March, 2004

It's the Economy (and Combined Ratio) Stupid: Examining the Medical Malpractice Litigation "Crisis" Myth and the Factors Critical to Reform

Mitchell J Nathanson

IT'S THE ECONOMY (AND COMBINED RATIO), STUPID: EXAMINING THE MEDICAL MALPRACTICE LITIGATION CRISIS MYTH AND THE FACTORS CRITICAL TO REFORM

By

Mitchell J. Nathanson*

I. Introduction

Certainly, it is difficult to frown upon the nobility of one who undertakes to reform a perceived crisis. And even if we, who stand back on the sidelines, disagree with the proposed course of reform, we are nevertheless often relieved that at least something is being done. Because after all, something is better than nothing, is it not? Unfortunately, as it pertains to the much publicized medical malpractice crisis, it is often far worse, with the result being that minor crises are transformed into major ones and major ones are transformed into crises of catastrophic social and economic potential.

Since the first perceived malpractice crisis of the 1970's, legislatures from all 50 states have taken various steps intended to reduce the costs associated with medical malpractice litigation as a means to increase the availability of reasonably-priced health care services for their citizens.[1] Unfortunately, however noble their intentions and despite the wide variety of approaches taken by these legislatures over the past 30 years, these efforts have one thing in common: they all, to a large degree, failed, as is indicated

---

* Assistant Professor of Legal Writing, Villanova University School of Law. Before coming to Villanova, Professor Nathanson was a litigator in the Healthcare Group of White and Williams in Philadelphia, PA and an Insurance Coverage Specialist with ACE USA (formerly CIGNA Property and Casualty Companies). He would like to thank Margaret Maucher for her invaluable research assistance and Dean Diane Edelman for her thoughtful comments on an earlier draft of this article.

[1] *See* Insurance Information Institute, *Hot Topics and Insurance Issues, at* http://www.iii.org/media/hottopics/insurance/medicalmal/ (accessed November 25, 2002) [hereinafter *iii Hot Topics*] (noting that subsequent to the medical malpractice crisis of the 1970's, every state except West Virginia passed reforms. West Virginia would later join the fold.)

by the subsequent malpractice crises of the 1980's and early 2000's, with each crisis more severe than the one preceding it. Moreover, not only have these legislative efforts failed to rectify the existing problems, they have, in some cases, created new, far more serious ones. With the Federal government threatening to intervene and impose sweeping new reforms which would supercede previously enacted reforms on the state level,[2] the time has come to examine the past so as to avoid similar peril in the future.

It is the position of this article that, for the most part, malpractice litigation reform has repeatedly failed because the crisis has not been appropriately identified.[3] This is largely because, contrary to the widely held view, there has never been a medical malpractice litigation crisis, per se. Rather, if anything, there have been cyclical insurance crises through the years; crises that have more to do with fluctuations in the bond market than anything associated with medical malpractice litigation. This is not to suggest, however, that malpractice litigation costs in no way affect physicians' malpractice premium rates and, consequently, the availability of quality health care to the public. To the contrary, these costs significantly affect premium rates in years in which the bond market is weak. Consequently, it is necessary to stabilize these costs in order to correct an insurance system which presently reacts violently in response to market fluctuations.

---

[2] *See* CNN.com, *Bush to Discuss Malpractice Reform, at* http://www.cnn.com/2003/allpolitics/01/16/bush.malpractice/index.html (January 16, 2003), noting that despite his "states' rights credentials," the President believes in a nationwide cap.

[3] *See* MD. CODE ANN., CTS. & JUD. PROC. § 3-2A-01 (2004); Lerman v. Heeman, 685 A.2d 782, 788 (Md. 1996) (stating that the "goal of Health Care Malpractice Claims Act is to lower cost of litigation involving allegations of malpractice"). *See also* Pearlstein v. Malunney, 500 So.2d. 585, 586 (Fla. 1986) (stating, without accompanying factual support, that Florida's Comprehensive Medical Malpractice Reform Act of 1985 "was enacted in response to a perceived crisis in availability of reasonably-priced health care services, prompted by escalating medical malpractice insurance premiums.") These vague, unsupported statements are indicative of the willingness of courts and legislatures to act in response to the crisis without first identifying the root cause.

Formatted: Font: Not Italic

In order to effectively do so, however, it is necessary to examine the medical malpractice reform issue through the eyes of the insurer, as it is the insurer that ultimately sets these rates and determines whether it is profitable to enter any given market. For if a particular method of reform is seen as a roadblock to profitability from the insurer's perspective, it will avoid the offending market altogether, thereby reducing the pool of prospective insurers and causing premiums to spike not for reasons related to malpractice litigation, but due instead to the absence of a competitive marketplace.

