵⁷ *Id.* at 1226.

⁵⁸ David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 901 (2005).

⁵⁹ *Id.* at 916.

⁶⁰ *Id.*

⁶¹ *Id.*

Any reduction in the amount of damages allowable also threatens to make it more difficult for a plaintiff to file an otherwise meritorious claim. Studies show that medical malpractice attorneys “routinely reject 80 percent or more of the requests for representation they receive.”⁶² Medical malpractice attorneys, faced with the already costly and uphill battle of finding willing and affordable expert testimony, are unlikely to take a case if the potential award is not significant.⁶³ In this respect, putting a damage cap on non-economic damages is likely to discourage otherwise legitimate claims from being brought.

C. Non-Economic Damage Caps Affects Women, Children, the Elderly and Economically Disadvantaged Disproportionately

Large non-economic damage caps also have the potential to negatively affect women, the elderly and children more heavily than it does men. Although proponents of the caps argue that the caps are facially neutral, these caps are in fact discriminatory because of their heavy reliance upon gender and age based generalizations in calculating damage awards.⁶⁴ The proposed damage caps do not cap damages for injuries that relate to income loss. Rather, the cap’s main focus is to limit damages that relate to pain and suffering, emotional distress, loss of companionship and punitive damage.⁶⁵ Since women typically earn less than men for the same job, or have accepted a domestic role in their household, non-economic damage caps have the effect of preventing women from recovering as much for the same injury.⁶⁶ Similarly, elderly patients who have long retired, or are no longer able to work are left with no alternative to economic damages in which they could be “made whole.” Children, who are left with the almost impossible task of proving future earning capacity with a degree of certainty, are also usually left with minimal economic damage awards when they are injured by medical negligence.⁶⁷ It is not uncommon for a jury to

⁶² Carol J. Miller & Joseph Weidhaas, *Medical Malpractice Noneconomic Caps Unconstitutional*, 69 J. MO. B. 344, 349 (2013).

⁶³ *Id.*

⁶⁴ Martha Chamallas, *The Architecture of Bias: Deep Structures in Tort Law*, 146 U. PA. L. REV. 463, 466 (1998).

⁶⁵ Rebecca Korzec, *Maryland Tort Damages: A Form of Sex-Based Discrimination*, 37 U. BALT. L.F. 97, 99-100 (2007).

⁶⁶ *Id.* at 99.

⁶⁷ See John Zevalking, Comment, *Cast Adrift: The Patently Unjust Shift of Healthcare Costs to Those Who Can Least Afford Them Is Constitutionally Intolerable*, 24 T.M. COOLEY L. REV. 347, 404-07 (2007). For background discussion on patents, Jasper L. Tran, *Timing Matters: Prior Art’s Age Infers Patent Nonobviousness*, 50 GONZ. L. REV. 189 (2014/2015) (discussing pharmaceutical patents); Jasper L. Tran, *Software Patents: A One-Year Review*

award earning losses as little as \$5,000 a year for children under the age of seven.⁶⁸

Other injuries, which happen almost exclusively to women, often cannot be expressed in economic terms. For example, the impact of reproductive harm—pregnancy loss injuries are not typically felt through economic aspects of one’s life.⁶⁹ “Rather, the impact is more in terms of emotional suffering and self-esteem—an impaired sense of self and ability to function as a whole person, or damaged relationships.”⁷⁰ These types of emotional injuries were once perceived as undeserving of compensation.⁷¹ However, over the past twenty years, society and juries alike have continually recognized that some aspects of women’s lives cannot be expressed in terms of price and market theory. This is evidenced by heavy non-economic damage verdicts issued in the mass product liability cases of Dalkon Shield, Norplant, breast implants, and super absorbent tampon cases.⁷² Limiting non-economic damages for medical malpractice suits would have the effect of setting back significant progress made in gender and age equality.

