

“It’s the [Tort System], Stupid:”¹ Consumer Deductibles; How to More Equitably Distribute the Risks of Medical Malpractice and Adequately Compensate Victims without Statutory Damage Caps.

Luke Ledbetter²

To be conscious that you are ignorant is a great step to knowledge.

Benjamin Disraeli, *Sybil*, 1845

I.	The Advent of “Consumer Deductibles”	3
	A. <i>Introduction</i>	3
	B. <i>The Deductible Analogy</i>	4
	C. <i>Spin, Half-truths, and Outright Lies</i>	7
	D. <i>Pervasive Statutory Caps</i>	11
	E. <i>The Effectiveness of Caps in Texas</i>	16
	F. <i>Proposed Federal Caps</i>	18
II.	Over and Under Compensation in the Tort System	20
	A. <i>The Theory</i>	20
	B. <i>Instances of the Compensation Gap</i>	21
	C. <i>Reasons for the Compensation Gap</i>	26
III.	Retroactive Application of Legislative Schemes to Tort Awards	30
	A. <i>Proposal</i>	30
	B. <i>Empirics</i>	30
IV.	Criticisms of Deductibles	36
	A. <i>Financing Function</i>	36
	B. <i>Undercompensation of the Legitimate Small Non-Economic Claim</i>	37
V.	Conclusion	38

¹ Taken from a plaque in James Carville’s office in Little Rock, Arkansas

² LL.M. Candidate, The University of Cambridge. J.D. Candidate May 2006, The University of Texas School of Law. This article is the winner of the 2005 Bracewell and Guiliani outstanding Law Reform Note. The author thanks Professor Wendy Wagner, Professor Charles Silver, and Dean Bill Powers for their help with this article. This article is dedicated to my beautiful, patient, and loving wife, Shari Ledbetter

I. The Advent of ‘Consumer Deductibles’

A. *Introduction*

For years academics, the bar, and the insurance industry have been engaged in a prolific debate on the merits of tort reform and the administration of our tort system. Unfortunately, until now most have misdiagnosed the problem, and thus attempted to implement misguided solutions which often perpetuate, and sometimes even enhance, the problems which the system. Furthermore, while some of the proposed solutions are motivated by genuine concerns about the functionality of the tort system, others are the fruit of mere political gerrymandering disguised as honest solutions. This Note will use empirical evidence to show that one such misguided solution, pervasive statutory gaps on non-economic damages, fails to finely tune the corrective justice between wrongdoer and victim and instead perpetuates a compensation gap. Furthermore, I will argue that “consumer deductibles” are an administrative tool to more equitably distribute awards. While a hypothetical cap of \$250,000 on non-economic damages does nothing to curb excessive awards for small claims and drastically harms the catastrophically injured plaintiff, a hypothetical deductible of \$50,000 on all claims for non-economic damages will curb the rampant overcompensation of small claims with minimal harm to a

seriously injured claimant.³ Because most caps implemented by state legislatures focus on medical malpractice liability this Note focuses on applying the deductible method to medical malpractice, but it may be a promising solution to liability reform in a number of areas.

B. The Deductible Analogy

Consumers shopping for automobile insurance generally have two choices if they are trying to lower their premiums: they can either accept a higher deductible or a lower total amount of coverage. That is they can either accept a greater amount of the initial risk and exposure, or they can lower their total outlying exposure. A reasoned decision-maker will accept the increased deductible, because while contingency of a catastrophic event is remote, it is too great a contingency to accept. Additionally, a relatively minor increase in the deductible will have the same effect as an incrementally substantial decrease in the policy limit or “blanket” coverage.⁴ However, while the private insurance market gives consumers options as to how to bear financial risks, legislative caps forcibly remove a plaintiff’s ability to utilize the tort system as blanket coverage and

³ For instance while a \$250,000 cap would negate \$750,000 of an objectively quantified \$1,000,000 claim, a \$50,000 still awards \$950,000 of that claim. Such a shift from caps to deductibles will radically alter litigation strategies. Instead of forcing the large plaintiff into settlement discussions, it forces the small plaintiff into settlement discussions. But after all, since there are many more small claimants, the administrative savings would be exponentially larger and if there truly is rampant overcompensation at the low end, forcing such settlements is a good thing.

⁴ One can merely fill out an insurance application to illustrate this phenomenon.

insulate physicians from the risk of reimbursing any catastrophic loss they inflict. Such legislation reduces physicians overall catastrophic exposure without an equivalent increase in their deductible, thus providing an apparent windfall.⁵

One could assume that physicians also make risk allocation decisions with respect to the medical liability insurance. And legislative caps will have opposite result with respect to physicians risk analysis. However interestingly, with liability coverage, the contingencies the physician is protecting pertain to another individual. For years the medical malpractice insurance crisis has been a favorite of the legal community, largely because of its public impact, emotional anecdotes, and political implications.⁶ Most researchers have largely assumed that physicians must either purchase malpractice insurance or bear the entire burden of liability for negligently inflicted injuries. However, instead of viewing medical liability as the sole burden of the physician, all interested

⁵ Clearly, such arguments about the appropriate allocation of risk quickly devolve into ontological arguments depending on which *a priori* policy assumptions one chooses about the nature of the patient/physician relationship. For instance, the plaintiff's bar is likely to adopt a worldview in which patient's have complete autonomy, physicians must inform the plaintiff of every possible negative result, and the physician is responsible for any adverse result, regardless of fault. On the opposite extreme, physicians are likely to expect patients to accept a certain risk of the possible negative outcomes of procedures considering the greater risk of doing nothing, and to understand that unlike an automobile or machine, each human body is unique and there is no procedure which has a 100% success rate.

Perhaps a tort or "fault" system no longer adequately addresses our communal societal interests regarding healthcare. Perhaps, without addressing fault, we embrace both of the diametrically opposed goals of encouraging physicians to take risks, while at the same time wanting patients who experience negative results to receive adequate care and compensation. If this is the case, then a patient compensation fund is a more logical system than a tort system which pits our values against each other.

⁶ Lynn A. Baker & Charles Silver, *Introduction: Civil Justice Fact and Fiction*, 80 Texas L. Rev. 1537, 1537-40 (2002); David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (If Anything) Should We Do About It?* 80 Texas L. Rev. 1640, 1640-43 (2000).

parties must begin to evaluate malpractice insurance as a mechanism to distribute the risk of adverse outcomes throughout the entirety of society. That is, in order to minimize the burden on physicians and the resulting “pass through” effect of insurance premiums being borne by consumers, we need to evaluate the appropriate distribution of the risk of adverse outcomes in medical procedures. Exploring such mechanisms is especially pertinent to non-economic damages, where incidents are isolated and therefore extremely unpredictable and costly when they occur.⁷ Ultimately, the public currently bears that cost through the increased cost of physician premiums, but perhaps we should implicate “consumer deductibles” into our risk distribution scheme. Consumer deductibles would recognize that as consumers of the medical market, consumers must bear some of the risk of an adverse event.⁸ Human beings are not machines and consumers of medical procedures need to accept some risk that a procedure, through no fault of the physician, may fail.⁹ Therefore, consumers through their legislators should embrace a deductible system, whereby we all forego the right to

⁷ See generally John Rawls, A THEORY OF JUSTICE (1971) Rawls argues that if we are each behind a veil of ignorance any self-interested person wishes to spread the risk of a particularly bad outcome throughout society so as to not accept the infinitesimally minute risk of such a horrendous outcome. The economic risks of medical malpractice are largely quantifiable and most individuals have health insurance to protect them regardless of a suit for malpractice, but people are likely willing and eager to spread the risks of the life altering affects associated with non-economic damages and pain and suffering.