Simply stated, because the goal of malpractice reform should be to create competition by enticing insurers to enter the market, that reform must necessarily increase the insurers' profitability. This article will analyze the three most common methods of medical malpractice reform undertaken over the past 30 years (i.e., the creation of medical malpractice screening and arbitration panels; the imposition of caps and multipliers on non-economic and/or punitive damage judgments; and the requirement of expert-based certificates of merit produced at the pleadings stage) in order to determine whether they do in fact result in increased insurer profitability.

This article will show that despite the best intentions of the various and numerous legislatures that passed them, screening and arbitration panels actually increase litigation costs and considerably reduce insurer profitability. In addition, although capping of damages does not result in any additional economic harm to the insurer, it has had minimal positive impact at best and has exacted enormous social costs. The certificate of merit requirement, on the other hand, has proven effective in reducing insurers' litigation costs without significant social costs. However, because many jurisdictions employ the certificate of merit requirement along with other, less effective and more damaging

means of litigation reform, the benefits of the certificate of merit reform are oftentimes cancelled out by the deleterious effects of the more harmful reform approaches.

II. The Roots of a Medical Malpractice "Crisis"

A. The Traditional (Majority) Perception

Historically, there has been little debate concerning the genesis of the malpractice crises. The popular perception has been that the problems began in the 1960's and 1970's, as was believed to be evidenced by a perceived increase in malpractice claims during that era.[4] That, in turn, was presumed to have led to a corresponding rise in malpractice premium rates effected in order to offset these rising costs.[5] As for why the number of claims suddenly rose during that era, commentators point to several factors, including the increased litigiousness of American society as a whole, and the breakdown of the intimate relationship between doctor and patient.[6] It was widely believed that these societal changes (trumpeted loudly by the media) set off a vicious cycle that resulted in an avalanche of medical malpractice litigation.[7]

Thus, this increase in litigation and media coverage was thought to have spurred the first malpractice crisis of the 1970's. For the first time, it has been argued, large segments of society not only felt disconnected from their health care providers, but were made aware of the medical profession's vulnerability to litigation as well.[8] Given the rise of institutionalized medicine and the loss of the close relationship between doctor and

---

[4] *See* Terry L. Trimble, *The Maryland Survey: 1994-1995 Recent Developments The Maryland General Assembly,* 55 MD. L. REV. 893, 894 (1996).
[5] *Id.*
[6] *See iii Hot Topics*, *supra* note 1.
[7] *Id.*
[8] *Id. See also* Robert J. Blendon, Sc.D. et al., *Patient Safety: Views of Practicing Physicians and the Public on Medical Errors* 347 N. ENG. J. MED. 1933 (December 12, 2002). The article made note of the fact that surveys indicated that half of the American public followed media coverage of a recent report by the Institute of Medicine, entitled *To Err is Human,* which concluded that more Americans die as a result of medical errors made in hospitals than as a result of injuries from automobile accidents.

patient, patients were now less hesitant to sue based on unfortunate medical results -- irrespective of actual malpractice.[9] Moreover, as the crisis of the 1970's deepened and more and more lawsuits were filed (with large jury verdicts and medical errors highlighted in the media like never before), a distrust developed between patients and health care providers, with patients starting to believe that medical standards were declining--a distrust that has only increased in magnitude over the past 30 years.[10]

Given this increasingly hostile climate, it was only natural that malpractice claims would increase. And once claims increased, insurers were left with no choice but to raise premium rates in order to offset the skyrocketing costs associated with this litigation explosion.[11] These rising costs, in turn, caused some insurers to leave the market altogether, thereby deepening the crisis even further as the market for available insurance contracted.[12] In fact, one commentator pinpoints the commencement of the Maryland malpractice crisis of 1975 as the day the state's largest malpractice carrier announced that it was withdrawing from the Maryland malpractice market after the state's Insurance Commissioner refused its requested rate increase.[13]

Thus, under the above (traditional) view, there is little doubt as to the root cause of the malpractice crisis. An increase in litigation led to rising costs, which led to one of two outcomes: either the insurers (a) raised their rates in order to offset these costs, necessarily to levels which caused their insurance to be overwhelmingly expensive; or (b) left the market altogether. Either way, under the traditional perception, the cause and effect between malpractice litigation and a malpractice crisis is direct and clear.

---

[9] *Id.*
[10] *See id*.
[11] Trimble, 55 MD. L.REV. at 894.
[12] *See id*. *See also iii Hot Topics, supra* note 1.
[13] Trimble, 55 MD. L. REV. at 895.