The problem becomes increasingly pronounced when one considers the fact that caps on non-economic damages will dissuade attorneys from taking otherwise meritorious cases. Faced with a cap on non-economic damages, attorneys will be increasingly unwilling to take cases involving medical malpractice cases that involve women, children, elderly, and the economically disenfranchised.⁷³ As the civil justice system becomes increasingly unavailable to these plaintiffs, the deterrent value of the system will fade, leading to even a greater number of medical malpractice incidents involving these classes of people.⁷⁴ Lucinda Finley, a prominent feminist legal scholar argues that the most profound loss associated with the damage caps is on “the fairness and equality of the justice system, as the effects of

of Alice v. CLS Bank, 97 J. PAT. & TRADEMARK OFF. SOC’Y 532, 534, 539–40 (2015) (discussing software patents); Jasper L. Tran, *Rethinking Intellectual Property Transactions*, 43 S.U. L. REV. 149, 152–57 (2015) (discussing components of a patent license).

⁶⁸ *Id.* at 405-06.

⁶⁹ Lucinda M. Finley, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 EMORY L.J. 1263, 1281 (2004).

⁷⁰ *Id.* at 1266.

⁷¹ See Lisa M. Ruda, Note, *Caps on Noneconomic Damages and the Female Plaintiff: Heeding the Warning Signs*, 44 CASE W. RES. L. REV. 197, 214 (1993); see also Leonard J. Nelson, III et. al., *Medical Malpractice Reform in Three Southern States*, 4 J. HEALTH & BIOMEDICAL L. 69, 97 (2008).

⁷² Lucinda M. Finley, *Female Trouble: The Implications of Tort Reform for Women*, 64 TENN. L. REV. 847, 855 (1997).

⁷³ Zevalking, *supra* note 67, at 407.

⁷⁴ *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, *supra* note 69, at 1313.

cap laws send the message that women, the elderly, and the parents of dead children should not bother to apply.”⁷⁵ If Lucinda Finley is correct, it appears as though damage caps will only serve to hurt a subclass of people whom it is purported to help.

D. Non-Economic Damage Caps Are Unconstitutional

Proponents of medical malpractice damage caps, especially those who advocate for a federally mandated damage cap, are at risk of violating several provisions the Constitution. While there has been no definitive ruling by the United States Supreme Court on the constitutionality of such caps, there is a substantial amount of scholarship that suggests that these caps implicate fundamental rights guaranteed by the United States Constitution, as well as various state constitutions.⁷⁶

The most common challenge to damage caps is that they violate the Right to Trial by Jury as guaranteed by the Seventh Amendment.⁷⁷ Those who oppose caps argue that damages are factual conclusions to be made by a jury.⁷⁸ Therefore, a person’s right to trial by jury is violated when a legislature removes the decision making power from a jury through the use of a non-economic cap on damages.⁷⁹ Right to Trial by Jury challenges have been brought against medical malpractice damage caps in fourteen states, and have seen varied success.⁸⁰ However, many of the damage caps that were upheld were done so on shaky grounds, and on the assumption “that the language of the Seventh Amendment was directed only to the court, thereby, expressing the intent of the framer’s to permit legislative encroachment on the jury right.”⁸¹ As expressed by a plethora of legal scholars, this view is historically inaccurate. In fact, the founders of the Constitution considered right to trial by jury as one of the essential rights to be preserved against government intrusion and as “the only anchor [...] by

⁷⁵ *Id.*

⁷⁶ See, e.g., Jasper L. Tran, *The Right to Attention*, 91 IND. L.J. __ (2016); Jasper L. Tran, *A Primer on Digital Rights Management Technologies*, in DIGITAL RIGHTS MANAGEMENT: A LIBRARIAN’S GUIDE (Catherine A. Lemmer & Carla Wale eds., 2016).

⁷⁷ Kenneth Owen O’Connor, *Funeral for a Friend: Will the Seventh Amendment Succumb to a Federal Cap on Non-Economic Damages in Medical Malpractice Actions?*, 4 SETON HALL CONST. L.J. 97, 102 (1993).

⁷⁸ *Id.* at 136.

⁷⁹ *Id.* at 150.

⁸⁰ Carly N. Kelly & Michelle M. Mello, *Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation*, 33 J.L. MED. & ETHICS 515, 520-21 (2005).

⁸¹ O’Connor, *supra* note 76, at 145-46.

which a government can be held to the principles of its constitution.”⁸² Some scholars have suggested that those courts that upheld damage caps were doing so out of “judicial contempt for jurors,” and not out of any honest regard to original intent.⁸³

A less commonly asserted, but an equally troublesome constitutional issue raised by non-economic damage caps is violation of Equal Protection Guarantees. Those who assert Equal Protection challenges to non-economic damage caps assert that cap laws create two illegal classification systems. First, by applying non-economic damage caps only to medical malpractice cases, caps divide plaintiffs into two groups: “medical malpractice plaintiffs and other [plaintiffs].”⁸⁴ Second, caps divide medical malpractice plaintiffs themselves “into two groups, allowing those” injured whose damages fall below the cap to collect full damages, but preventing those whose damages exceed the cap from recovering much of their losses.⁸⁵ While most challenges to caps on Equal Protection grounds are upheld on the grounds that they pass the rational basis standard, the courts are mistaken to apply this test, and not a form of higher scrutiny. This is because the second type of classification system is likely to have a disproportionately disparate impact upon women, children, and the elderly, who make less money than men, and who often suffer from injuries that often can only be expressed in non-economic terms.⁸⁶ Classification systems that divide based on gender and ages are usually subject to a more rigorous standard than rational basis review. Therefore, it appears as if these caps should be subjected to a more rigorous judicial scrutiny than allowed under the rational basis test.

A few states have recognized the unsuitability of the rational basis test for these types of tort damage classifications. For example, the New Hampshire Supreme Court in *Carson v. Maurer* rejected the rational basis standard, holding that “the rights affected by damage caps were of sufficient importance that any classifications created by damage caps must be reasonable and must have a fair and substantial relation to the object of the legislation.”⁸⁷ Similarly, the Alabama Supreme Court in *Moore v. Mobile Infirmary Association* went beyond the typical rational-basis review when it held that the state had failed to demonstrate that a \$400,000 cap on

⁸² *Boyd v. Bulala*, 672 F. Supp. 915, 919 (W.D. Va. 1987) (quoting THE WRITINGS OF THOMAS JEFFERSON 71 (Washington ed. 1861)).

⁸³ O'Connor, *supra* note 76, at 147.

⁸⁴ Kelly & Mello, *supra* note 80, at 522.

⁸⁵ *Id.*

⁸⁶ See discussion *infra* Part III.C.

⁸⁷ *Carson v. Maurer*, 424 A.2d 825, 831 (N.H. 1980); Kelly & Mello, *supra* note 80, at 523.

non-economic damages had a substantial means/end fit with the purpose of the legislation.⁸⁸

While certain states have incorrectly held that damage caps do not violate constitutional protections, an objective investigation into the historical context of these protections as well as the disproportionate impact of non-economic damage caps suggests that caps lead to curtailment of essential rights. The patient, who is the payer of the insurance premiums, should not have his or her constitutional rights indiscriminately curtailed while those truly responsible remain largely unaffected.

V. VIABLE ALTERNATIVES TO NON-ECONOMIC DAMAGE CAPS

The glaring social, economic, and constitutional issues related to non-economic damage caps suggests that alternative solutions should be investigated before caps are declared as the solution to the healthcare crisis. Three potential alternatives to the crisis are introduced in this note. The first approach involves reducing the amount of frivolous and unmeritorious lawsuits through a “certificate of merit requirement.” The second approach advocates for the prevention of medical errors before they occur. This can be achieved by developing strategies that encourage the reporting and discussion of repeated medical errors. The third approach advocates for the implementation of a liability premium underwriting system based upon a physician’s past claim and payout history. It is important to note that the healthcare crisis is highly complex, poses unique issues in each state, and likely requires a multi-faceted solution. Therefore, these approaches are only likely to achieve the desired result if they are used in conjunction with one another, and with other creative solutions. It is also important to note that each of these proposed alternatives poses their own, albeit less concerning, constitutional and economic questions, but are beyond the scope of this article.

A. *Certificate of Merit Requirement*

A recently emerging tort reform tactic, which is a viable alternative to non-economic damage caps are “certificates of merit.” Certificates of merit are affidavits, signed and notarized by a medical expert, attesting to the validity and legitimacy of the medical claim.⁸⁹ If the plaintiff does not

⁸⁸ See *Moore v. Mobile Infirmary Ass'n*, 592 So. 2d 156, 171 (Ala. 1991); Kelly & Mello, *supra* note 80, at 523.

⁸⁹ Certificate of merit requirement technicalities vary in every state. For example, Maryland requires that a certificate of merit be filed within 90 days of filing a complaint. New Jersey

file an affidavit with the court, or if the court has doubts regarding the viability of the claim, the case is dismissed, sometimes with prejudice.⁹⁰ By requiring experts to verify the legitimacy of claims before an actual suit is filed, insurance defense costs are lowered, increasing their ability to lower insurance premiums.⁹¹ In fact, studies suggest that the greatest source of insurance company economic waste lies in defense costs for lawsuits ultimately resolved in the favor of the defense.⁹² Most importantly, certificate of merit requirements do not increase the cost to plaintiff attorneys to bring meritorious suits;⁹³ nor do they limit the amount of damages available for a legitimately injured plaintiff.⁹⁴ Rather, certificate of merit requirements require that plaintiffs undertake the same expense and burden, but at a much earlier stage in the litigation.⁹⁵ Therefore, unlike non-economic damage caps, certificate of merit requirements do not dissuade plaintiff attorneys from representing an otherwise meritorious claim. It appears then, that the only people negatively affected by the certificate of merits requirements are those who bring frivolous and doubtful claims.

Precise statistical data regarding the long-term efficacy and benefits of the certificate of merit is muddled by other, contemporaneously implemented modes of reform.⁹⁶ Many of these modes of reform, such as arbitration and screening panels, are less effective, and “unintentionally encourage the filing of doubtful claims and offset the economic benefits to insurers [incurred from the certificate of merit requirement].”⁹⁷ Nevertheless, there is still some hard, statistical data that suggests that the implementation of a certification requirement may offset the costs of medical malpractice insurance. For example, following Maryland’s implementation of a certification of merit requirement, the number of medical malpractice cases filed in the state decreased by 36% the following

requires that the certificate of merit be filed within 60 days of filing the complaint. Other states require that the certification of merit be filed in conjunction with the complaint. Illinois requires that the affidavit contain the name and address of the physician consulted. 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, 1111-1113 (2004).

⁹⁰ See *id.* at 1112.

⁹¹ Jefferey A. Parness & Amy Leonetti, *Expert Opinion Pleading: Any Merit to Special Certificates of Merit?*, 1997 B.Y.U. L. REV. 537, 548.

⁹² See Nathanson, *supra* note 89, at 1101 (arguing that in 1986 Maryland’s largest insurer spent half of its legal budget on cases eventually closed without payment).

⁹³ *Id.* at 1111.

⁹⁴ *Id.* at 1121.

⁹⁵ *Id.* at 1120.

⁹⁶ *Id.* at 1121.

⁹⁷ *Id.* at 1121-22.

year.⁹⁸ Pennsylvania is also a state that has seen very positive results from the certificate of merit requirement, experiencing a 46.5% dip in the amount of case filings in the state since the implementation of the requirement.⁹⁹ Illinois, Connecticut, and New Jersey are other states that have successfully crafted and implemented certificate of merit statutes.¹⁰⁰ Opponents of the certificate of merit point to obvious and inherent flaws within the testimony for fee arrangement. It is well known that certain medical experts make a living off of being a “professional witness,” and will testify on behalf of anyone who will meet their fee requirements.¹⁰¹ However, there are many ways to avoid this problem. For example, Maryland requires that the medical expert who is testifying not spend more than 20% of their time per year giving personal injury litigation testimony.¹⁰² Illinois requires that the expert be within the same practice area and specialty of the case and allows for a court to consider the amount of time an expert spends as a professional witness in determining their credibility.¹⁰³

Contrary to its opponent’s objections, the certificate of merit requirement has shown significant success in certain states where all else has failed. While other, less effective modes of reform may dilute its true benefits, significant data suggests that the requirement does limit the amount of frivolous lawsuits claimed. Furthermore, easy solutions exist to address obvious flaws and concerns within the system. The certificate of merit requirement should at least be given a good effort before more drastic measures such as non-economic damage caps are implemented.

B. Patient Safety Initiatives

The most obvious alternative to non-economic damage caps involves preventing medical errors in the first place. A 1999 study conducted by the Institute of Medicine calculated that almost 100,000

⁹⁸ Miller, *supra* note 40, at 1487.

⁹⁹ Jeff Blumenthal, *Pa. Medical Malpractice Filings Fall to 14-Year Low*, PHILA. BUS. J. (May 8, 2015, 11:15 AM), http://www.bizjournals.com/philadelphia/morning_roundup/2015/05/pa-medical-malpractice-filings-fall-to-14-year-low.html.

¹⁰⁰ Parness & Leonetti, *supra* note 91, at 569; CONN. GEN. STAT. § 52-190a(a)(2007); N.J. STAT. ANN. § 2A:53A-27 (2004).

¹⁰¹ Miller, *supra* note 40, at 1487.

¹⁰² See MD. CODE ANN., CTS. & JUD. PROC. § 3-2A-04(b)(4) (LexisNexis 2006) (“[T]he attesting expert may not devote annually more than 20 percent of the expert’s professional activities to activities that directly involve testimony in personal injury claims.”).

¹⁰³ See 735 ILL. COMP. STAT. ANN. 5/8-2501 (LexisNexis 2006) (requiring that the ruling court must take into account several factors before qualifying a witness to testify as a medical expert).

patients die every year, and millions more injured as a result of preventable medical error.¹⁰⁴ “Medical error is either the eighth-leading, sixth-leading, or third-leading cause of death in the United States, depending on the source.”¹⁰⁵ The total cost for preventable medical error is nearly 29 billion dollars yearly.¹⁰⁶ Instead of limiting recoveries to those most gravely injured, states should begin employing approaches that seek to promote patient safety, and thus limit the amount of preventable medical errors in the first place. Three potential approaches could alleviate the amount of medical errors.

First, states could be more active in reviewing the history and licenses of those physicians seeking to practice within the state. Stricter standards should be developed for those with higher than average ratio of claims within their respective specialties. Insurance companies, who often do not establish premium rates based on past history, cannot be depended on to be a sufficient gatekeeper of reckless physicians practicing within the state.¹⁰⁷ Patients must also be allowed easy access to past disciplinary actions against physicians that they are considering treatment with.¹⁰⁸

Second, states could implement more meaningful mandatory reporting and peer review standards in order to learn from, and correct repeating medical errors. Studies have shown that medical errors frequently go unreported and are driven underground by fear of medical malpractice lawsuits, and by a general mistrust of peer review programs.¹⁰⁹ While certain healthcare accreditation organizations establish peer-review procedures, hospitals are often free to draft the bylaws of the program in favor the hospital.¹¹⁰ Other accreditation agencies do not lay out any standards at all in regards to peer review.¹¹¹ As a result, peer review

¹⁰⁴ Schwartz, *supra* note 56, at 1225-26.

¹⁰⁵ Hyman & Silver, *supra* note 58, at 901.

¹⁰⁶ Kristen R. Salvatore, *Taking Pennsylvania Off Life Support: A Systems-Based Approach to Resolving Pennsylvania's Medical Malpractice Crisis*, 109 PENN ST. L. REV. 363, 377 (2004).

¹⁰⁷ See discussion *infra* Part IV C.

¹⁰⁸ Ruth E. Flynn, *Demand for Public Access to the National Practitioner Data Bank: Consumers Sound Their Own Death Cry*, 18 HAMLINE J. PUB. L. & POL'Y 251, 276-77 (1996).

¹⁰⁹ Randall R. Bovbjerg, *Beyond Tort Reform: Fixing Real Problems*, 3 IND. HEALTH L. REV. 3, 17 (2006).

¹¹⁰ Yann H.H. van Geertruyden, *The Fox Guarding the Henhouse: How the Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes Have Helped Protect Bad Faith Peer Review in the Medical Community*, 18 J. CONTEMP. HEALTH L. & POL'Y 239, 243 (2001).

¹¹¹ Carol R. M. Moss, *You Do Know What You're Doing? Right, Doc? Minnesota Supreme Court Contemplates Negligent Credentialing and Privileging*, 30 HAMLINE L. REV. 125, 140 (2007).

programs end up having less to do with pursuit of quality care, and more to do with shielding hospitals from potential liability.¹¹² Most importantly, peer review programs are widely perceived by the medical community as bureaucratic, political, adversarial, and ultimately non-confidential.¹¹³ At a minimum, there should be continuous state oversight over the activities of peer review systems to guarantee their impartiality.¹¹⁴ States should also consider adopting more expansive non-discoverability provisions to ensure complete confidentiality in the review process.¹¹⁵ Finally, the state oversight body should have the ability to determine whether hospitals have adequately and appropriately responded to the allegations of malfeasance.¹¹⁶

A third, yet less known approach involves encouraging the reporting of substantial and repeating medical errors to administrative agencies through financial incentives. This strategy allows for the reports to be confidential in order to ensure no reprisal by the medical provider. Upon the finding of serious malfeasance, or the existence of sub-par systems, the providers would be fined. These fines would ultimately fund the program, as well as the financial incentives to the reporting employee. Most importantly, because these fines are penalties, they would not be covered by insurance. David Hyman and Charles Silver, leading scholars in health law policy, suggest that this type of approach, which is loosely based on the False Claims Act, could “generate significant information about seriously-deficient health care providers.”¹¹⁷ Additionally, this approach could bring to light deficient systems and malfeasance that would otherwise remain in the dark because they cause injuries too small to justify the high cost of bringing a medical malpractice lawsuit.¹¹⁸

C. Merit Rating

Another viable alternative to non-economic damage caps is the implementation of a liability premium assessment system based upon a physician’s past claim and payout history. While insurance companies base

¹¹² Paul K. Ho, *Hcqa Does Not Provide Adequate Due Process Protection, Improve Healthcare Quality and Is Outdated Under “Obama Care”*, 11 IND. HEALTH L. REV. 303, 336 (2014).

¹¹³ Schwartz, *supra* note 56, at 1243.

¹¹⁴ See Eleanor D. Kinney, J.D., M.P.H., *Hospital Peer Review of Physicians: Does Statutory Immunity Increase Risk of Unwarranted Professional Injury?*, 13 MICH. ST. U. J. MED. & L. 57, 84 (2009).

¹¹⁵ See Schwartz, *supra* note 56, at 1243.

¹¹⁶ See Kinney, *supra* note 114, at 84.

¹¹⁷ Hyman & Silver, *supra* note 58, at 988-89.

¹¹⁸ See *id.* at 989.

their medical liability premium rates upon specialty, service, procedures, and geographical location, a physician's "prior claim or payout history does not affect [their] premium rates."¹¹⁹ This is despite the fact that past history has been shown to be extremely accurate in predicting future risk of malfeasance by a physician.¹²⁰ Additionally, studies have shown that only a few physicians are responsible for the majority of malpractice payment dollars paid.¹²¹ In this respect, insurance companies are failing to place the burden of rising medical malpractice insurance rates on those who caused them and are most likely to affect them in the future.¹²² Instead, insurance companies spread the costs of medical error evenly to physicians across the board, even though the "vast majority of physicians practice responsibly."¹²³

Other types of insurance have successfully employed a merit-based approach. For example, automobile insurance companies take into account geographical location, type of car used, and demographic characteristics in underwriting policies.¹²⁴ However, the most critical factor in underwriting premium rates relates to the driver's past history of accidents and traffic violations.¹²⁵ In this respect, auto insurance operates, as it should: placing the burden of automobile insurance payouts on those who cause them, and who are likely to cause them in the future. Additionally, auto insurance merit rating systems reinforce safe driving by rewarding low-risk drivers who are least likely to incur future claims and payouts.¹²⁶ Other types of insurance policies which have successfully utilized a form of the merit based rating system include workers compensation insurance and unemployment insurance.¹²⁷ Unfortunately, medical malpractice premiums have yet to incorporate a similar merit-rating scheme.

The benefits of a merit-based premium rating system for medical liability insurance are threefold. First, the system will lower rates for those

¹¹⁹ Carrie Lynn Vine, Comment, *Addressing the Medical Malpractice Insurance Crisis: Alternatives to Damage Caps*, 26 N. ILL. U. L. REV. 413, 427 (2006).

¹²⁰ See Randall P. Ellis et al., *Should Medical Professional Liability Insurance Be Experience Rated?*, 57 J. RISK & INS. 66 (1990).

¹²¹ Zevalking, *supra* note 67, at 419.

¹²² *Id.* at 418.

¹²³ *Id.* at 419.

¹²⁴ See Regina Austin, *The Insurance Classification Controversy*, 131 U. PA. L. REV. 517, 564 (1983).

¹²⁵ *Id.* at 545.

¹²⁶ *Id.* at 564-65.

¹²⁷ PITT ET AL., 5 COUCH ON INS. § 69:23 (3d ed. 2015); *Insurance Against Temporary Disability: A Blueprint for State Action*, 60 YALE L.J. 647, 672 (1951).

doctors who do not have a record of medical errors.¹²⁸ The reduction in premium rates for these doctors will translate into lower overhead head costs, and in turn, lower rates for patient services and procedures.¹²⁹ This has the effect of increasing availability of affordable healthcare to individuals. Second, the increase in rates for providers who have a substantial history of medical errors may be so cost-prohibitive that it prevents them from continuing to practice medicine altogether.¹³⁰ Third, the risk of having their medical insurance premiums increased acts as a deterrent to those doctors considering engaging in unnecessary, risky, and negligent conduct.¹³¹ In fact, several studies have demonstrated that fear of rate increases deters negligent conduct.¹³² In this respect, a merit-based system would have the effect of decreasing the amount of claims, increasing the availability of affordable healthcare, and increasing patient safety.

It is conceded that implementation of a merit-based system would require heavy coordination amongst insurance companies and possibly legislative action in order to be effective. Without coordination amongst insurance companies, a physician could easily change insurance carriers and obtain a clean history.¹³³ In order for the merit system to be effective, a physician's claim history must follow him.¹³⁴ It also must be determined whether pending litigation counts for premium underwriting purposes.¹³⁵ Despite some of the obvious technical obstacles that need to be worked through, the merit-based premium rate approach should at least be attempted before states cap non-economic damages to those injured by medical error. We should be distributing the excessive costs of the healthcare system to those primarily responsible for human suffering and the unaffordable cost of healthcare. States should refrain from placing the burden on the victims of negligence, and upon those who are suffering the most.

¹²⁸ See Austin, *supra* note 124, at 564.

¹²⁹ See *id.*

¹³⁰ Frank A. Sloan, *Experience Rating: Does it Make Sense for Medical Malpractice Insurance?*, 80 AMER. ECON. REV. 128, 132 (1990).

¹³¹ *Id.*

¹³² Ellis, *supra* note 120, at 431.

¹³³ Vine, *supra* note 119, at 431.

¹³⁴ *Id.*

¹³⁵ *Id.* at 432.

VI. CONCLUSION

Non-economic damage caps are not the solution to the growing healthcare or medical malpractice insurance crisis. While proponents of non-economic damage caps argue that they are necessary to address the exorbitant costs of medical malpractice insurance, the medical and financial data put forth by these proponents is largely inflated and inaccurate. Additionally, implementation of non-economic damage caps is likely to reduce the essential deterrent element of our tort system, leading to more cases of medical negligence. Non-economic damage caps also disproportionately affect low-income individuals, children, the elderly, as well as women, who often experience injuries that cannot be expressed in economic terms. Most critically, these caps pose troublesome constitutional questions. These glaring issues suggest that alternative solutions should be implemented before non-economic damage caps are declared as the solution to the soaring costs of medical malpractice premiums. The “certificate of merit” requirement is one solution that should be used to reduce the amount of frivolous claims. Additionally, certain strategies can be implemented to encourage the reporting of malfeasance and increase patient safety. Finally, insurance underwriting practices should be revamped to include a liability premium assessment system that incorporates a physician’s past claim and payout history. As a nation, we should be suspect of solutions that shift the healthcare burden upon those who are most gravely injured and are most unable to change their circumstances. Non-economic damage caps are only likely to serve the interests of those who are truly responsible for the crisis and will continue to suppress those most in need of help.