⁸ This is especially true considering that courts will not allow physicians to contract around liability for negligence.

⁹ Thomas Szasz, Professor of Psychiatry Emeritus at the SUNY Upstate Medical University, has suggested such a solution by introducing the idea of consumer purchased “malresult insurance.” That is, he suggests that because the juries may make an emotional rather than objective decision as to liability, that patients could be required to purchase insurance for injuries which are not bona fide malpractice, but where a sympathetic jury might find malpractice. Available at <http://www.reason.com/hod/ts011005.shtml>

sue for some initial amount of injury, while preserving our ability to provide to the most catastrophically injured and most in need of compensation. This note will argue that statutory caps on damages have pervaded our medical malpractice liability system, but that they are not the appropriate solution. All empirical evidence indicates that our tort system consistently overcompensates plaintiffs with minimal injuries, while consistently overcompensating those with catastrophic injuries.¹⁰ Therefore, the partial solution to the medical liability crisis is not caps on maximum damages, but rather a baseline deductible where no one can recover some initial amount of non-economic damages. This solution will more equitably distribute the risk of adverse events, while preserving compensation for those who are in true need.

C. *Spin, Half-truths, and Outright Lies*

Most analysis of the faults in our medical liability scheme has been spun by distorted statistics and anecdotal evidence.¹¹ Some have painted a picture where almost 1% of patients are victims of iatrogenic adverse events and that a very small

¹⁰ See *infra* Part II “Over and Undercompensation in the Tort System”

¹¹ Lynn A. Baker & Charles Silver, *Introduction: Civil Justice Fact and Fiction*, 80 Texas L. Rev. 1537, 1540 (2002) (arguing that “many interest groups gain” by various spin regarding litigation); Daniel S. Bailis & Robert J. MacCoun, *Estimating Liability Risks with the Media as Your Guide: A Content Analysis of Media Coverage of Tort Litigation*, 20 Law & Hum. Behav. 419 (1996) (arguing that the media focuses little attention on small awards or defendant verdicts); see also Stephen Daniels & Joanne Martin, *It Was the Best of Times, It Was the Worst of Times: The Precarious Nature of Plaintiffs' Practice in Texas*, 80 Texas L. Rev. 1781 (2000) (arguing that stories of multi-million dollar verdicts are by far the exception and there are a variety of pitfalls to a plaintiff’s practice in Texas).

percentage of such victims, ever file suit, much less are they fully compensated for their injuries.¹² However, this and most academic discussions have focused on the ‘underutilization’ of the tort system, which is an entirely different issue from the administration and adequacy of compensation once claims are filed. Additionally, some such studies are based by a constructive post hoc definition of what defines a preventable medical error.¹³ After all, all medical errors are preventable in hindsight.¹⁴

¹² See generally Patricia M. Danzon, *MEDICAL MALPRACTICE* (1985); Paul C. Weiler *et al.*, *A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION* (1993) (arguing that there is undercompensation and that many plaintiffs with legitimate cases do not utilize the tort system. The key failure of these studies is that an artificially high definition of what defines an iatrogenic adverse event would result in a view that negligent physician behavior is quite common. Such a study by its nature calls for a subjective definition of negligence. For instance, because medical malpractice is such a rare occurrence, if the Danzon study falsely diagnosed negligence in 1 out of every 200 procedures, the occurrence of negligence would drop to .5%. If the study falsely diagnosed 2 out of every 300 procedures, the occurrence of negligence would drop to .33%); see also Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 *Texas L. Rev.* 1595, 1609 (2002) (arguing that “only a tiny fraction of patients injured due to negligence file a claim.”); see also Charles Silver, *Does Civil Justice Cost Too Much?*, 80 *Texas L. Rev.* 2073, 2076 (2000) (arguing that “most victims of wrongful conduct do not sue.”); Other studies have purported to find rates of adverse events caused by negligence also hovering around 1%. David M. Studdert, Troyen A. Brennan & Eric J. Thomas, *Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado*, 33 *Ind. L. Rev.* 1643, 1650, 1658-59 (2000) (arguing that 27% of the 3.7% adverse event rate in a New York Study, 32.6% of the 2.9% adverse event rate in a Utah study, and 27.5% of the 2.9% adverse event rate in a Colorado study were attributed to negligence. This results in negligent adverse event rates of .99% in New York, .945% in Utah, and .798% in Colorado.).

¹³ A number of articles attempt to confirm these statistics regarding the occurrence of negligence. See Troyen A. Brennan *et al.*, *Reliability and Validity of Judgments Concerning Adverse Events Suffered by Hospitalized Patients*, 27 *Med. Care* 1148 (1989); Troyen Brennan *et al.*, *Identification of Adverse Events Occurring During Hospitalization: A Cross-Sectional Study of Litigation, Quality Assurance, and Medical Records at Two Teaching Hospitals*, 112 *Annals Internal Med.* 221 (1990); A. Russell Localio *et al.*, *Identifying Adverse Events Caused by Medical Care: Degree of Physician Agreement in a Retrospective Chart Review*, 125 *Annals Internal Med.* 457 (1996).

While there is little consensus on the rate of medical errors, some have focused more generally on reducing malpractice regardless of its rate. For instance some suggest a variety of “activities and initiatives,” including “(1) regulation (2) error reporting systems (3) information technology (4) the malpractice system and other vehicles for accountability; and (5) workforce and training issues. Many of the regulatory mechanisms focus on federal JCAHO legislation. Much of the problems with reporting is

While this section will highlight some of the bantering that occurs between the parties with respect to medical error, it is only done to illustrate that *all* parties appear to be ignoring the over and undercompensation phenomenon.¹⁵ Insurance companies blame the plaintiff's bar by using anecdotal evidence of exorbitant awards.¹⁶ Physicians blame the plaintiff's bar for forcing them to retreat into a system of defensive medicine, as well as changing specialties and locations.¹⁷ Physicians also blame the insurance

the notion that the systems have "intrinsic value in and of [themselves]." While information technology has had success, especially in "decreasing medication errors," many such systems have faces widespread "physician rebellion." There is virtually no consensus as to the issues with malpractice. Finally, with respect to training issues, most "requirements for physicians remain far less stringent than those imposed on pilots." See generally Robert M. Wachter, *End of the beginning: patient safety five years after To Err is Human*, Health Affairs Web Exclusives (Supplement), November 30, 2004, pp. 1-12, available at http://content.healthaffairs.org/cgi/search?ck=nck&andorexactfulltext=and&resourcetype=1&disp_type=&author1=Wachter&fulltext=&pubdate_year=&volume=&firstpage=

¹⁴ Many articles have refuted contentions of such high rates of malpractice. David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (If Anything) Should We Do About It?* 80 Texas L. Rev. 1640, 1643, n. 6, n. 11 (2000); see Rodney A. Hayward & Timothy P. Hofer, *Estimating Hospital Deaths Due to Medical Errors: Preventability Is in the Eye of the Reviewer*, 286 JAMA 415, 415 (2001) (arguing that most deaths from apparently preventable errors would have happened regardless of treatment); Clement J. McDonald et al., *Deaths Due to Medical Errors are Exaggerated in Institute of Medicine Report*, 284 JAMA 93, 93 (2000) (describing a flaw in a Harvard study for ignoring the baseline death risk among patients who suffered adverse events); but see Lucian L. Leape, *Institute of Medicine Medical Error Figures Are Not Exaggerated*, 284 JAMA 95, 97 (2000) (recognizing many problems with the IOM study, but arguing that it "did not exaggerate the extent of medical injury and death"); see Troyen A. Brennan, *The Institute of Medicine Report on Medical Errors - Could It Do Harm?*, 342 New Eng. J. Med. 1123 (2000) (defending the study, but recognizing that preventable adverse errors and medical errors are not the same thing.).