Moreover, although most commentators acknowledge that the past 30 years has seen three clear eras of "crisis" (the mid 1970's, mid 1980's and early 2000's)[14], they nevertheless view the malpractice crisis as a single, gradually evolving phenomenon, with roots firmly planted in the 1960's and early 1970's.[15]

B. The Emerging (Minority) Viewpoint

As much as the above hypothesis concerning the roots of the malpractice crisis makes intuitive sense, recent studies have shown that it is simply not accurate. Rather, these studies (discussed below) demonstrate that it is the economy, and not an increase in litigation, which accounts for the various malpractice crises. However, these studies go further and attack the traditional perspective as rhetoric propagated by the insurance industry foisted upon the medical community and public as an excuse for skyrocketing rates.[16] Further, and somewhat curiously, these studies conclude that the insurance industry is at fault for these malpractice crises due to investment mismanagement.[17] Although the minority viewpoint's statistical proof regarding the root cause of rising premiums is persuasive, their resulting conclusion (laying blame solely at the feet of the insurance industry) is not.

These studies, performed by a coalition of nearly 100 consumer groups around the country entitled "Americans for Insurance Reform" ("AIR"), are perhaps most surprising for their conclusion that there has historically been no relation between malpractice

---

[14] *See* Americans For Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates,* http://www.insurance-reform.org (Oct. 12, 2002) [hereinafter *Stable Losses/Unstable Rates*].
[15] *See* Trimble, 55 MD. L. REV. at 894.
[16] *See Stable Losses/Unstable Rates, supra* note 14. *See also* Washington State Medical Association, *The Real Story About Medical Malpractice Insurance and Tort Law Reform (Federal and State), at* http://www.wsma.org/tort_resources.html (accessed Feb. 11, 2003) [hereinafter, *The Real Story*].
[17] *Id.*

payouts and premiums.[18] Contrary to the cause and effect supposition discussed above, the AIR studies found that, over the past 30 years, the amount that medical malpractice insurers have paid out (including jury awards as well as settlements), directly tracks the rate of medical inflation.[19] Thus, despite the alarms rung as a result of the breakdown of the traditional doctor-patient relationship and the increased media attention paid to medical mistakes and jury verdicts, this has not translated to a resulting explosion in payouts to medical malpractice claimants.[20]

Premiums, the studies found, are a different story. Rather than correspond to payouts, they rise and fall in direct relation to the state of the economy.[21] More specifically, premiums rise when interest rates rise and fall when interest rates fall.[22] Examining the two prior malpractice crises (which occurred in the mid 1970's and mid 1980's, respectively), the studies found that they occurred during years of a weakened economy and falling interest rates.[23] Although each crisis brought attempts at malpractice reform in many states, it only subsided when the economy finally recovered and interest rates rose.[24]

The results of these studies beg the obvious question: were these correlations merely due to coincidence, or is there a reason why premiums track interest rates so closely? A detailed examination of the investment strategies of the insurance industry

---

[18] *See Stable Losses/Unstable Rates, supra* note 14. *See also* Americans For Insurance Reform, *New Study Shows Average Medical Malpractice Payout Over Last Decade Only $28,524; New Data Reveals Same Trends in 2001, at* http://www.insurance-reform.org (accessed Feb. 11, 2003) [hereinafter *New Study*].
[19] *Stable Losses/Unstable Rates.* While the author of the report fails to define "medical inflation", it is believed to be the equivalent of general inflation.
[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*

provides insight into why the correlation between premiums and interest rates is both real and direct.

Not surprisingly, the insurance industry is a highly regulated one.[25] Investments made on behalf of insurers are monitored both in kind and quality by every state in which an insurer does business.[26] Moreover, and more specific to the medical malpractice issue, 80% of the investments made by Physician Insurers Association of America member companies are required to be in high grade bonds.[27] This is consistent with the investment practice and requirements of most commercial insurers who annually target at least 80% of their investment dollars for the conservative, high grade, low yield bond market.[28] When the bond market is strong, as it was during much of the 1990's, insurers are able to keep premium rates low.[29] However, when that market collapses, as it has done notably three times within the past 30 years (the mid 1970's, mid 1980's and early 2000's), investment income drops significantly, causing premium rates to rise in order to offset this loss of income, and can even skyrocket if the collapse is particularly acute.[30]

In this regard, the first few years of the 21st century have been historic for two reasons: both in the depths to which the bond market has plunged as well as the duration of this plunge. As a result, the medical malpractice crisis of the early 2000's has

---

[25] *See The Real Story. See also* Steve Kanigher, *Medical Malpractice: The Costs of Coverage,* LAS VEGAS SUN WEEKEND EDITION, June 21, 2002, *available at* http://www.lasvegassun.com (discussing the connection between rising premiums and the state mandated investment strategies of Nevada's insurers. The article noted that malpractice rates in Nevada are regulated by the Nevada Insurance Division. In addition, Nevada, like other states, requires insurers to keep most of their investments in government and corporate bonds that carry at least an "A" rating.)

[26] *Id.*

[27] *See The Real Story, supra* note 16.

[28] *See* CNN.com, *Doctors Take To Streets To Win Malpractice Reforms, at* http://www.cnn.com (Feb. 1, 2003) [hereinafter *Doctors Take To Streets*].

[29] *Id. See also Stable Losses/Unstable Rates, supra* note 14.

[30] *See Doctors Take To Streets, supra* note 28. The article noted that between 1990 and 2002, bond yields, the main source of insurers' income, were down practically 50%, from 9% to approximately 5%. These losses invariably left insurers to look to the premium market as a source to recoup this dramatic decrease in income.

appeared to be more severe than anything that came before.[31] The Federal Reserve cut interest rates repeatedly during this time, diminishing the investment returns of commercial insurers with every reduction.[32] This, in turn, has caused premiums to increase repeatedly in order to offset these losses.[33] Thus, according to the emerging minority view, it is the economy, and not a litigation explosion, which is the cause of the multiple malpractice "crises".[34] Therefore, according to the minority perspective, each crisis is not a crisis after all but rather, a natural and expected response to the cyclical nature of the market.[35]

Although the minority viewpoint is persuasive with regard to its cause and effect analysis, the conclusions drawn as a result of this analysis are considerably less so. Commentators adhering to this position conclude that because it is the economy which dictates premium rates, tort reform is not only unnecessary but irrelevant to the problem.[36] For support, they point to examples such as Nevada which, in July 2002, imposed a medical malpractice $350,000 cap on non-economic damages, only to be informed mere weeks later that despite the new law, two major insurers still insisted that they would not reduce rates in the foreseeable future.[37] The problem, as these commentators see it, is not simply the economy but, as stated above, investment mismanagement on behalf of the insurance industry which allows it to fall victim to these economic swings.[38] As insurers have made their own bed, the argument concludes, they

---

[31] *See* Kanigher, *supra* note 25.
[32] *See Stable Losses/Unstable Rates, supra* note 14.
[33] *See Doctors Take To Streets, supra* note 28.
[34] *Stable Losses/Unstable Rates, supra* note 14.
[35] *Id.*
[36] *Id.*
[37] *Id.*
[38] *See supra* notes 24-29.

should be forced to lie in it. However, as the following section shows, this is not necessarily the case.

C. Reconciling the Majority and Minority Viewpoints

The AIR studies are invaluable for challenging the traditional perception of the recurring medical malpractice crises. Although statistics certainly never tell the entire story, they are helpful in testing the validity of assumptions -- particularly ones which, at least on the surface, appear logical. Upon further review, in light of these studies, it now no longer appears that there is much validity to the historically popular view that blames an increase in claims as the culprit for these crises. Rather, it is more likely that market factors play a substantial role in determining premium rates and that, when the bond market is weak, rates rise and create a perceived "crisis."[39]

However, the conclusions drawn as a result of this market-based analysis do not appear to be as soundly based. For it is difficult to understand how the economic link between bond rates and premium rates is somehow the result of the insurance industry's mismanagement of investments. As most investors understand, the bond market typically represents the safest, most conservative investment opportunities. While, as the "junk bond" scandals of the 1980's attest, there are certainly risks present in the bond market, most states prohibit commercial insurers conducting business within their borders from investing in these more risky opportunities, requiring them instead to limit their investments to those government or corporate bonds carrying at least an "A" rating.[40] Because most states, as well as the largest insurance associations, also require their member insurers to target a minimum of 80% of their investment dollars toward these

[39] *See supra* notes 20-23.
[40] *See* Kanigher, *supra* note 25.

most conservative of investments,[41] it simply does not logically follow that such an approach represents a mismanaged investment scheme. Even if it were a mismanaged scheme, the fault for such an approach cannot rightfully be laid at the feet of the insurance industry, for the approach is governmentally imposed upon it.[42]

Moreover, it is difficult to imagine a preferable alternative investment model. The reduction of governmental control would most likely lead to riskier investments which, over the past three decades may very well have resulted in heavy reliance on technology and/or Internet stocks as well as the aforementioned junk bonds. Given the steep decline of the stock market in the early 2000's, it is safe to assume that these investment strategies would have led to premium rate spikes at least as severe, if not much more so, than the ones that otherwise resulted.

More appropriately, if there was mismanagement from the standpoint of the insurer, it did not result from poor investment strategies but was, rather, the result of aggressive and shortsighted pushes during strong markets to increase market share.[43] During these economic boom times, some insurers have historically resorted to slashing premiums to encourage new customers, and/or expanding geographically or into additional healthcare markets in an effort to gain access to the additional premium dollars generated so as to be able to invest them in the expanding market.[44] Although access to this additional money results in short term gains, these gains are more than offset during down markets when the additional claims emerge; claims resulting from artificially low

---

[41] *See supra* notes 24-27.
[42] *See* Kanigher, *supra* note 25.
[43] *Id. See also* Josh Goldstein, *Collapse Spreads Misery,* PHILA. INQUIRER, Mar. 2, 2003 at E1. Goldstein's article analyzes the collapse of one of the Philadelphia area's largest malpractice insurers, PHICO. The article concludes that miscalculated growth opportunities eventually led to the liquidation of PHICO in 2002.
[44] Goldstein, *supra* note 43. The article highlights PHICO's premium-slashing techniques as a means to gain market share in the "highly competitive malpractice insurance marketplace."

premiums which can do nothing but result in a net loss to the insurer's bottom line.[45] Although this practice certainly adds to the severity of the crises which result from down markets, it is difficult to curtail. Even though malpractice insurance rates are regulated by each state's insurance division, it is highly unlikely that any such division would take the politically suicidal approach of mandating higher premium rates on behalf of insurers.[46]

The AIR studies can also be criticized for their conclusion that, given the strong market forces which currently determine premium rates, tort reform of any sort is irrelevant to the problem. Although the studies are helpful in demonstrating why the types of reforms attempted in the past have largely failed, their usefulness as a predictive tool is much less clear. Moreover, it is difficult to fathom how the absence of reform will solve the problem of cyclically spiking premiums since, to the contrary, the studies indicate that without reform, the problem is destined to recur every decade or so, throwing the healthcare industry into a crisis mode, regardless of the cause.

Without effective change on some level, malpractice premiums can be expected to soar out of control every several years, creating an environment where many physicians are no longer able to obtain affordable insurance. To simply accept this lurking economic doomsday as inevitable and to tell doctors to 'wait it out' until the bond market recovers is to ignore the hardships that accompany these cyclical downturns. These hardships figure only to increase in magnitude with each successive crisis because, with the increasing prevalence of Health Maintenance Organizations ("HMO's") and

---

[45] *Id.* The article notes that PHICO eventually expanded into all 50 states. This resulted in a short term doubling of PHICO's premium revenue but an eventual tripling of payments on claims. *Id.*

[46] *See* Kanigher, *supra* note 25. According to the executive vice president of Nevada Mutual Insurance Company: "It's very difficult for a state regulatory agency to tell you that you need to increase rates. That doesn't fly well so there's a lot of political pressure on them not to raise rates." *Id.*

Medicare and their ever expanding power to dictate and cut the amount of reimbursements for medical services rendered, doctors are less able than ever before to pass on even a small percentage of their rising premium rates to their patients.[47] This trend is likely to continue and become even more pronounced in the future.

Finally, it is unreasonable to conclude that, despite the historical power of the market in the establishment of premium rates, this is the sole factor that determines insurer profitability and therefore premium rates. For if this were truly the case, then all lines of insurance should be expected to see sharply spiking premiums whenever the bond market weakens. This, in turn, would logically create a crisis in all lines of insurance, rather than just the malpractice market. However, this has not happened. Historically, only the medical malpractice and product liability lines have seen recurrent crises over the past thirty years, as dictated by the bond market.[48] Therefore, there clearly is something different about these lines which make them more market sensitive than others. The AIR studies correctly identify the root cause of the recurrent malpractice crises but then fail to ask the appropriate question based on the results of their studies. Contrary to the finger pointing of the AIR and its insistence that tort reform is irrelevant to the issue, the correct question in light of their findings is: Why does medical

---

[47] *See Doctors Take To Streets, supra* note 28. The article noted that the malpractice crisis of the early 2000's is worse than the ones which occurred in the 1970's and 1980's because medical services rates are now largely controlled by physician contracts with HMO's and Medicare. *Id.* This results in the increasing inability of physicians to pass on at least part of their rising premiums to patients. *Id.*

[48] *See* Frances E. Zollers, Dandra N. Hurd & Peter Shears, *Looking Backward, Looking Forward: Reflections on Twenty Years of Product Liability Reform* 50 SYRACUSE L. REV. 1019, 1024, 1028-29 (2000). The authors note that federal legislative efforts to reform product liability litigation began in the late 1970's. *Id.* An explosion of lawsuits, excessive awards and skyrocketing insurance premiums were cited as the reasons necessitating reform. *Id.* More likely, and as with the medical malpractice insurance market, the declining bond market of the time was to blame for rising rates. This supposition is supported by the fact that the authors note that a second product liability "crisis" occurred in the mid-1980's, when insurance premiums nearly tripled. *Id.* As this second "crisis" likewise mirrors the mid-1980's bond market decline which precipitated the second medical malpractice "crisis," it is apparent that the product liability insurance premium market, much like the medical malpractice insurance premium market, is overwhelmingly market-driven.

malpractice insurance become unprofitable when the bond market crashes, while most other lines maintain profitability? Stated another way: What accounts for the acute market sensitivity of the medical malpractice line of insurance? Only after that question is answered can the issue of tort reform be properly addressed.

The AIR studies are correct in their conclusion that historically, tort reform has failed. However, that does not necessarily mean that it cannot work in the future. The traditional perception may have been incorrect in its identification of the root cause of the malpractice crisis, but it nevertheless is correct in its insistence that reform of some type is necessary. For the market, being the market, will continue to rise and fall cyclically forever. It is unreasonable to expect the medical profession to 'grin-and-bear-it' during the down periods, particularly considering the strong likelihood that reimbursements will only continue to decrease in the future.[49] The key is identifying the type of reform which will respond to the problem.

In order to do so, it is first necessary to understand how profitability is measured from the insurer's perspective. Once this is identified, it will then be possible to judge whether a particular type of reform will impact this measurement. For if it does not, then it is truly, as the AIR studies suggest, irrelevant to the problem. However, if the reform does impact the measurement, then it is highly relevant because if it enables medical malpractice insurers to remain profitable even during down markets, it will bring the medical malpractice line of insurance in line with other types of insurance which remain profitable even when the bond market is weak.[50] It would then enable malpractice insurance to behave similarly to other, more stable, insurance lines and avoid periods of

[49] Kanigher, *supra* note 25.
[50] *See infra* notes 60-62 and accompanying text.

crisis during market downturns. The following section will analyze the determination of insurer profitability through a discussion of the three holiest words in the insurance industry: the combined ratio.

III. Determining Insurer Profitability Through the Combined Ratio

In order to understand profitability as measured by the insurance industry, it is necessary to become familiar with the combined ratio. At its most basic level, the combined ratio represents the percentage of each dollar collected in the form of insurance premium spent on claims, legal expenses (defense costs) and underwriting costs.[51] It is the sum of two other ratios: the loss ratio (which expresses the relationship between losses and premiums in percentage terms); and the expense ratio (which expresses the relationship between underwriting costs and premiums, likewise in percentage terms).[52] When combined, the loss and expense ratios express profitability or loss in the absence of investment income (i.e., the relationship between the amount of money coming in through underwriting income, and the amount of money going out through losses and other expenses).[53] Conveniently for calculation purposes, a combined ratio of 100 is considered the "break even" point, with combined ratios under 100 indicating a net profit (absent investment income), and combined ratios over 100 indicating a net loss (again, absent investment income).[54] For example, an insurer with a combined ratio of 95 spends 95 cents on losses and expenses for every dollar of underwriting income it takes in, generating a net profit of five cents per premium dollar. Conversely, an insurer with a

---

[51] INSURANCE INFORMATION INSTITUTE, THE INSURANCE INFORMATION INSTITUTE FACT BOOK 2002, 23 (2002) [hereinafter *iii Fact Book*].
[52] *Id.*
[53] *Id.*
[54] *Id.*

combined ratio of 105 spends $1.05 on losses and expenses for every dollar of underwriting income it generates, resulting in a net loss of five cents per premium dollar.

Of course, as stated above, this ratio does not take into account investment income which, as shown through the AIR studies, can radically alter the profit/loss picture drawn by the combined ratio, sometimes to the point of consuming it whole.[55] For instance, in 1995 the overall combined ratio for the U.S. property and casualty insurance industry was 105; a small loss which was more than offset by investment income resulting from the high interest rates and vigorous economy of the time.[56] However, when the bond market weakens significantly, investment income can no longer offset these losses. As a result, those lines of insurance with the highest combined ratios undoubtedly suffer the most. Not surprisingly, the medical malpractice insurance market is one of those lines.

Specifically, the combined ratio of the medical malpractice insurance market as a whole marched notably higher and higher through the 1990's and into the early 2000's.[57] Between 1991 and 2000, the combined ratio in this line jumped from a respectable 103.7 to a robust 133.5.[58] This skyrocketing trend continued in 2001 when it shot up another 6.5 points to 140, meaning that, nationwide, medical malpractice insurers were paying out $1.40 in losses and expenses for every premium dollar they were taking in.[59] While this differential may have been tolerable in a strong market (where investment income becomes the overriding factor), it is unquestionably intolerable in a weak one, where

---

[55] *Id. See also, Stable Losses/Unstable Rates, supra* note 14. This illustrates the extent to which bond market fluctuations dictate medical malpractice insurer profitability regardless of the combined ratio. *Id.* Although, historically, the bond market has determined profitability in both up and down cycles, it is the position of this article that this does not have to be the case.
[56] *See iii Fact Book, supra* note 51, at 23.
[57] *Id.* at 74.
[58] *Id.*
[59] *See iii Hot Topics, supra* note 1.

investment income becomes irrelevant and where premiums must track losses closely in order for the insurer to maintain profitability.[60]

The strikingly high medical malpractice combined ratio explains why the medical malpractice insurance line is more market-sensitive than most others. Although net losses are more than offset by investment income from the strong bond market when interest rates are high, they become an albatross around an insurer's neck when the market softens and bond rates plummet. This market-driven scenario differs from the nationwide property and casualty market as a whole, which throughout the 1990's maintained a combined ratio between 99.9 and 108.8 -- allowing it to reap substantial profits when the bond market was strong but suffer only minimal losses when the market crashed.[61] Although it is likely that premiums likewise rose as the market fell, they undoubtedly did not spike as sharply as the medical malpractice line, as there was much less of a net loss to account for. Certain lines, such as the burglary and theft line, most likely saw little or no premium increases at all when the bond market fell, due to annual combined ratios typically in the low 60's.[62] Others, such as the personal auto and homeowners lines, probably saw small premium increases due to combined ratios typically in the low 100's.[63]

Given the above, the goal of any medical malpractice reform should be to reduce the combined ratio and bring it as close to 100 as possible. This will cause the medical malpractice line to behave like the property and casualty line overall and reduce its

---

[60] *See The Real Story, supra* note 16 (discussing how when investment yields decline due to falling interest rates, they are no longer able to subsidize premium rates to the extent they once did. Therefore, in weak markets, premium rates must necessarily closely match the actual cost of losses in order to maintain the insurer's profitability.).
[61] *See iii Fact Book, supra* note 51, at 23.
[62] *Id.* at 79.
[63] *Id.* at 35, 60.

sensitivity to fluctuations of the market, since when the bond market is weak and premiums have no choice but to track losses closely, the corresponding rate increases will be far less dramatic and the recurrent crises will be averted.[64] Moreover, on a purely economic level, since lowering the combined ratio will stabilize the medical malpractice line and increase profitability regardless of the economy, more insurers will have incentive to enter this previously dangerous, volatile insurance market.

Once the goal of malpractice reform has been identified, the next issue is to determine the most effective means towards reaching it. Importantly, from the insurers' perspective, it does not inherently matter if reform is focused on reducing indemnity costs, expense (defense) costs or a combination of both. As described above, all losses count equally in the eyes of the combined ratio.[65] A dollar spent as the result of a settlement or jury verdict counts the same as a dollar spent defending a claim that ultimately is dismissed for lack of merit. To an insurer, the sole determination of the effectiveness of any particular method of reform is its ability to reduce the combined ratio, regardless of the side of the equation utilized to achieve this goal.

However, most tort reform efforts focus exclusively on payouts and not defense costs. By way of example, Pennsylvania's 2003 medical malpractice reform bill contains five elements of tort reform--four which are related to reducing indemnity costs (through the abolition of the collateral source rule, reduction of excessive verdicts, periodic payment of malpractice verdicts, and reduction to present value of various jury awards), and none related to the reduction of expense costs.[66] Although the reasons for this disparity are obvious, they are nonetheless imprudent if, as will be demonstrated

[64] *See iii Hot Topics, supra* note 1.
[65] *See supra* notes 50-53 and accompanying text.
[66] H.R. 1802, 185th Gen. Assem., Reg. Sess. (Pa. 2002).

throughout the remainder of this article, they are ultimately irrelevant to the reduction of the combined ratio.

In order for a particular method of reform to succeed, it must be directed towards areas of wasteful spending which could effectively be reduced. Unfortunately, this level of analysis rarely is undertaken when reform is proposed, or even adopted. In Pennsylvania for instance, which has long been the poster child for all that ails the medical malpractice litigation industry, much of the push for the most recent round of reform stems from publicity given to the sheer amount of money awarded annually in the form of jury verdicts and settlements.[67] These payouts, in terms of dollar amount as well as the sheer number of large verdicts and settlements, when viewed in light of skyrocketing premiums, have mobilized physicians throughout the country to organize and lobby state legislatures for a reduction of this number, arguing the cause and effect connection discussed earlier.[68] However, as popular and easily embraceable as this argument is, reform geared toward responding to these indemnity concerns is ultimately fruitless since it is not directed toward the major area of wasteful spending in the medical malpractice litigation context. Rather, it is in the area of defense costs where an abundance of wasteful spending occurs. Although it is perhaps more difficult to cultivate public outrage over wasted defense cost dollars than by highlighting an extreme jury verdict, an analysis of the insurance industry's defense costs in the medical malpractice

[67] *See* Goldstein, *supra* note 43. "Doctors and hospitals pushing for changes to the state malpractice laws have argued that the high Philadelphia jury awards and settlements are a major reason their malpractice insurance premiums have risen dramatically." *Id.* The article also notes that "Philadelphia awards and settlements make up nearly half of the record $348 million paid out by a state fund in the last 12 months." *Id.*

[68] *See id.*

line of coverage relative to other lines demonstrates the volume of waste generated in this area as well as the need for tort reform to be targeted here.

Specifically, of the total amount of incurred losses, medical malpractice carriers spend approximately 40% not on indemnity payouts (either through jury verdicts or settlements), but rather, on defense costs.[69] Stated in other terms, approximately 40 cents of every dollar paid out by medical malpractice insurers is spent defending claims rather than paying indemnity dollars to claimants. This defense-cost containment percentage contrasts sharply with the mere 12-13% spent on defense costs overall in all insurance lines.[70] As for the cause of this disparity, one need look no further than the following statistic: between the years 1985-1999, 62.3% of all medical malpractice claims filed were eventually dismissed, dropped or withdrawn in favor of the defendant.[71] This helps explain why medical malpractice insurers spend more each year defending claims than on all other administrative costs combined.[72] The disproportionate amount of money spent by the insurance industry on meritless claims, as well as the high percentage of them are telling indicators of economic waste. While, due to the inherently higher cost of defending medical malpractice actions relative to other areas of litigation, it is perhaps unreasonable to expect any reform to bring the defense-cost containment percentage of medical malpractice carriers in line with the 12-13% ratio of all lines, it is reasonable to assume that reform which substantially reduces the percentage of meritless claims would also have a significant effect on this percentage. And if it reduces this percentage significantly, it will likewise reduce the combined ratio significantly as well.

---

[69] *See iii Fact Book, supra* note 51, at 118. (43.2% in 1999 and 38.5% in 2000).
[70] *Id.* (13.1% in 1999 and 12.0% in 2000).
[71] *See iii Hot Topics, supra* note 1.
[72] *See* Trimble, *supra* note 4, at 909.

Although the traditional perception of the cause of the malpractice crisis contained the faulty assumption that rising claims led to increased payouts to plaintiffs, it was nevertheless correct that the increase in claims has negatively impacted the insurance market. While the increase in claims has not exerted a significant impact on the indemnity side of the combined ratio (as evidenced by the relative stability of payouts from 1991-2000), it has played a large role on the defense side (as evidenced by the increase in the combined ratio during this time in the absence of a surge in indemnity costs).[73] Therefore, in order to reduce the combined ratio, it is the defense side, rather than the indemnity, which needs to be addressed. Unfortunately, this is rarely done.

The following sections will demonstrate why the historically popular forms of medical malpractice tort reform (i.e., capping and screening/arbitration panels) have repeatedly failed: because they ultimately prove irrelevant to the combined ratio and, therefore, are unable to increase the insurer's profitability during economic downturns. Moreover, not merely ineffective, they have exacted enormous social costs at times. Only when the area of economic waste is targeted, i.e., defense costs, will the combined ratio drop. This article will conclude that one area of reform, generally referred to as the certificate of merit requirement, effectively targets this area and does so not only in a way which significantly reduces the combined ratio, but in a manner which extracts a minimum of social costs.

IV. Analysis of Popular Tort Reform Approaches

A. Medical Malpractice Screening/Arbitration Panels

1. Purpose and Procedure

[73] *See iii Fact Book, supra* note 51, at 74.

In the aftermath of the initial medical malpractice crisis of the 1970's, several states responded by creating a wide variety of medical malpractice screening or arbitration panels, whose mandate was to determine whether a particular claim had sufficient merit to proceed through the judicial (or, depending on the panel, arbitration) system.[74] The benefits of this system were thought to be threefold: it would (1) weed out unjustified suits;[75] (2) encourage pretrial settlements,[76] which would (3) ultimately reduce court congestion by decreasing the volume of cases careening toward trial.[77] This, it was assumed, would result in reduced liability insurance which would naturally lead to reduced medical care costs.[78]

A very popular method of medical malpractice tort reform, these screening panels exist, in one form or another, in approximately half of the states.[79] Although there is some variation from state to state, generally these panels are comprised of between three and seven members.[80] Typically, one member is an attorney while another is a health care provider.[81] Some states also require a sitting or retired judge to sit on the panel,[82] while others, such as Maryland, allow for a layman.[83] Procedurally, the hearings are generally more informal than a trial with relaxed rules of evidence and procedure.[84]

---

[74] *See* Harold A. Sakayan, *Arbitration and Screening Panels: Recent Experience and Trends,* 17 FORUM 682 (1982).
[75] *See Id.*
[76] *See Id.*
[77] *See Id. See also Newell v. Richards,* 594 A.2d 1152, 1159 (Md. 1991).
[78] *See Id.*
[79] *See* Trimble, *supra* note 4, at 900.
[80] *See* Jean A. Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills,* 58 GEO. WASH. L. REV. 181, 189 (1990).
[81] *Id.*
[82] *Id.* at 190.
[83] *See* Trimble, *supra* note 4, at 896.
[84] *See* Macchiaroli, *supra* note 80, at 190. *See also* Robert L. