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Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages

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Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages

Summary

Medical malpractice liability is governed by state law, but Congress has the power, under the Commerce Clause of the U.S. Constitution (Art. I, § 8, cl. 3) to regulate it. On March 13, 2003, the House passed H.R. 5, 108th Congress, which would preempt state law with respect to certain aspects of medical malpractice lawsuits. H.R. 5 finds "that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients." It seeks to prevent the decreased availability of medical services, "reduce the incidence of 'defensive medicine' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs." Opponents of medical malpractice reforms have argued that "there is a very minimal relationship between health care costs and malpractice litigation," and that, "[a]s the Harvard Medical Practice Study reported in 1990, . . . about one in eight negligently injured patients file a malpractice claim. The study's authors concluded that 'we do not now have a problem of too many claims; if anything, there are too few.'"

This report does not address the question of the effects of medical malpractice litigation, or of medical malpractice liability reform, on the health care system or on the cost of liability insurance premiums. Rather, it discusses the reforms proposed by H.R. 5, as passed.

H.R. 5, as passed, would, among other things, impose caps on noneconomic damages and punitive damages, permit defendants to be held liable for no more than their share of responsibility for a plaintiff's injuries, require that damage awards be reduced by amounts plaintiffs receive from collateral sources such as health insurance, limit lawyers' contingent fees, create a federal statute of limitations, and require that awards of future damages in some cases be paid periodically, rather than in a lump sum. This report explains each of these ideas and enumerates some of their pros and cons. An appendix to this report presents a chart of current state caps on punitive damages and noneconomic damages.

S. 11, which was introduced on June 27, 2003 and placed on the Senate calendar rather than referred to a committee, is largely identical to H.R. 5. The most significant respect in which it differs is that it would include section 5(c), not in H.R. 5, which would require that expert witnesses in health care lawsuits meet specified qualifications.

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Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages

The Tort of Medical Malpractice

Medical malpractice is a tort, which is a civil (as distinct from a criminal) wrong, other than a breach of contract, that causes injury for which the victim may sue to recover damages. Actions in tort derive from the common law, which means that the rules that govern them were developed by the courts of the fifty states, and no statute is necessary in order to bring a tort action. Statutes, however, can change the court-made rules that govern tort actions, and many states have enacted tort reform statutes, including medical malpractice reform statutes. Congress also has the power, under the Commerce Clause of the U.S. Constitution (Art. I, § 8, cl. 3), to regulate medical malpractice litigation.

Medical malpractice liability arises when a health care professional engages in negligence or commits an intentional tort. Negligence has been defined as conduct "which falls below the standard established by law for the protection of others against unreasonable risk of harm."[1] In most instances it arises from a failure to exercise due care, but a defendant may have carefully considered the possible consequences of his conduct and still be found to have imposed an unreasonable risk on others. "Negligence is conduct, and not a state of mind."[2] The following is a "traditional description" of the standard of care to which doctors are held to avoid liability for medical malpractice:

> This legal duty requires that the physician undertaking the care of a patient possess and exercise that reasonable and ordinary degree of learning, skill, and care commonly possessed and exercised by reputable physicians practicing in the same locality.[3]

Today, however, "[t]he growing majority of jurisdictions employ some variation of the national standard of care."[4]

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[1] RESTATEMENT (SECOND) OF TORTS, § 282.

[2] W. Page Keeton, Prosser and Keeton on Torts, § 31 (5th ed. 1984).

[3] Quoted in David M. Harney, MEDICAL MALPRACTICE, § 21.2 (3d ed. 1993).

[4] Nalder v. West Park Hospital, 254 F.3d 1168, 1176 (10th Cir. 2001).

> The skill, diligence, knowledge, means and methods [required] are not those "ordinarily" or "generally" or "customarily" exercised or applied, but those that are "reasonably" exercised or applied. Negligence cannot be excused on the ground that others practice the same kind of negligence. Medicine is not an exact science and the proper practice cannot be gauged by a fixed rule.[5]

Medical malpractice liability, as noted, may arise from an intentional tort as well as from negligence. One commentator explained:

> [A]n important part of medical malpractice law in some jurisdictions – failure [of the patient] to give consent – falls into the category of intentional torts . . . . The reasoning is that because the doctor did not fully explain the risks that might arise from the contact, the doctor's contact with the patient was done without permission. In traditional liability law, such contact is a battery, which is an intentional tort.[6]

H.R. 5, 108th Congress

On March 13, 2003, the House passed H.R. 5, 108th Congress, the "Help Efficient, Accessible, Low-Cost, Timely Health Care (HEALTH) Act of 2003," which finds "that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients." It seeks to prevent the decreased availability of medical services, "reduce the incidence of 'defensive medicine' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs." Opponents of medical malpractice reforms have argued that "there is a very minimal relationship between health care costs and malpractice litigation," and that, "[a]s the Harvard Medical Practice Study reported in 1990, . . . about one in eight negligently injured patients file a malpractice claim. The study's authors concluded that 'we do not now have a problem of too many claims; if anything, there are too few.'"[7]

H.R. 5 (§ 9(7),(8),(9)) would apply not only to medical malpractice claims, but to claims against a "manufacturer, distributor, supplier, marketer, promotor, or seller of a medical product."[8]

H.R. 5 would, among other things, impose caps on noneconomic damages and punitive damages, permit defendants to be held liable for no more than their share of responsibility for a plaintiff's injuries, require that damage awards be reduced by amounts plaintiffs receive from collateral sources such as health insurance, limit lawyers' contingent fees, create a federal statute of limitations, and require that

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[5] *Id.*

[6] Victor E. Schwartz, *Doctors' Delight, Attorneys' Dilemma*, Legal Times, Health-Care Law Supplement (Feb. 28, 1994) at 30.

[7] Barry J. Nace, *Changing medical malpractice liability will not reduce health care costs*, National Law Journal (Oct. 11, 1993).

[8] The definition of "medical product" in § 9(14) would incorporate the definitions of "drug," "device," and "biological product" in, respectively, 21 U.S.C. § 201(g)(1) and (h), and 42 U.S.C. § 262(a), but "262(a)" should apparently be "262(i)."

awards of future damages in some cases be paid periodically, rather than in a lump sum. This report will explain each of these ideas and enumerate some of their pros and cons. An appendix will present a chart of current state caps on punitive damages and noneconomic damages.

Preemption. Under H.R. 5, medical malpractice lawsuits would continue to be based on state law, but H.R. 5 would preempt state law with respect to certain aspects of such lawsuits. It would not, however, preempt any state law "that imposes greater procedural or substantive protections for health care providers and health care organizations from liability, loss, or damages than those provided by this Act or create a cause of action (§ 11(b)). It would also not preempt "any State law (whether effective before, on, or after the date of enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this Act . . ." (§ 11(c)).[9]

S. 11, 108th Congress

S. 11, titled the "Patients First Act of 2003," which was introduced on June 27, 2003 and placed on the Senate calendar rather than referred to a committee, is largely identical to H.R. 5. The most significant respect in which S. 11 differs is that it would include section 5(c), not in H.R. 5, which would require that expert witnesses in health care lawsuits meet specified qualifications. Unless they testify only "as to the degree or permanency of medical or physical impairment," expert witnesses would have to be "appropriately credentialed or licensed in 1 or more States to deliver health care services," and "typically treat[ ] the diagnosis or condition or provide[ ] the type of treatment under review," and they would have to demonstrate that they were "substantially familiar with applicable standards of care and practice as they relate to the [subject of the lawsuit]."[10]

Every reference to H.R. 5 below, unless S. 11 is contrasted with it, may be read to refer to S. 11 as well.

Cap on Noneconomic Damages

H.R. 5 (§ 4(b)) would impose a $250,000 cap on noneconomic damages in any healthcare lawsuit, "regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same

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[9] This preemption provision raises the question whether a state that wishes to have no cap may enact a cap that is so high – say, $1 billion – that it is effectively no cap, and thereby not be subject to the bill's cap.

[10] Other differences are noted below under "Cap on Punitive Damages" and "Periodic Payment of Damages." A difference not noted below is that the definition of "medical product" in § 9(14) of S. 11 would drop the reference to "biological product" in H.R. 5 (see note 8, *supra*). Also not noted below are apparently non-substantive differences in the wording of the preemption provision (§ 11(b)), and in the (apparently superfluous) provision stating that economic damages would not be capped (§ 4(a)).

injury." As noted, this cap would apply only in states that have no cap before enactment of H.R. 5 and that do not enact one subsequently.[11]

Economic damages refer to monetary losses that result from an injury, such as medical expenses, lost wages, and rehabilitation costs. (H.R. 5 would not cap economic damages.) Noneconomic damages consist primarily of damages for pain and suffering. Determining the amount of noneconomic damages "is an area traditionally subject to broad discretion on the part of juries, who find themselves forced to equate two variables – money and suffering – which are admittedly incommensurable."[12] Judges, however, have the authority to reduce damage awards that they find excessive.[13]

Pro. Advocates of caps on damages for pain and suffering argue that a lack of caps "guarantees unevenness and unpredictability in the recovery system, and forces insurers to counter the uncertainty of awards by charging higher premiums. . . . [D]isagreement over the amount of pain and suffering damages is a major obstacle to out-of-court settlement, thus prolonging the plaintiff's uncompensated suffering. . . . Additionally, the spectre of a disproportionate jury award causes insurers to overpay on settlements of smaller claims. The net result is a skewing of the pattern of compensation, with windfall gains to smaller claimants while the largest claims go significantly undercompensated. Further complicating the picture is the inclination of juries to inflate pain and suffering recoveries to cover some or all of the plaintiff's attorney's fees."[14]

Con. Caps on noneconomic damages punish the worst afflicted, because the more pain and suffering that a plaintiff has endured, the more a cap deprives him of damages to which he would otherwise have been entitled. "By forever freezing compensation at today's levels, caps discriminate against a single class of Americans whose members are destined to suffer a lifetime of deprivation of dignity and independence."[15] The $250,000 cap that H.R. 5 would impose was adopted by California in 1975 "at a time when pain-and-suffering awards rarely exceeded that amount."[16] Twenty years later, in 1995, the median award for pain and suffering in

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[11] H.R. 5 (§ 4(c)) provides that, for purposes of applying the $250,000 cap, "future noneconomic damages shall not be discounted to present value." This apparently means that, if a jury awards, say, $260,000 in future noneconomic damages, and such amount could be paid in the form of an annuity that costs $240,000, the higher figure would control, and the future noneconomic damages would be reduced to $250,000, not to $240,000.

[12] Brown and McGuire, *Damages for Pain and Suffering: What are the Courts Really Doing?*, Case and Comment (Nov./Dec. 1978) at 20.

[13] *See* Michael Higgins, *Homogenized Damages: Judge suggests using statistical norms to determine whether pain and suffering awards are excessive*, American Bar Association Journal (Sept. 1997) at 22.

[14] Brown and McGuire, *supra* note 12, at 21-22.

[15] Peter Perlman, *Don't Punish the Injured*, American Bar Association Journal (May 1986) at 34.

[16] Edward Felsenthal, *Why a Medical Award Cap Remains Stuck at $250,000*, Wall Street
(continued...)

malpractice cases reportedly was $300,000, and inflation has also taken a toll.[17] "Instead of embracing arbitrary limits that are unfair if not inhumane – and useless as a device for controlling insurance premiums – we must continue to rely on our time-tested jury system for determining what's right."[18]

Cap on Punitive Damages

H.R. 5 (§ 7(a)) provides that punitive damages may be awarded if otherwise permitted by state law, if the claimant proves "by clear and convincing evidence" that the defendant "acted with malicious intent to injure the claimant, or . . . deliberately failed to avoid unnecessary injury that [the defendant] knew the claimant was substantially certain to suffer." H.R. 5 would thus preempt state law regarding the burden of proof and the standard for awarding punitive damages, except in states that provide greater protection for defendants.[19]

H.R. 5 (§ 7(b)(2)) would also impose a cap on punitive damages of $250,000 or two times the amount of *economic* (not all compensatory) damages awarded, whichever is greater. As with H.R. 5's cap on noneconomic damages, the cap on punitive damages would apply only in states that have no cap before enactment of H.R. 5 and that do not enact one subsequently.

H.R. 5 (§ 7(c)) would provide that "[n]o punitive damages may be awarded against the manufacturer or distributor of a medical product, or a supplier of any component or raw material of such medical product," if the product had been approved by the Food and Drug Administration or is generally recognized as safe and effective under FDA regulations. S. 11 (§ 7(c)), by contrast, would require plaintiffs, to receive punitive damages, to demonstrate by clear and convincing evidence that the manufacturer or distributor of a medical product, or supplier of any component or raw material, "failed to comply with a specific requirement of the Federal Food, Drug, and Cosmetic Act or the regulations promulgated thereunder"; and that "the harm attributed to the particular medical product resulted from such failure to comply . . . ."

In 1851, the Supreme Court wrote:

> It is a well-established principle of the common law, that in actions . . . for torts, a jury may inflict what are called exemplary, punitive, or vindictive damages upon a defendant, having in view the enormity of his offense rather than the

[16] (...continued)
Journal (Nov. 1995).

[17] *Id*.

[18] Perlman, *supra* note 15.

[19] See CRS Report RL31721, *Punitive Damages in Medical Malpractice Actions: Burden of Proof and Standards for Awards in the Fifty States*.

> measure of compensation to the plaintiff. We are aware that the propriety of this doctrine has been questioned by some writers.[20]

When may punitive damages be awarded? A treatise states:

> Something more than the mere commission of a tort is always required for punitive damages. There must be circumstances of aggravation or outrage, such as spite or "malice," or a fraudulent or evil motive on the part of the defendant, or such a conscious and deliberate disregard of the interests of others that the conduct may be called wilful or wanton. There is general agreement that, because it lacks this element, mere negligence is not enough, even though it is so extreme as to be characterized as "gross," a term of ill-defined content, which occasionally, in a few jurisdictions, has been stretched to include the element of conscious indifference to consequences, and so to justify punitive damages.[21]

Among the restrictions that have been proposed with regard to punitive damages, besides that they be capped, is (1) that the circumstances in which they may be awarded be narrowed, (2) that plaintiffs be required to prove by "clear and convincing" evidence that they are entitled to them (instead of having to prove it by a mere "preponderance of the evidence."), (3) that liability for punitive damages be determined in a separate proceeding from liability for compensatory damages,[22] and (4) that punitive damages be paid in part to the government or to a fund that serves a public purpose instead of to the plaintiff.[23]

Pro. Critics charge that punitive damage awards in medical malpractice cases "are often unfair, arbitrary and unpredictable, and result in overkill. . . . One publication argues that reform is needed because there has been an outpouring of 'the most outrageous punitive damage awards' in medical malpractice."[24] "Even though punitive damage awards occur in a small percentage of cases, they can have a devastating impact on individual defendants and can impose big costs on the economy as a whole . . . ."[25]

Con. "The preliminary findings of the American Bar Foundation's research indicate that punitive damage awards are not routine. They are not, typically, given

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[20] Day v. Woodworth, 54 U.S. (13 How.) 363, 371 (1851).

[21] W. Page Keeton, *supra* note 2, § 2.

[22] In *BMW of North American, Inc. v. Gore*, 517 U.S. 559, 618 (1996), the Supreme Court listed state statutes that provide for this.

[23] In *BMW of North American, Inc. v. Gore*, 517 U.S. 559, 616 (1996), the Supreme Court listed state statutes that provide for this. Of the four proposals mentioned in the above paragraph, the fourth one – paying part of the punitive damages award to the government or a fund – is the only one that H.R. 5 would *not* implement.

[24] Micahel Rustad and Thomas Koenig, *Reconceptualizing Punitive Damages in Medical Malpractice: Targeting Amoral Corporations, Not "Moral Monsters,"* 47 Rutgers Law Review 975, 978, 980-981 (1995).

[25] Mark Thompson, *Applying the Brakes to Punitives – But is There Anything to Slow Down?*, American Bar Association Journal (Sept. 1997) at 68, 69.

in amounts that boggle the mind."[26] Punitive damages have been called "a necessary tool in the effective control of socially undesirable conduct. . . . Punitive damages must be allowed to fill the gaps the criminal law leaves open."[27] Finally, trial judges often reduce punitive damages awards that they find excessive, and a recent Supreme Court decision "makes it easier for appellate courts to reduce punitive damages."[28]

Limiting Joint and Several Liability

H.R. 5 (§ 4(d)) would eliminate joint and several liability in health care lawsuits. Joint and several liability is the common-law rule that, if more than one defendant is found liable for a plaintiff's injuries, then each defendant may be held 100 percent liable. With joint and several liability, the plaintiff may not recover more than once, but he may recover all his damages from fewer than all liable defendants, with any defendant who pays more than its share of the damages entitled to seek contribution from other liable defendants.

Some states have eliminated joint and several liability, making each defendant liable only for its share of responsibility for the plaintiff's injury. Other states have adopted compromise positions, eliminating joint and several liability only for noneconomic damages (presumably with the view that it is more important for the plaintiff to recover all his economic damages than all his noneconomic damages), or eliminating joint and several liability only for defendants responsible for less than a specified percentage (*e.g.*, 50 percent) of the plaintiff's harm (presumably with the view that it is especially unfair for such defendants to be held liable for up to 100 percent of the damages).

Pro. Advocates of abolishing or limiting joint and several liability argue that it "frequently operates in a highly inequitable manner – sometimes making defendants with only a small or even *de minimis* percentage of fault liable for 100% of plaintiff's damage. Accordingly, joint and several liability in the absence of concerted action has led to the inclusion of many 'deep pocket' defendants such as governments, larger corporations, and insured entities whose involvement is only tangential and who probably would not be joined except for the existence of joint and several liability."[29]

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[26] Stephen Daniels, *Punitive Damages: The Real Story*, American Bar Association Journal (Aug. 1986) at 60, 63.

[27] Lisa M. Broman, *Punitive Damages: An Appeal for Deterrence*, 61 Nebraska Law Review 651, 680 (1982).

[28] Tania Zamorsky, *Impact of High Court's Ruling In "Leatherman": Punitive awards reduced in four cases,* National Law Journal (Aug. 1, 2001), citing *Cooper Industries, Inc. v. Leatherman Tool Group, Inc.*, 532 U.S. 424 (2001), which held that appellate courts should perform *de novo* review, rather than apply an abuse-of-discretion standard, when determining whether punitive damages are excessive in violation of the Eighth Amendment.

[29] *Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability* (Feb. 1986) at 64.

Con. Advocates of joint and several liability cite the reason that the common law adopted it: it is preferable for a wrongdoer to pay more than its share of the damages than for an injured plaintiff to recover less than the full compensation to which he is entitled.

Abolishing the Collateral Source Rule

The collateral source rule is the common-law rule that allows an injured party to recover damages from the defendant even if he is also entitled to receive them from a third party (a "collateral source"), such as a health insurance company, an employer, or the government. To abolish the collateral source rule would be to require courts to reduce damages by amounts a plaintiff receives or is entitled to receive from collateral sources. H.R. 5 (§ 6) would provide that, in any health care lawsuit, any party (usually the defendant) may introduce evidence of collateral source benefits, and the opposing party (usually the plaintiff) may introduce evidence of amounts paid to secure those benefits (*e.g.*, health insurance premiums). H.R. 5 does not state that collateral source benefits, minus amounts paid to secure such benefits, would have to be deducted from damage awards, but that would presumably be the purpose of introducing evidence of these matters.

Often a collateral source, such as a health insurer or the government, has a right of subrogation against the tortfeasor (the person responsible for the injury).[30] This means that the collateral source takes over the injured party's right to sue the tortfeasor, for up to the amount the collateral source owes the injured party. Though the collateral source rule may enable the plaintiff to recover from both his insurer and the defendant, the plaintiff, if there is subrogation, must reimburse his insurer the amount it paid him. H.R. 5 would prohibit providers of collateral source benefits from asserting a right of subrogation. This means that plaintiffs would recover only once (from the collateral source), and the collateral source could not recover the benefits it paid. H.R. 5 thereby would benefit health care providers and their liability insurers at the expense of health insurers and other providers of collateral source benefits.[31]

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[30] The Medical Care Recovery Act, 42 U.S.C. § 2651(a), provides: "In any case in which the United States is authorized or required by law to furnish or pay for hospital, medical, surgical, or dental care and treatment . . . to a person who is injured or suffers a disease . . . under circumstances creating a tort liability upon some third person . . . , the United States shall have a right to recover . . . from said third person, or that person's insurer, the reasonable value of the care and treatment . . . and shall as to this right be subrogated to any right or claim that the injured or diseased person . . . has against such third person to the extent of the reasonable value of the care and treatment . . . ."

[31] By contrast, S. 607, 108th Congress, would abolish the collateral source rule only when the payor of collateral source benefits has no right of subrogation. This means that, when the payor has no right of subrogation, the plaintiff's damages would be reduced, but he could keep his collateral source benefits, and, as under H.R. 5, health care providers would benefit at the expense of health insurers. When, however, the payor has a right of subrogation, the plaintiff's damages would not be reduced, but he would not recover twice because he would not be permitted to recover collateral source benefits.

One commentator has noted that eliminating the collateral source rule could indirectly reduce damages for pain and suffering, "because juries often render pain and suffering awards as a multiple of actual economic awards. The extent of this impact may depend . . . on . . . [w]hat figures will be given to the jury[.] If the collateral source rule is abolished, will the jury be told that the plaintiff 'lost' $3,000 (the amount he or she actually paid out) or $50,000 (the full amount of the medical bills and/or loss of wages, much of which may have been paid by a collateral source)? This may seem a technical point, but it can have tremendous practical implications in the trial of cases, including whether a case involves sufficient damages to establish diversity jurisdiction in federal court."[32]

Pro. Advocates of abolishing the collateral source rule object to the fact that it "permits the plaintiff to obtain double recovery for certain components of his damages award," unless the collateral source is subrogated to the plaintiff's claim against the defendants.[33] Abolishing the collateral source rule will reduce damage awards without denying plaintiffs full recovery of their damages.

Con. Advocates of the collateral source rule cite the reason that the common law adopted it: it is preferable for the victim than for the wrongdoer to profit from the victim's prudence (as in buying health insurance) or good fortune (in having some other collateral source available). One commentator has also noted that, when the collateral source is the government, and the benefit it provides are future services, such as physical therapy, there is no guarantee that it will provide such services for as long as they are needed, as government programs can be cut back.[34]

Limiting Lawyers' Contingent Fees

A contingent fee is one in which a lawyer, instead of charging an hourly fee for his services, agrees, in exchange for representing a plaintiff in a tort suit, to accept a percentage of the recovery if the plaintiff wins or settles, but to receive nothing if the plaintiff loses. Recovery is thus contingent upon there being a recovery. Plaintiffs agree to this arrangement in order to afford representation without having to pay anything out-of-pocket, and lawyers agree to it because the percentage they receive – usually from 33⅓ to 40 percent – generally amounts to more than an hourly fee would.

H.R. 5 (§ 5) would impose a cap with a sliding scale in medical malpractice cases.[35] As of 1989, 25 states reportedly regulated contingent fees in medical malpractice cases in one or more of the following ways: "(1) establishment of a sliding scale for the attorney fees; (2) establishment of a maximum percentage of the

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[32] *Id*. at 30.

[33] *Report of the Tort Policy Working Group*, *supra* note 29.

[34] Barry J. Nace and Virginia C. Nelson, *Plaintiffs' Lawyers Have Already Seen Many of the Proposed Tort Reforms in the States, and Find Them Disastrous for Clients*, National Law Journal (Jan. 17, 1994) at 29.

[35] 40% of the first $50,000 recovered, 33⅓% of the next $50,000, 25% of the next $500,000, and 15% of any additional amount.

award that may be paid for attorney fees; and (3) provision for court review of the reasonableness of the attorney fees."[36]

H.R. 5 does not address whether plaintiffs' attorneys would be allowed to "add costs, including expert-witness fees, travel, and photocopying on top of the cap[.] Or must costs be recouped from the lawyer's . . . recovery? In medical malpractice cases, where costs can skyrocket, the difference is significant."[37]

Pro. Advocates of limiting contingent fees argue that such fees cause juries to inflate verdicts, result in windfalls for lawyers, and prompt lawyers to file frivolous suits in the hope of settling. They also argue that, where there is no dispute as to liability, but only as to damages, there is no contingency and therefore no justification for contingent fees. One study proposed that, if a defendant makes a prompt settlement offer, then counsel fees be "limited to hourly rate charges and capped at 10% of the first $100,000 of the offer and 5% of any greater amounts. . . . When plaintiffs reject defendants' early offers, contingency fees may only be charged against net recoveries in excess of such offers."[38]

Con. Opponents of limiting contingent fees argue that such fees enable injured persons, faced with medical bills and lost wages, to finance lawsuits that they otherwise could not afford – especially if their injury has disabled them from working. They argue that lawyers are unlikely to file frivolous lawsuits if they stand to recover nothing if they lose, and that studies have shown that contingent fees do not encourage frivolous lawsuits.[39] Finally, they note, "[a]n hourly fee arrangement [such as defendants' lawyers use] can encourage delay, inefficiency, and unnecessary action," whereas "[a] contingent fee is an added inducement for a lawyer to be efficient and expeditious."[40]

Creating a Federal Statute of Limitations

H.R. 5 (§ 3) provides:

> The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years after the date of manifestation of injury unless tolled for any of the following – (1) upon proof of fraud; (2) intentional concealment; or

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[36] American Medical Association, *AMA Tort Reform Compendium* (1989) at 19, 132-134; *see also*, Office of Technology Assessment, *Impact of Legal Reforms on Medical Malpractice Costs* (1993) at 93.

[37] Schwartz, *supra* note 6 at 30.

[38] The Manhattan Institute, *Rethinking Contingency Fees* (1994) at 28, 29.

[39] See studies cited in Association of Trial Lawyers of American, *Keys to the Courthouse: Quick Facts on the Contingent Fee System* (1994) at 4, 5.

[40] *Id*. at 6.

> (3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

It is not clear whether this provision is, strictly speaking, a statute of limitations. A statute of limitations is typically an affirmative defense, which means that the defendant must raise it; if the defendant fails to raise it, then the plaintiff may sue regardless of how much time has passed.[41] H.R. 5, by contrast, could be interpreted to place the burden of proof on the plaintiff to show that his injury occurred within the time period allowed. The Judiciary Committee report calls H.R. 5's time limitation a "statute of limitations"[42]; the Energy and Commerce Committee report does not.[43]

The statute of limitations for medical malpractice suits under state law is typically two or three years, starting on the date of injury. Sometimes, however, the symptoms of an injury do not appear immediately, or even for years after, malpractice occurs. Many states therefore have adopted a "discovery" rule, under which the statute of limitations starts to run only when the plaintiff discovers, or in the exercise of reasonable diligence, should have discovered, his injury – or, sometimes, his injury and its cause. Plaintiffs would favor allowing a statute of limitations to run only upon discovery of an injury and its cause because it may take additional time after symptoms become manifest to discover that an injury was caused by medical malpractice.

H.R. 5, rather than imposing a time limitation that begins on the date of injury or on the date of discovery of the injury, would cut off the right to sue upon the earlier of two different periods – 3 years and 1 year – that begin, respectively, on the date of manifestation of injury and discovery of the injury. H.R. 5 defines neither term, but the Committee on Energy and Commerce explains the former term: "The term 'manifestation of injury' means the injury has become reasonably evident. Thus, if someone unknowingly receives tainted blood, 'manifestation of injury' is not the date of receiving the blood. Instead, it is the date on which adverse symptoms become reasonably evident."[44]

The discovery of the injury, then, would apparently occur on the date that the patient learns that his blood is tainted. Suppose that medical tests reveal the tainted blood one year after the patient experienced his first symptoms. There would still be two years to run on the three-year manifestation period, but the patient would apparently have to sue within one year of discovering that his blood is tainted – even if it takes more than one year to learn that his blood's being tainted is the result of medical malpractice. A patient could also apparently discover his injury, perhaps through a routine medical test, before its symptoms become manifest, and, again, the one-year discovery time period would apparently apply.

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[41] See, *e.g.*, Federal Rule of Civil Procedure 8(c).

[42] H.Rept. 108-32, Part 1 (Mar. 11, 2003) at 59.

[43] H.Rept. 108-32, Part 2 (Mar. 11, 2003) at 28.

[44] *Id.*

Periodic Payment of Damages

Traditionally, damages are paid in a lump sum, even if they are for future medical care or future lost wages. In recent years, however, "attorneys for both parties in damages actions have occasionally foregone lump-sum settlements in favor of structured settlements, which give the plaintiff a steady series of payments over a period of time through the purchase of an annuity or through self-funding by an institutional defendant."[45] "There are many forms of periodic payment statutes throughout the United States. Many of these involve mind boggling calculations, creating barriers for those who use the periodic payment process."[46]

H.R. 5 (§ 8) provides:

> In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000, is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments. In any health care lawsuit, the court may be guided by the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Law.[47]

S. 11 (§ 8) is identical except that it would make use of the Uniform Periodic Payment of Judgments Act mandatory.

By contrast with H.R. 5 and S. 11, the periodic payment provision of President Clinton's proposed Health Security Act[48] would have allowed any party to request periodic payments of all damages, not just future damages, and not just damages of a specified amount.

Section 8 of H.R. 5, quoted above, states that awards of future damages shall not be reduced to present value for the purpose of determining whether it equals the $50,000 minimum necessary for a party to require the court to order periodic payments. This is apparently a different question from whether the amount of the award of future damages that the defendant must pay would be converted to present value. Not to require such conversion "could be a very major change, significantly reducing awards, if it is intended to allow a defendant to pay, for example, a $1 million award over a 10-year period at $100,000 a year. On the other hand, if it requires the jury award to be converted into present value terms – an annuity with a present value of $1 million – the reform doesn't mean that much; as a practical

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[45] Annotation, *Propriety and Effect of "Structured Settlements" Whereby Damages are Paid in Installments Over a Period of Time, and Attorneys' Fees Arrangements in Relation Thereto*, 31 ALR4th 95, 96.

[46] Paul J. Lesti, STRUCTURED SETTLEMENTS (2d ed., 1993) at § 21.5.

[47] The Uniform Act was promulgated in 1990; it was preceded in 1980 by the Model Periodic Payment of Judgments Act.

[48] Section 5306 of H.R. 3600 and S. 1757, 103d Congress.

matter, the defendant would be paying the same amount as before."[49] The defendant, that is, would have to spend $1 million for an annuity that would yield the plaintiff more than $1 million, over the years of its distribution. Had the defendant paid the plaintiff a lump sum of $1 million, then the plaintiff could have purchased that same annuity.

H.R. 5 does not explicitly address the question of whether the amount of the award of future damages would be converted to present value. The Uniform Periodic Payment of Judgments Act, however, which H.R. 5 incorporates, provides in section 5(a) that, in a trial, "evidence of future changes in the purchasing power of the dollar is admissible on the issue of future damages." This suggests that an award of future damages will be already be increased to take account of future inflation, and there arguably would be no need to convert it to present value to ensure that the plaintiff receives his due. The lesser amount that the defendant might pay for an annuity might, that is, equal the amount he would have paid had evidence of future changes in the purchasing power of the dollar not been admissible.[50]

Another issue that H.R. 5 does not explicitly address in connection with periodic payments is the effect of the plaintiff's death on unpaid amounts. The Uniform Periodic Payment of Judgments Act provides in section 13 that, "liability to a claimant for periodic payments not yet due for medical expenses terminates upon the claimant's death." Damages for other economic losses, however, except in actions for wrongful death, must be paid to the plaintiff's estate.

Pro. "Both defendants and plaintiffs are often benefited by such arrangements: the defendant need not immediately pay out a large sum of money, since the cost of the annuity or other method of payment is less than a conventional lump-sum settlement; and the plaintiff is prevented from dissipating a recovery and is provided a secure, tax-free income for a long period of time without having to assume the costs and risks of managing an investment portfolio ."[51] "Periodic payment of malpractice awards is nothing more than what lawyers have been doing for years in structured settlements. It is workable and often the only means of providing full compensation for an injured claimant when resources are otherwise unavailable."[52]

Con. If periodic payments will in fact benefit plaintiffs, then they will agree to them, as they sometimes do, without legislation. Some plaintiffs, however, may prefer to invest their awards themselves and not risk the insolvency of the defendant or the company from which the defendant purchases an annuity.

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[49] *See* Schwartz, *supra* note 6 at 30.

[50] The Judiciary Committee report, *supra* note 42, at 59, is consistent with this interpretation: "[T]he defendant is able to acquire the annuity or similar system of secured payment at a price less than the aggregate amount of the damages that must be paid to the plaintiff."

[51] *Annotation*, *supra* note 45, at 96.

[52] A. Blackwell Stieglitz, *Defense Counsel Will Find the President's Medical Malpractice Proposals So Benign as to be Meaningless*, National Law Journal (Jan. 17, 1994) at 27.

Appendix: Fifty State Survey of Caps on Punitive Damages and Noneconomic Damages

The following chart summarizes state laws that impose caps on punitive damages and noneconomic damages in medical malpractice cases. An empty box in the chart indicates that the state apparently imposes no cap in medical malpractice suits, either because the state constitution prohibits caps or because the state legislature has chosen not to enact a cap. We quote (in italics) some, but not necessarily all, state constitutional provisions that prohibit caps.

The caps listed in the chart, as well as the entry "punitive damages prohibited," do not necessarily apply to tort actions other than for medical malpractice, though in many cases they do.

The term "economic damages" refers to past and future monetary expenses of an injured party, such as medical bills, rehabilitation expenses, and lost wages. "Noneconomic damages" refers primarily to damages for pain and suffering. Economic and noneconomic damages are both compensatory damages; *i.e.*, they are intended to compensate the injured party.

Punitive damages (also called exemplary damages), by contrast, are awarded not to compensate plaintiffs but to punish and deter particularly egregious conduct on the part of defendants – generally meaning reckless disregard for the safety of others, and more than negligence or even gross negligence. Punitive damages are noneconomic by nature, but state statutes that impose caps on punitive damages usually treat them separately from compensatory noneconomic damages.

The dollar amount in the right-hand column refers to the cap on compensatory noneconomic damages, except that "total cap" means a cap on all damages – economic, noneconomic, and punitive damages – combined. Caps that a state's highest court have declared to violate the state's constitution are not necessarily noted.

STATE	PUNITIVE DAMAGES	NONECONOMIC DAMAGES
Alabama	§ 6-11-21. The greater of three times compensatory damages or $500,000 ($1.5 million if physical injury), except that, if the defendant is a small business (net worth of $2 million or less), then cap is greater of $50,000 or 10% of the business' net worth. Amounts to be adjusted in accordance with the consumer price index. No caps in class actions or in actions for wrongful death or for intentional infliction of physical injury.	§ 6-5-544, which imposes a $400,000 cap on "noneconomic losses, including punitive damages," held to violate state constitution. *Moore v. Mobile Infirmary Ass'n*, 592 So.2d 156 (Ala. 1991). § 6-5-547. $1,000,000 total cap in wrongful death actions against a health care provider; to be adjusted in accordance with consumer price index.
Alaska	§ 09.17.020. Greater of 3 times compensatory damages or $500,000, except if defendant was motivated by financial gain and actually knew the adverse consequences, then the greatest of 4 times compensatory damages, 4 times financial gain, or $7,000,000.	§ 09.17.010. "$400,000 or the injured person's life expectancy in years multiplied by $8,000, whichever is greater," but "$1,000,000 or the person's life expectancy in years multiplied by $25,000, whichever is greater, when the damages are awarded for severe permanent physical impairment or severe disfigurement."
Arizona	*Arizona Constitution, Art. 2, § 31, provides: "No law shall be enacted in this State limiting*	*the amount of damages to be recovered for causing the death or injury of any person."*
Arkansas	§ 16-55-208. The greater of $250,000 or three times compensatory damages, not to exceed $1,000,000, to be adjusted as of 1/1/06 and at three-year intervals thereafter, in accordance with the CPI. No cap if defendant intentionally caused injury or damage.	*Arkansas Constitution, Art. 5, § 32, provides "[N]o law shall be enacted limiting the amount to be recovered for injuries resulting in death or for injuries to persons or property . . . ."*
California		Civil Code § 3333.2. $250,000.
Colorado	§ 13-21-102. The amount of actual damages awarded, but 3 times that amount if the defendant continues to act in a willful and wanton manner during the pendancy of the case.	§§ 13-21-102.5, 13-64-302. $250,000 noneconomic cap, but $500,000 cap if court finds justification for more than $250,000. Both caps adjusted for inflation. $1,000,000 total cap in suits against health care providers.

STATE	PUNITIVE DAMAGES	NONECONOMIC DAMAGES
Connecticut		
Delaware		
District of Columbia		
Florida	§ 766.207(7)(d). Punitive damages prohibited.	§ 766.118, as added by 2003 Fla. Laws Ch. 416, effective 9/15/03. $500,000, except $1 million cap on all practitioners in the aggregate if permanent vegetative state or death, or if, because of special circumstances, noneconomic harm is particularly severe and injury was catastrophic. For non-practitioners, above caps are $750,000 and $1.5 million, respectively. For emergency services, caps are $150,000 for practitioners, $750,000 for non-practitioners, with maximum damages recoverable by all claimants $300,000 and $1.5 million, respectively.
Georgia	§ 51-12-5.1. $250,000.	
Hawaii		§ 663-8.7. $375,000 (cap does not apply to intentional torts).
Idaho	§ 6-1604, as amended by 2003 Session Laws, Ch.122. For actions accruing after 7/1/03, the greater of $250,000 or three times compensatory damages.	§ 6-1603. $250,000 for actions accruing after 7/1/03, subject to increase or decrease in accordance with the average annual wage.
Illinois	735 ILCS 5/2-1115. "Punitive damages are not recoverable in healing art and legal malpractice cases."	None. (Cap in 735 ILCS 5/2-1115.1 held unconstitutional in *Best v. Taylor Machine Works*, 689 N.E.2d 1057 (Ill. 1997)).
Indiana	§ 34-51-3-4. Greater of 3 times compensatory damages or $50,000.	§ 34-18-14-3. $1,250,000. For "qualified" health care provider, $250,000 total cap.
Iowa		

STATE	PUNITIVE DAMAGES	NONECONOMIC DAMAGES
Kansas	§ 60-3702(e), (f). The lesser of the defendant's annual gross income or $5,000,000, but if the profitability of the mis-conduct exceeds such amount, the cap is 1.5 times the profit.	
Kentucky	*Kentucky Constitution, § 54, provides: "The General Assembly shall have no power to limit the amount to be*	*recovered for injuries resulting in death, or for injuries to person or property."*
Louisiana	Punitive damages prohibited at common law.	§ 40:1299.42. $500,000 total cap, exclusive of "future medical care and related benefits" (as defined). "Qualified" health care provider: $100,000 total cap per patient.
Maine	T. 18-A, § 2-804(b). $75,000 for wrongful death actions.	
Maryland		Courts and Judicial Proceedings § 11-108. $500,000 if cause of action arises on or after Oct. 1, 1994, increased by $15,000 on Oct. 1 of each succeeding year for causes of action that arise on or after the date of the increase.
Massachusetts	Ch. 229, § 2. In wrongful death cases, not *less* than $5,000 where punitive damages are appropriate. Punitive damages otherwise prohibited at common law.	Ch. 231, § 60H. $500,000, unless death resulted or "special circumstances" are found. Ch. 231, § 85K. $20,000 total cap if charitable institution.
Michigan	Exemplary damages "are awardable where the defendant commits a voluntary act which inspires feelings of humiliation, outrage, and indignity. . . . The purpose of exemplary damages is not to punish the defendant, but to render the plaintiff whole. When compensatory damages can make the injured party whole, exemplary damages must not be awarded." *Jackson Printing Co., Inc. v. Mitan*, 425 N.W.2d 791 (Mich. 1988).	§ 600.1483. $280,000, "recoverable by all plaintiffs, resulting from the negligence of all defendants," but $500,000 if a serious injury enumerated in the statute occurred.

STATE	PUNITIVE DAMAGES	NONECONOMIC DAMAGES
Minnesota		
Mississippi	§ 11-1-65. $20 million if defendant's net worth exceeds $1 billion; $15 million if it exceeds $750 million but is not more than $1 billion; $10 million if it exceeds $500 million but is not more than $750 million; $7½ million if it exceeds $100 million but is not more than $500 million; $5 million if it exceeds $50 million but is not more than $100 million; 4% of defendant's net worth if defendant's net worth is $50 million or less.	§ 11-1-60. $500,000 for claims filed before 7/1/2011; $750,000 from 7/1/2011 - 6/30/2017; $1 million from 7/1/2017. Cap does not apply if the judge determines that a jury may impose punitive damages, and does not limit damages for disfigurement.
Missouri		§ 538.210. $350,000 per defendant, subject to increase or decrease each January 1 to reflect inflation or deflation.
Montana		§ 25-9-411. $250,000.
Nebraska	Punitive damages prohibited at common law.	§ 44-2825. $1,250,000.
Nevada	§ 42.005. Three times compensatory damages if compensatory damages are $100,000 or more; $300,000 if they are less.	§ 41A.031. $350,000, but a higher award may be made if "gross malpractice" or if "justified because of special circumstances." If defendant has insurance of not less than $1 million per occurrence and $3 million in the aggregate, then noneconomic damages may not exceed the amount of the policy after subtracting the economic damages awarded.
New Hampshire	§ 507:16. "No punitive damages shall be awarded in any action, unless otherwise provided by statute." No statute provides for punitive damages in medical malpractice actions.	§ 507-C:7. $250,000.
New Jersey	2A:15-5.14. Greater of 5 times compensatory damages or $350,000.	

STATE	PUNITIVE DAMAGES	NONECONOMIC DAMAGES
New Mexico		§ 41-5-6. $600,000 total cap, "[e]xcept for punitive damages and medical care and related benefits," which are not subject to the cap. "Monetary damages shall not be awarded for future medical expenses in malpractice claims."
New York		
North Carolina	§ 1D-25. Greater of 3 times the amount of compensatory damages or $250,000.	
North Dakota	§ 32-03.2-11(4). Greater of two times compensatory damages or $250,000.	§ 32-42-02. $500,000.
Ohio		§ 2323.43, as amended by 2001 Ohio S.B. 281 (approved by the Governor on Jan. 10, 2003). The greater of $250,000 or three times plaintiff's economic loss, to a maximum of $350,000 for each plaintiff or a maximum of $500,000 for each occurrence. But, if specified serious injuries occur, cap is $500,000 for each plaintiff or $1 million for each occurrence.
Oklahoma	T. 23, § 9.1. Where reckless disregard, greater of $100,000 or actual damages awarded. Where intentionally and with malice, greatest of $500,000, twice actual damages awarded, or financial benefit derived by defendant. If court finds beyond a reasonable doubt that defendant engaged in conduct life-threatening to humans, then no cap.	T. 63, § 1-1708.1F (added by Ch. 390, § 6 (2003)). $300,000 per action regardless of the number of defendants, but cap applies only in cases involving "[p]regnancy or labor and delivery, including the immediate post-partum period," and "[e]mergency care in the emergency room of a hospital or follow-up to" such care. Cap does not apply if judge finds clear and convincing evidence of negligence, or in wrongful death action. Cap terminates July 1, 2008.

STATE	PUNITIVE DAMAGES	NONECONOMIC DAMAGES
Oregon	§ 18.550. Prohibited against specified health practitioners.	§ 18.560. $500,000 cap held to violate Oregon Constitution, Art. VII, § 3, which provides that "no fact tried by a jury shall be otherwise re-examined." But the cap apparently applies in wrongful death actions because there is no right to a jury trial for them. *Lakin v. Senko Products, Inc.*, 987 P.2d 463 (Ore. 1999).
Pennsylvania	40 P.S. § 1303.505(d). "Except in cases alleging intentional misconduct, punitive damages against an individual physician shall not exceed 200% of the compensatory damages awarded. Punitive damages, when awarded, shall not less than $100,000 unless a lower verdict amount is returned by the trier of fact."	*Pennsylvania Constitution, Art. 3, § 18, provides: "[I]n no other cases [than those involving employees] shall the General Assembly limit the amount to be recovered for injuries resulting in death, or for injuries to persons or property . . . ."* (Art. 3, § 18 is titled "Compensation laws allowed to General Assembly," which may explain the existence of a cap on punitive damages.) 40 P.S. § 1303.712(c)(2)(i) caps total liability of the Medical Professional Liability Catastrophe Loss Fund at "$500,000 for each occurrence and $1,500,000 per annual aggregate."
Rhode Island		
South Carolina		
South Dakota		§ 21-3-11. $500,000 "total general [noneconomic] damages"; "no limitation on the amount of special [economic] damages."
Tennessee		

STATE	PUNITIVE DAMAGES	NONECONOMIC DAMAGES
Texas	Civil Practice and Remedies § 41.008, as amended by 2003 Tex. Gen. Laws 204, effective 9/1/03. Greater of (1) two times the amount of economic damages plus the amount of noneconomic damages up to $750,000; or (2) $ 200,000.	Civil Practice and Remedies § 74.301 *et seq*. (2003 Tex. Gen. Laws 204), effective 9/1/03. $250,000 per claimant against a physician or health care provider and $250,000 per claimant against a health care institution. If more than one health care institution is liable, cap against them all is $500,000 per claimant. In wrongful death or survival action against a physician or health care provider, cap on total damages (including punitive damages) is $500,000 per claimant, subject to increase or decrease in accordance with consumer price index.
Utah		§ 78-14-7.1. $400,000, adjusted for inflation.
Vermont		
Virginia	§ 8.01-38.1. $350,000.	§ 8.01-581.15. $1.5 million total cap, to increase by $50,000 every July 1 from 2000 through 2006, and by $75,000 on July 1, 2007 and 2008, with no subsequent increases.
Washington	Punitive damages prohibited at common law.	
West Virginia		§ 55-7B-8 (as amended in 2003). $250,000 per occurrence, regardless of the number of plaintiffs or defendants, except cap is $500,000 if death or permanent serious injury. Annual increases based on consumer price index. Caps apply only if defendant has insurance of at least $1 million per occurrence.
Wisconsin		§§ 655.017, 893.55(4), 895.04(4). $350,000, adjusted annually to reflect changes in the consumer price index, except $500,000 in the case of a deceased minor.

STATE	PUNITIVE DAMAGES	NONECONOMIC DAMAGES
Wyoming	*Wyoming Constitution, Art. 10, § 4, provides: "No law shall be enacted limiting the*	*amount of damages to be recovered for causing the injury or death of any person."*