¹⁵ It is entirely possible that some industry groups are aware of the phenomenon, but realize that other measures such as caps will reduce costs regardless of the fairness of such measures.

¹⁶ Lynn A. Baker & Charles Silver, *Introduction: Civil Justice Fact and Fiction*, 80 Tex. L. Rev. 1537, 1540 (2002).

¹⁷ W. Kip Viscusi & Patricia Born, *Medical Malpractice Insurance in the Wake of Liability Reform*, 24 J. Leg. Stud. 463, 465 (1995) ("medical malpractice premiums led to unnecessary procedures and particularly, unnecessary tests" and "premiums led doctors to change their fields of specialization to avoid high litigation"); see also Robert Zimmerman & Joseph T. Hallinan, *As Malpractice Caps Spread, Lawyers Turn Away Some Cases*, Wall Street J., October 8, 2004, at A1, A13 (discussing a Texas surgeon who

companies for breaking down the free market for medical services and for investing premiums, leading to unpredictable rises and declines in premiums.¹⁸ Finally, the plaintiff's bar blames the apparent sea of negligent and harmful physicians in society and calls for implementation of strictly monitored automatic disclosure of all negligent injuries.¹⁹ All of these parties fail to recognize that their enemy is not each other, but rather systemic faults in the medical liability scheme. And if the system is failing, legislators should fix it, rather than becoming captive to self-serving groups who may be able to nurse their wounds by legislation without addressing inherent systematic problems. While innumerable players are involved in legislative and regulatory efforts, it does appear that the insurance industry has been able to use its behemoth size to control the direction of reform efforts towards caps and cost cutting measures. While pervasive statutory caps may reduce malpractice premiums at the expense of severely injured plaintiffs, they fail to recognize that the true drain on the system is the vast group of overcompensated insignificantly injured plaintiffs.

was forced to close his practice by high premiums, but also citing that since the passage of H.B.4 over 10 new malpractice insurers have entered the state, and citing one Dallas plaintiff's attorney's contention that H.B. 4 will reduce the number of malpractice claims in the state by 85%); see also *American Medical Association, Professional Liability Insurance: Clamoring for Relief (Apr. 24, 2002)*, available at <http://ama-assn.org/ama/pub/article/3216-6145.html> (arguing that "outrageous liability rates are driving physicians from their practices, leaving patients vulnerable and the entire field of medicine in a state of turmoil. Physicians across the country are reporting massive hikes in their medical professional liability insurance: the average increase for 2001 was fifteen percent, and it is predicted that rates could rise as much as fifty percent this year for specific specialties in some regionsTo make matters worse, several carriers are abandoning the liability insurance business, leaving many remaining physicians with no coverage.").

¹⁸ David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (If Anything) Should We Do About It?* 80 Texas L. Rev. 1640, n. 1 (2000).

¹⁹ *Id.*

D. Pervasive Statutory Caps

In the most recent effort to enact medical malpractice tort reform, the 78th Texas legislature, under the leadership of Governor Rick Perry, the Texas Legislature enacted House Bill 4.²⁰ Among other things, the bill caps non-economic damages at \$250,000 in medical malpractice cases.²¹ The stated purpose of the H.B. 4 is to end the alleged endemic lawsuit abuse which is inhibiting Texan's access to "quality affordable healthcare."²² Pundits however, argue that such legislation actually awards negligent

²⁰ Act of June 11, 2003, 78th Leg., R.S. ch. 204, 74.302, 2003 Tex. Sess. Law Serv. 847, 873. Section 74.301 states in part:

(a) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider other than a health care institution, the limit of civil liability for non-economic damages of the physician or health care provider other than a health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$ 250,000 for each claimant, regardless of the number of defendant physicians or health care providers other than a health care institution against whom the claim is asserted or the number of separate causes of action on which the claim is based.

(b) In an action on a health care liability claim where final judgment is rendered against a single health care institution, the limit of civil liability for non-economic damages inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$ 250,000 for each claimant.

(c) In an action on a health care liability claim where final judgment is rendered against more than one health care institution, the limit of civil liability for noneconomic damages for each health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$ 250,000 for each claimant and the limit of civil liability for noneconomic damages for all health care institutions, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$ 500,000 for each claimant.

²¹ *Id.* However, one should note as will be illustrated later in this note that by merely naming more healthcare providers and physicians in a suit, plaintiff's attorneys can drive this cap up to \$750,000.

²² State of Texas, Office of the Governor, *available at* <http://governor.State.tx.us/priorities/healthcare> (last visited Jan 29, 2004) (describing the five key healthcare priorities of the Governor); For

physicians at the expense of the rights of injured victims.²³ Some have even gone so far as to question the constitutionality of the bill.²⁴ Such arguments are likely to have little merit considering that the Texas Constitutional Amendment identified as Proposal 12 expressly allows for diminished recovery statutes and that federal courts have been unwilling to strike down caps,²⁵ especially when the statute is designed to reach only the non-economic portion of a plaintiff's recovery.²⁶ Furthermore, a variety of challenges based on equal protection, due process, open courts, the right to a trial by jury and other arguments have failed.²⁷ While it is a virtual certainty that statutory caps

an antagonistic analysis of the likely results of such legislation, *see* Ruben R. Reyes, *Comment: Capping Your Rights: The Texas Statute of Non-economic Damage Caps in Medical Malpractice Cases and Its Assault on the Rights of the Injured and the Power of the Courts*, 6 *Scholar* 347 (2004); Ashley Stewart, *Texas' House Bill Four's Non-economic Damage Caps Impose The Burden of Supporting The Medical Industry Solely Upon Those Most Severely Injured and Therefore Most in Need of Compensation*, 57 *SMU L. Rev.* 497 (2004); James L. Wright & M. Matthew Williams, *Remember the Alamo: The Seventh Amendment of the United States Constitution, the Doctrine of Incorporation, and State Caps on Jury Awards*, 45 *S. Tx. L. Rev.* 449, 516 (2004).

²³ *See* Reyes *supra* note 22 at 349

²⁴ *See* Reyes *supra* note 22 at 354-66 (arguing that the bill violates equal protection of the laws, the right to a trial by jury and the Texas Constitution's 'Open Courts' Provision among other things. While the arguments based on the U.S. Constitution may have some appeal, the arguments regarding the Texas Constitution do not pass Constitutional muster as the 78th legislature is explicitly authorized to regulate damages based on the constitutional amendment in H.J.R. 3 approved by the voters in September of 2003); *see* Tex. H.J.R. Res. 3, 78th Leg., R.S. (2003) (The text of H.J.R. 3 is not limited to medical malpractice claims and it is anticipated that the legislature will use the amendment to curb damages in other arenas in the future)

²⁶ *See supra*, note 24 Tex. H.J.R. Res. 3, 78th Leg., R.S. (2003).

²⁷ *See Hoffman v United States* (1985, CA9 Cal) 767 F.2d 1431 (holding a California statute limiting non-economic damages did not violate the federal equal protection clause because the limitation was part of a plan to alleviate escalating malpractice insurance premiums and therefore has a reasonable basis and a legitimate purpose since there was no suspect classification); *see also Davis v Omitowaju* 883 F.2d 1155 (1989) (rejecting arguments based on due process and equal protection because a limitation on a common law claim does not violate a fundamental right or create suspect classification); *see also Fein v. Permanente Medical Group*, 38 Cal.3d 137 (1985) (upholding statute); *but see Moore v Mobile*

are constitutional, their effectiveness in solving the medical malpractice crisis is largely unknown, mainly because physicians, academics, and the Bar cannot even agree in diagnosing the symptoms of the liability crisis, much less its origins or a cure.

Texas is not alone in its decision to cap damages in medical malpractice liability. “Since 1970, at least 30 states have enacted legislation capping the damages plaintiffs can recover in a lawsuit.”²⁸ Additionally, the federal government has also entertained thoughts of liability reform. In 1996, Congress adopted the Commonsense Legal Reform Act which capped damages in product’s liability cases; however President Clinton vetoed the bill.²⁹ State statutes pertaining to caps on medical malpractice liability have come in three waves; the mid 1970’s, the mid 1980’s, and the early 2000’s.³⁰ While it is apparent that industry and political support for such measures is cyclical, it is largely dependant on the predictability and variation in physician malpractice premiums.³¹ Furthermore, while the caps sometimes merely alter the common law damage rules with respect to medical malpractice, some caps apply

Infirmity Ass'n 592 So.2d 156 (1991) (striking down statute by refusing to identify under what type of scrutiny it should be reviewed); For a summary of the trend of statutes limited to non-economic damages being upheld see Carol A. Crocca, *Validity, Construction, and Application of State Statutory Provisions Limiting Amount of Recovery in Medical Malpractice Claims*, 26 A.L.R.5th 245 (1995).

²⁸ Linda Babcock & Greg Pogarsky, *Damage Caps and Settlement: A Behavioral Approach*, 28 J. Legal Stud. 341, 341. (1999).

²⁹ *Id* at 344.

³⁰ *Id.*

³¹ *Id.* at 345

unilaterally to all cases.³² Additionally, there is wide variation as to whether caps apply only to punitive, non-economic, exemplary, or compensatory damages of some combination thereof.³³ There is also striking variation with respect to caps limited to medical malpractice liability.³⁴ While it appears that such caps are constitutional as well as effective in reducing litigation and the net compensation of putative plaintiff's, it has yet to be seen if they are a necessary or wise aspect of our compensatory scheme.³⁵ Studies have illustrated that caps are effective at minimizing the "self serving biases" that each side has during settlement negotiations and encouraging settlement, thus

³² *Id.* at 345-346, n. 16-22. There is large variation in the legislative scheme by which caps are employed. For instance, while Georgia employs a straightforward cap of \$250,000 for punitive damages others attempt to tailor caps based on the defendant's benefit of the tortious conduct and the defendant's assets. GA. CODE ANN. 51-12-5.1(g). See KAN. STATE. ANN. 60-3071 for an example of a complicated statute.

³³ *Id.*; see ALA CODE 6-11-21 (1993) (punitive damage cap of \$250,000); N.D. CENT CODE 32-03.2-11(4) (Supp. 1994) (capping punitive damages at the greater of \$250,000 or twice compensatory damages); CAL CIV. CODE 3333.2 (Bancroft & Whitney 1995) (\$250,000 cap on non-economic damages); Idaho Code 6-1603 (1994) (inflation adjusted non-economic cap of \$400,000); W. VA. CODE 55-7B-8 (1994) (\$1,000,000 non-economic cap); VA. CODE ANN. 8.01-581.15 (Michie 1984) (\$350,000 punitive damage cap); CONN. GEN. STATE. ANN. 52-240b (West 1989) (limiting punitive damages in product's liability cases to twice actual damages); N.C. GEN. STAT. 1 D-25 (1995) (limiting punitive damages to the greater of three times compensatory damages or \$250,000).

³⁴ *Id.* at 345, n. 22; see COLO. REV. STAT. 13-64-302 (1994) (cap of \$1,000,000 per patient in a medical malpractice action against a hospital or physician); MD. CODE ANN., CTS. & JUD. PROC. 11—108 (1991) (\$350,000 limit on non economic damages in a medical malpractice claim).

³⁵ *Id.* at 362-63; Some have suggested that tort reform in the medical malpractice arena is not only unwise, but entirely unnecessary considering the extreme selectivity with which lawyers approach such cases. Stephen Daniels and Joane Martin, *It Was the Best of Times, It Was the Worst of Times: The Precarious Nature of a Plaintiff's Practice in Texas*, 80 Texas L. Rev. 1781, 1798 (2002) (arguing that "[m]edical malpractice cases are expensive and risky" and that since you can "easily spend \$100,000 without blinking" lawyers "screen cases very carefully and take only a small number of the cases that come to them.").

reducing litigation costs.³⁶ However, the windfalls out of such settlements largely favor defendants because of the plaintiff's worse negotiating position due to their inability to risk a negative jury verdict. Additionally, it has been shown that caps substantially reduce the value of settlements.³⁷ Additionally, caps have been shown to reduce the loss ratios of insurers.³⁸ Regardless of wisdom of caps on damages, it is clear that they "will achieve the objective of cost reduction."³⁹ But at what cost?⁴⁰ And, to whom?

³⁶ *Id.* Three experiments conducted in Chicago in 1999 using test subjects showed that when aware of a \$250,000 cap on non-economic damages, 73% of cases settled, whereas in an uncapped scenario only 57% of cases settled.

³⁷ *Id.* Additionally, while the mean settlement in the capped scenario was \$182,098 the mean settlement in uncapped scenario's was \$490,129. Later, I will discuss the impact of caps in Texas by applying the current cap under H.B. 4 to prior settlements. While I reduce settlements above \$250,000 to \$250,000, this study suggests that the settlements may be even lower than my post hoc analysis reveals, due the emotional impact of the caps serving as an anchor by which caps are decreased rather than awarding the entire sum.

³⁸ W. Kip Viscusi & Patricia Born, *Medical Malpractice Insurance in the Wake of Liability Reform*, 24 J. Leg. Stud. 463, at Table 1 (1995) (finding that from 1984 to 1991 medical malpractice loss ratio's in Michigan dropped from an average of 1.428 to .723 based on statutory caps). For those unfamiliar with the concept of a loss ratio it is based off every dollar in premiums that the insurer writes. With a loss ratio of .723 an insurer has spent 72.3 cents in claims and must pay expenses and turn a profit with the remaining 27.7 cents. Thus, one can see the problem of a loss ratio of 1.428; the insurer has lost 42.8 cents on the dollar before even paying administrative costs.

³⁹ *Id.* at 463; *but see id.* (arguing that "caps on non-economic damages have not had the dramatic impact that supporters think" and noting that "juries may find other other ways to adjust the components of the ward so the effect on malpractice costs will not be substantial"); *see also* Robert Zimmerman & Joseph T. Hallinan, *As Malpractice Caps Spread, Lawyers Turn Away Some Cases*, Wall Street J., October 8, 2004, at A1, A13 (arguing that caps are not only effective in limiting rewards, but also have an adverse impact on the cases certain contingency fee attorneys are willing to accept. Citing a wrongful death claim of a homemaker who died of a cerebral aneurysm whose husband could not get representation for a number of reasons: as a homemaker almost all of her claims were non-economic and thus barred by the Texas cap, the case would likely cost over \$100,000 to prepare for trial and the economics did not make sense for a plaintiff's attorney with a cap on damages of \$250,000, and because insurance covered most of her medical bills much of the claims were covered by the collateral source rule. Also citing the California 1975 Medical Injury Compensation Reform act which has been exceedingly effective by reducing overall liability of defendants by 30%, reducing the median reward for non-economic damages by \$366,000, and reducing claims relating to infants by 71% or \$1.5 million.

E. *The Effectiveness of Caps in Texas*

As of yet, there is very little evidence that H.B. 4 has played a substantial role in reducing physician's medical malpractice premiums in Texas. Nonetheless, a number of carriers have returned to the state. Since the passage of H.B. 4, at least ten carriers have returned to the state. As the Table below illustrates there has only been a 3.2% overall decrease in premiums.⁴¹

⁴⁰ *Id.* at 464-65 (arguing that “a rigid damages cap of, for example, \$ 250,000 on non-economic damages will continue to permit possibly excessive jury awards for insignificant injuries, such as temporary poisonings, while at the same time limiting awards to more deserving victims, such as the catastrophically injured, who may suffer from brain damage or paraplegia,” and “ultimately medical malpractice insurance costs will primarily be borne by patients.”). Furthermore, because insurance companies are exempt from many anti-trust violations under § 2(b) of the McCarran-Ferguson Act (Act), many physicians have argued that instead of lowering premiums “liability reforms affect the profitability of insurance.” *Id.* at 465. See also <http://doctorsknowus.blogspot.com/>, a physician-based internet blog making this argument.

⁴¹ Chart on file with author. See email from Ana Rodriguez at the Texas Department of Insurance, sent January 25, 2005.

Company Name	Reported 2003 Physician Premium (in millions)	2003 Premium Weight	Cumulative Physician Change From Sept. 2003
Texas Medical Liability Trust	189.6	37.3%	-16.4%
The Medical Protective	134.0	26.4%	10.0%
Texas Medical Liability Ins. Underwriting Association (TxJUA)	57.7	11.4%	0.0%
American Physicians Insurance Exchange	53.8	10.6%	0.0%
Everest National Insurance Company	32.2	6.3%	0.0%
The Doctors Company, An Interinsurance Exchange	14.9	2.9%	0.6%
Anesthesiologists' Professional Assurance Company	8.0	1.6%	0.0%
Preferred Professional Insurance Company	7.3	1.4%	0.0%
The Medical Assurance Company	5.1	1.0%	34.4%
Nation Union Fire Insurance Company of Pittsburg, PA	2.3	0.5%	0.0%
Texas Medical Insurance Company	1.5	0.3%	-12.0%
Continental Casualty Company	0.8	0.2%	-11.5%
Texas Hospital Insurance Exchange	0.6	0.1%	0.0%
Total All Companies Listed	507.8	100.0%	-3.2%

This table illustrates that there has been little consensus that H.B. 4 has driven down premiums. Instead, changes in rates have been rather sporadic. While The Medical Assurance Company increased its rates by 34.4%, Texas Medical Insurance Company and Continental Casualty reduced their rates by 12% and 11.5% respectively.

Additionally, the Commissioner of insurance disapproved the requested 19% rate increase of a carrier. This company then moved its insureds into a purchasing group which is not subject to review by the Commissioner and implemented a 10% increase. In July of 2004, the Commissioner brought an action against them in the State Office of Administrative Hearings on both the 10% and 19% increases. Finally, in October of 2004 the Texas Medical Liability Trust (TMLT) filed for a 5% reduction in rates, effective as of 2005. While it appears to early to come to a consensus regarding the rates of malpractice liability insurance in light of H.B. 4, there is positive news that more carriers are entering the market.

F. Proposed Federal Caps

In addition to pervasive state caps, the federal government has considered taking legislative action to implement caps. In January of 2003, President Bush outlined a plan very similar to H.B. 4: “For the sake of affordable and accessible health care in America, we must have a limit on what they call non-economic damages -- I propose a cap of \$250,000.”⁴² He further commented, “excessive jury awards will continue to drive up insurance costs, will put good doctors out of business, will run them out of your community and will hurt communities... . That's a fact.” Additionally, Congress has considered implementing nationwide. Most of the legislation that the House Committee

⁴² Available at <http://www.cnn.com/2003/ALLPOLITICS/01/16/bush.malpractice/>

on Commerce has focused on the \$250,000 model.⁴³ The lack of such legislation may have an adverse affect on the potential benefits of state caps. In other words, without Congressional legislation plaintiff's may file suit against out of state defendants, such as parent companies of hospitals in order to gain federal jurisdiction based on diversity. Shortly after President Bush's 2003 State of the Union address, the a caps bill was introduced into the 78th Congress.⁴⁴ The bill was officially titled "To Improve Patient Access to Health Care Services and Provide Improved Medical Care by Reducing the Excessive Burden the Liability System Places on the Health Care Delivery System." In March of 2003 the House of Representatives by a vote of 229 to 196 to pass H.R. 5.⁴⁵ Shortly after the passage of the House Bill, Senator Ensign introduced S. 11 which closely tracked H.R. 5. However, on On July 9, 2003 the bill was killed by filibuster.⁴⁶ However, it is almost certain that under the leadership of President Bush, further attempts at federal legislation will occur.

⁴³ Available at <http://www.consumerwatchdog.org/healthcare/nw/nw003186.php3>

⁴⁴ H.R. 5, 108th Cong. (2003), available at <http://www.congress.gov/cgi-bin/bdquery/z?d108:HR00005:@@L&summ2=m>

⁴⁵ *Id.*

⁴⁶ See generally, Adam D. Glassman, *The Imposition of Federal Caps in Medical Malpractice Liability Actions: Will They Cure the Current Crisis in Health Care?* 37 Akron L. Rev. 417 (2004) for a fuller discussion of the legislative history.

II. Over and Under Compensation in the Tort System

A. *The Theory*

In 1992, Michael J. Saks argued that any tort scheme must be judged not only on its theory or the policies behind the system, but by its practical realities.⁴⁷ Whether legislators implement a market based, regulatory and administrative, or a no-fault scheme for tort liability, such decisions must be made with regard to the purported purposes of the tort system: deterrence and compensation.⁴⁸ Saks chose to attack the inherent flaws in the compensatory scheme of our tort system, but unfortunately legislators across the country have chosen to ignore his advice with respect to medical malpractice liability.⁴⁹ While non-economic caps appeal to some segments of the public

⁴⁷ Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System - And Why Not?*, 140 U. Pa. L. Rev. 1147, 1150, n4 (1992). See also Karl N. Llewellyn, *Some Realism about Realism- Responding to Dean Pound*, 33 Harv. L. Rev. 1222, 1235-37 (1931) (noting that realists believe in “[a]n insistence on evaluation of any part of the law in terms of its effects.”).

⁴⁸ *Id.*

⁴⁹ See e.g. Nancy K. Bannon, *AMA TORT REFORM COMPENDIUM* 70-78 (1989) (noting that over 26 state legislatures have implemented caps on malpractice liability. Most of these statutes have no mechanism to adjust for inflation, nor do they make exceptions for unusually egregious conduct or gross negligence).

and are lauded by the industry, they fly in the face of everything we know about how our tort system works.⁵⁰ Cap based tort reform is like stitching up a highly visible but innocuous scrape on a patients' face while allowing a cancer to multiply and spread through the patient's whole body.⁵¹ Sak's article shows that if there is a problem with compensation in our tort system it lies in overcompensating small claims while continually undercompensating large claims.⁵² If this is true, it would make more sense for legislators to enact a mechanism by which smaller claims are reduced and therefore more equitable, than to implement caps which would tend to increase the inequities in compensation by reducing the non-economic damages of larger plaintiffs. Such overcompensation of smaller claims and undercompensation of larger claims has been seen in a number of areas and should be anticipated by a number of psychological phenomena and the realities of the courtroom.⁵³

B. Instances of the Compensation Gap

⁵⁰ See generally Saks *supra* note 35.

⁵¹ Some might argue that the scrape does not even exist, or at least that it is manufactured by the industry as a guise to decrease defendant liability.

⁵² *Id.* at 1216-23.

⁵³ *Id.*

Inadequate compensation for high end economic loss has been illustrated in the final outcomes of settlements and jury awards in aviation accidents.⁵⁴ Because there is a virtual presumption of negligence and most victims die in such cases, liability is rarely disputed and losses are simplified.⁵⁵ The Rand study which calculated full economic loss and then compared it to actual compensation found that aviation accident compensation comports with the over and under compensation theory.⁵⁶ While the aircraft study only addressed economic loss, and ignored non-economic loss because of the inherent subjectivity in its calculation, it nonetheless illustrates the compensation gap. Additionally, because of the difficulty of quantifying non-economic damages the over and undercompensation in such damages is likely even greater.

⁵⁴ *Id.*

⁵⁵ *Id.* The rapid nature of death in aviation cases has caused courts to be unwilling to impose traditional pain and suffering damages. Some have allowed minimal awards for the infliction of emotional distress associated with the fear of being in a crashing airplane.

⁵⁶ *Id.*; James S. Kakalik et al., COSTS AND COMPENSATION PAID IN AVIATION ACCIDENT LITIGATION 86-95 (1988); Elizabeth M. King & James P. Smith, COMPUTING ECONOMIC LOSS IN CASES OF WRONGFUL Death (1988); Elizabeth M. King & James P. Smith, ECONOMIC LOSS AND COMPENSATION IN AVIATION ACCIDENTS 100-04 (1988). Unlike medical malpractice where physicians usually quibble with how an iatrogenic event is defined or how to adequately estimate non-economic loss, the Rand study defined economic loss as the “present value of the decedent’s before-tax market earnings and non-market services.” Thus, while future earning potential does require some estimation it is a far more undisputable number than intangibles such as pain and suffering or loss of consortium.

TABLE I: Compensation and Litigation Expenditures In Relation to Economic Loss to Survivors (In Aircraft Accident Cases)⁵⁷			
Economic Loss to Survivors (in 000's)	Number of Cases	Mean Compensation per Death	Compensation as a Percentage of Economic Loss
0-99	519	148,160	296
100-249	376	192,620	110
250-499	267	255,049	68
500-749	144	362,334	58
750-999	126	468,449	54
1000-1499	177	585,598	47
1500-1999	109	822,395	47
2000 plus	265	876,098	39

As Table I illustrates, in the case of small claims the mean compensation is \$148,160 as compared with an actual mean economic loss of \$50,000. This creates on average 296% of actual economic loss as compensation. Thus, the smaller claimants are being vastly overcompensated. However, with regards to plaintiffs with economic claims of greater than \$2,000,000 their actual compensation was on average \$876,098. This illustrates the vast undercompensation of larger claims, and results in an average of 39% of economic loss in actual compensation. One might argue that in order to resolve these inequities courts or legislatures should step in and reduce compensation for small

⁵⁷ This table is from Michael J. Saks, *Do We Really Know Anything About the Behavior of the Tort Litigation System -- And Why Not?*, 140 U. Pa. L. Rev. 1147, 1217 and is based on data from Kakalik et. al. *supra* note 56, at 58 tbl. 4.7.

claims and using those funds to adequately compensation the large claims. However, this will not work because the net overcompensation of smaller claims is minute as compared with the net undercompensation of the large claims. For instance, while the net undercompensation of economic claims over \$2,000,000 was \$364,000,000 in a mere 265 cases, the net overcompensation in 519 cases of claims of under \$100,000 was just slightly over \$5,000,000. This illustrates that basic point that in order to adequately redistribute compensation equitably between large and small claims there would need to be almost 140 times as many of the smaller claims, which there are not.⁵⁸ Therefore, redistribution of compensation is not a viable solution to the compensation gap.

A number of studies have also illustrated the over and undercompensation phenomenon with regard to automobile accidents, though to a lesser extent.⁵⁹ One such study argues that in regards to smaller claimants some received up to \$3.20 of non-economic compensation for every dollar of economic loss.⁶⁰ Furthermore, a study by Alfred Conrad illustrates the “small loss overcompensation, large loss

⁵⁸ (\$364,000,000/ 265= \$1,373,585 average undercompensation); (\$5,000,000/ 519 = average overcompensation of \$9634); (\$1,373,585/ \$9634 = 142.57 times more small claims needed in the system to adequately redistribute the compensation gap), (519/216= 2.4 times more small claims there are in the system) Thus, the gap could not be filled by mere redistribution.

⁵⁹ See *supra* note 57 Saks at 1220; James K. Hammit, AUTOMOBILE ACCIDENT COMPENSATION: PAYMENTS BY AUTO INSURERS 45-46 (1985); Alfred F. Conard et. al., AUTOMOBILE ACCIDENT COSTS AND PAYMENTS: STUDIES IN THE ECONOMICS OF INJURY REPARATION 248-52 (1964).

⁶⁰ See *supra* note 57, Saks at n. 253, 1222; James K. Hammit, AUTOMOBILE ACCIDENT COMPENSATION: PAYMENTS BY AUTO INSURERS 45 (1985).

undercompensation” phenomenon with regard to automobile accidents.⁶¹ However, the compensation gap was not as great as the Hammit Study.

Additionally, it has been argued that the tort system, as applied to torts akin to those which the worker’s compensation system addresses results in systematic overcompensation.⁶² This would comport with the over and under compensation model, since most worker’s compensation claims are small claims composed of lost wages and moderate healthcare costs.⁶³ One author has argued that because of this overcompensation, an administrative worker’s compensation system, while it may actually undercompensate, will adequately deter potential tortfeasors because of the associated burden of complying with state regulations.⁶⁴ That is, while actual individual claims may be undercompensated, once the regulatory and administrative costs of a claim are added in, a level of adequate deterrence may exist.⁶⁵

Surprisingly, the compensation gap stays the same regardless of whether a case is tried or settled.⁶⁶

⁶¹ Alfred F. Conard et. al., AUTOMOBILE ACCIDENT COSTS AND PAYMENTS: STUDIES IN THE ECONOMICS OF INJURY REPARATION 248-52 (1964) (finding the over and undercompensation model, but to a more limited extent than the Hammit study).

⁶² Theodore F. Haas, *On Reintegrating Workers’ Compensation and Employers’ Liability*, 21 Ga. L. Rev. 843, 857 (1989).

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ Therefore the burdens of an administrative system may adequately deter while at the same time undercompensating plaintiffs because of the “wasted” expenses of complying with the scheme.

⁶⁶ See *supra* note 56 Saks at 1220.

In Rand's 1985 study of auto crash cases, 2% of the cases went to trial. The average awards for these cases were approximately equal to those for comparable settled cases. Similarly, King and Smith found those air crash cases that went to trial resulted in an average recovery of 44% of the actual loss, compared to 48% in cases settled without a lawsuit and 50% in cases settled following the filing of a suit.⁶⁷

However, while there is a consistency in either the trial or settlement amount of the economic claims address in the aircraft and automotive cases, one would expect for the aggregate of non-economic claims in trials and settlements to be equal while allowing for huge disparities in individual cases.

C. *Reasons for the Compensation Gap*

In addition to the tort systems ability to overcompensate some plaintiffs and undercompensate other plaintiffs, academics have had difficulty analyzing the “false positives” and “false negatives” with respect to compensation. Certainly, some victims who have quantifiable injuries never filed suit or filed suit and wrongly been the victim of defendant verdict, resulting in the most extreme examples of undercompensation.⁶⁸ On

⁶⁷ See *supra* note 56 Saks at 1220.

⁶⁸ Yxta M. Murray, *Employer Liability After Johnson Controls: A No-Fault Solution*, 45 Stan. L. Rev. 453, 474, n. 128; see also Stephan D. Sugarman, *Doing Away with Tort Law*, 73 Cal. L. Rev. 555, 594 (1985) (noting that “the tort system leaves a large proportion of seriously hurt victims uncompensated or substantially undercompensated.”). Interestingly, Professor Wendy Wagner illustrates instances where judicial decisions limit liability in cases of an “informationally advantaged plaintiff.” Similarly, a legislative

the other hand, there must be some ‘victims’ who have not actually suffered an injury due to negligence and nonetheless either receive a settlement or jury award. Surely, these represent the greatest instances of overcompensation.⁶⁹ Under the current tort system smaller claimants are more able to inflict more disproportionate costs on defendants than are larger plaintiffs because there is a minimum critical cost of entering the tort system. Therefore, a small claimant can ask for a relatively absurd settlement and have the defendant accept such a settlement. For instance, if an objective evaluation of a claim is \$50,000, a plaintiff can offer to settle for 200% of the value (\$100,000) and such a settlement will often be accepted because of the costs of proceeding to trial. However, in a much larger claim, the plaintiff who has an objectively valued claim of \$1,000,000 is likely to be laughed at when asking for 200% (\$2,000,000) as a settlement.

Nonetheless, most academics argue that the nature of the tort system itself results in many more false negatives than false positives. That is, in more cases there is an extreme absence of compensation, rather than an abundance of undeserved rewards. Some have argued that the tort systems barriers to entry result in vast undercompensation. While some victims may have minimal injuries and be unable to

body could decide to implement a deductible system with respect to non-economic damages in relation to what I call the “administratively advantaged plaintiff.” Wendy E. Wagner, *What’s It All About, Cardozo?*, 80 Texas L. Rev. 1577, 1585, n. 32 (2002); see also Robert G. Bone, *Modeling Frivolous Lawsuits*, 145 U. Pa. L. Rev. 519, 542 (1997) (using the similar term of “informed plaintiff” to describe the case when “the plaintiff knows his suit is frivolous, but ... the defendant does not.”).

⁶⁹ *Id.*; See also Robert E. Keeton & Jeffrey O’Connell, *Basic Protection for the Traffic Victim* (1965) (summarizing studies involving tort laws tendency to undercompensate).

file suit, others will be unable to retain representation from contingency fee attorneys who only accept the best cases.⁷⁰ These tendencies would be consistent with the over and undercompensation phenomenon because a contingency fee attorney is only likely to accept a small claim that has some extrinsic emotional appeal that will result in a larger award, which would justify accepting the case. Similarly, plaintiff's attorneys may be inclined to accept large, but frivolous claims merely because of the small potential for a huge payout. Of course, the initial element in both small and large claims is the cost to "work up" the case regardless of the potential payout.

Many reasons have been proposed as to why the system over and undercompensates certain claims. One such theory suggests that people are good at calculating linear equations, but poor at accounting for exponential increases.⁷¹ Therefore, while liberal estimates of damages in small cases may overcompensate, mere factoring instead of exponential increases in those damages would result in undercompensation at the high end.⁷² Additionally, one commentator has justified the phenomenon with "popular views of social justice."⁷³ While jurors may feel that no life is "worth less than some amount," regardless of what the present value of future earnings

⁷⁰ *Id.*

⁷¹ See Saks, *supra* note 56 at 1218, n. 244; see also Michael J. Saks & Robert F. Kidd, *Human Information Processing and Adjudication; Trial by Heuristics*, 15 *Law & Soc'y Rev.* 123, 140-42 (arguing that intuitive decision-makers make estimates by starting with an "anchor" and then adjusting upward or downward on a variety of factors.).

⁷² *Id.*

⁷³ *Id.*

potential imply, resulting in the overcompensation of some plaintiffs, they may also feel that no life is worth more than a certain amount, resulting in extreme undercompensation of the high end claimant.⁷⁴

Finally, one of the pitfalls of a well functioning tort system is that it *should* result in undercompensation of high end injuries in the pre-trial phase.⁷⁵ That is, at some point before trial every settlement offer approaches a point at which it would be more costly for a plaintiff to try the case than to accept the offer.⁷⁶ The tort system will also inevitably result in the overcompensation of some small claims. No matter how certain a defendant is that a claim is only worth some amount at trial, that defendant will, at times be willing to pay a higher amount before trial to avoid litigation costs and the slight, but unacceptable, risk that an emotional appeal at trial will result in an exorbitant award.

⁷⁴ *Id.*

⁷⁵ *Id.* at 1221.

⁷⁶ *Id.*

III. Retroactive Application of Legislative Schemes to Tort Awards

A. *Proposal*

If the over and undercompensation model is correct, and all empirical evidence we have suggests it is, then statutory caps need to be replaced by deductibles for non-economic damages. While caps do result in lower liability, thus creating lower premiums and cheaper consumer access to healthcare, they do so at the expense of those most in need. Additionally, caps do nothing to address the windfall received by those smaller claimants who force high settlements knowing that defendants will suffer the costs of prolonged litigation.⁷⁷ Empirical evidence from the Texas Department of Insurance will show that deductibles will accomplish the goals of lower premiums, cheaper consumer access to healthcare, protection of those most in need, and the curbing of windfalls.

B. *Empirics*

The Texas Department of Insurance requires all insurers in the state to compile information regarding the final settlement in all liability claims.⁷⁸ One cross section of

⁷⁷ Hypothetically, jurors may begin to use caps as a judgment of ‘severity.’ For example, not necessarily all claims that received above \$250,000 before the caps will continue to receive that amount. Perhaps jurors will instead begin to “weigh and grade” such that they will only award \$250,000 to a claim formerly valued in the millions, and a claim formerly valued at \$250,000 less than that because it is not as severe as the claim for millions. Of course, there is no objective evidence indicating such a trend.

⁷⁸ Available at <http://www.tdi.state.tx.us/general/forms/tdirpts.html>.

these claims is medical malpractice liability. These claims are classified by the “business class” of the liability insurance, and I have included the five categories of physicians and surgeons, dentists, oral surgeons, hospitals, and nursing homes to compile a comprehensive analysis of the cross section of medical malpractice liability. For the years of 1998-2002 I have then looked at the total damages and the non-economic damages. Additionally, I have retroactively in a static fashion applied the statutory caps of H.B. 4 to show the net result in limitations on liability, and have then constructed a model whereby there is not cap, but instead a non-recoverable initial deductible of \$50,000 for the plaintiff, per defendant sued. Finally, because plaintiff’s attorneys are likely to change their suit behavior due the implementation of H.B. 4 I have included a more accurate and dynamic assessment of the predicted savings of H.B. 4. Because the \$250,000 cap on non-economic damages jumps to \$750,000 when the plaintiff sues multiple healthcare providers and defendants, this model accounts for the likelihood that strategic plaintiffs will virtually always sue a number of parties under H.B. 4

Sum of Non-Economic Damages Upon Settlement or Final Trial Verdict in All Texas Medical Malpractice Claims Closed From 1998-2002 (Source data from Tx. Dept. Ins. Closed claim data, and computed by the author. Data available at <http://www.tdi.state.tx.us/general/forms/tdirpts.html>. Compilation matrixes on file with author.)

Table II	Non-Economic	Non-Economic Damages if H.B. 4 (\$250,000 cap) was in place	Non-Economic Damages with a "\$50,000 Plaintiff Deductible" for Each Defendant Sued	Non-Economic Damages if Dynamic Plaintiff Reaction (\$750,000 cap by suing more parties) was in place	% of Actual Non-Economic Damages once H.B. 4 is Applied	% of Actual Non-Economic Damages once the "\$50,000 Deductible Plan" is applied	% of Actual Non-Economic Damages once Dynamic Plaintiff Reaction H.B. 4 is applied.
1,998	109,254,148	44,209,551	82,610,462	69,009,648	40%	76%	63%
1,999	154,570,787	53,604,888	121,712,312	93,867,672	35%	79%	61%
2,000	165,245,039	50,665,850	136,015,716	90,356,538	31%	82%	55%
2,001	128,449,742	48,152,029	96,783,846	85,541,279	37%	75%	67%
2,002	126,757,503	43,604,352	99,948,908	76,988,518	34%	79%	61%
Sum	684,277,219	240,236,670	537,071,244	415,763,655	35%	78%	61%
5 Year Average	136,855,444	48,047,334	107,414,249	83,152,731	35%	78%	61%

Table's II clearly illustrate that it is virtually impossible to account for the savings which a statutory cap on damages provides by the mere implementation of a reasonable deductible system. This is largely because it requires twenty cases where a \$50,000 deductible is applied to account for one case where an award is reduced by \$1

million. Because there are overall a relatively small number of malpractice cases each year, it is difficult to spread the savings of a few multi-million dollar verdicts over the rest of the smaller claims. With a pure retroactive application of H.B. 4 to all the cases over the last 5 years, non-economic awards shrink from \$136,855,444 to a mere \$48,047,334.⁷⁹ This retroactive application would have drastically diminished rewards by 283%, leaving a mere 35% of non-economic damages rewarded. Unfortunately, a reasonable \$50,000 deductible, which would better comport with the empirical theory of overcompensation of small claimants and undercompensation of large claims, could not accomplish such drastic cuts in awards. Instead, retroactive application of this model would only result in an average yearly reduction from \$136,855,444 to \$107,414,249, which leaves just over 78% of non-economic damages in tact. In reality however, straight application of H.B. 4 is not an accurate prediction of the behavior of plaintiff's attorneys after the statute comes into effect. Because the statute allows for an increase in non-economic damages up to \$750,000 for additional healthcare providers and physicians sued almost all plaintiffs are likely to utilize this strategy. Therefore Table II also illustrates the effect of H.B. 4 when plaintiffs dynamically strategize around the legislation. Such a model reflects diminished non-economic damages from \$136,855,444 to \$83,152,731 on average per year.⁸⁰ This model shows average yearly

⁷⁹ This information is also on file with the author. I have retroactively applied the H.B. 4 cap to each medical malpractice claim for the last 5 years.

⁸⁰ Perhaps it is slightly unfair to assume that the plaintiff's bar will sue at least three parties in *every* case, but certainly it will react to any loophole in the legislation with vigilance.

non-economic damages at 61% of that in the pre-H.B. 4 world. Even this model is more substantial than the deductible model, 78% to 61% of damages remaining, but other unquantifiable dynamics suggest that H.B. 4 will not be as successful as its statutory intent. For instance, if contingency fee attorneys can find a technique to consistently be awarded the statutory maximum of \$750,000, they may be inclined to bring more cases and run them through the system in an efficient manner, at least forcing settlement. While the deductible system may not fully account for the savings in non-economic damages that a strict cap provides, it does provide part of a more equitable solution. Additionally, while a statutory cap is likely to incite the aggression of the plaintiff's bar, a deductible system more adequately addresses the empirical evidence regarding over and undercompensation, while distributing risk through society.

The analysis from the basis of an average claim for non-economic damages, as seen in Table III, illustrates a similar story of equitable distribution of risk through deductibles.

Table III	Average Non-Economic Damages Upon Settlement or Final Trial Verdict in All Texas Medical Malpractice Claims Closed From 1998-2002 (Source data from Tx. Dept. Ins. Closed claim data, and computed by the author. Data available at http://www.tdi.state.tx.us/general/forms/tdirpts.html . Compilation matrix's on file with author.)			
	Non-Economic Damages	Non-Economic Damages if H.B. 4 (\$250,000 cap) was in place	Non-Economic Damages with a "\$50,000 Plaintiff Deductible" for Each Defendant Sued	Non-Economic Damages if Dynamic Plaintiff Reaction (\$750,000 cap by suing more parties) was in place
1,998	322,284	130,412	243,689	203,568
1,999	413,291	143,329	325,434	250,983
2,000	476,210	146,011	391,976	260,393
2,001	402,664	150,947	303,398	268,154
2,001	408,895	140,659	322,416	248,350
Average Claim	404,669	142,271	317,382	246,290

While the retroactive H.B. 4 model diminished average non-economic damages from \$404, 669 to \$142,271, the deductible plan on the other hand preserves 78% or \$317,382 of non-economic damages. Additionally, once we turn from static application of H.B. 4 towards a dynamic reactionary model of H.B. 4, non-economic damages rise to \$246,290. Thus, on average the deductible model and the dynamic model are only different by the relatively small amount of \$71,000. One possible solution to this

discrepancy is to raise the deductible above \$50,000, but this may corrode public support as well as begin to impinge upon the compensation of the more catastrophically injured claimants.

Other possibilities could include an increased deductible based on a contract model, whereby a plaintiff could purchase insurance for the increased deductible. Or perhaps the deductible system could be combined with a very high cap on non-economic damages and a publicly funded catastrophically injured patient compensation fund to adequately compensate the most severely injured.

IV. Criticisms of Deductibles

A. *Financing Function*

The plaintiff's bar is likely to argue that non-economic damages serve as a financing function for litigation because of their contingent fee structure, but in reality pervasive caps are more likely to harm plaintiff's attorneys than deductibles. While caps encourage attorneys to only accept smaller "bread and butter" cases unless there are huge economic damages, deductibles would allow plaintiffs attorneys to focus on the larger high stakes cases. Because high stakes medical malpractice cases are expensive to prepare, are unwilling to bring such suits when there is a maximum reward. For instance, If a suit is worth \$200,000 in actual damages, \$1,000,000 in non-economic damages, and is going to cost \$150,000 to prepare a cap of \$250,000 on non-economic damages is going to result in a total reward of \$450,000. Thus a

contingency fee of 1/3 leaves the attorney uncompensated. However, in the same scenario with a \$50,000 non-economic deductible instead, the client will receive \$1,150,000, of which 383,000 will be left for the attorney. Surely, \$233,000 is sufficient compensation after the costs of preparation are taken out.

B. Undercompensation of the Legitimate Small Non-Economic Claim

If the public is seriously concerned about the potential loss of the first \$50,000 of a non-economic damages claim, surely a market will arise for companies to insure the deductible. Furthermore, a legislature could split the deductible liability between the physician and the consumer. For instance, they could create a scenario which mandates a \$25,000 deductible on physician liability insurance and have the physicians absorb the first \$25,000 of the deductible. Interestingly, such a scenario would also have other benefits. It would create incentives for physicians to avoid malpractice, since many argue that insurance takes away such incentives. Furthermore, it would limit the consumer's exposure and would hit "repeat offender physicians" with the greatest liability. Finally, perhaps as our medical system becomes truly market based, some physicians would adopt the cost of insuring the deductible as a value add for their services.

V. Conclusion

Regardless of their Constitutionality, statutory caps on non-economic damages do not comport with everything we know about our functioning tort system. Because the most injured, and thus those most seriously in need are already undercompensated, legislators should find other mechanisms to achieve societal goals of reduced damages and healthcare costs. The creation of a deductible on non-economic damages is a partial solution to this problem. It will discourage the bringing of smaller claims which are already overcompensated and place an administrative burden on the tort system.

We should look beyond and reliance on medical malpractice liability insurance in addressing the issues of medical malpractice and instead view the entire tort system as a dynamic part of that insurance system. While physicians may initially pay for high cost premiums, consumers will ultimately bear the brunt of the burden and by lowering premiums a deductible on malpractice claims will more equitably distribute the risk of injury, while preserving recourse for the severely injured.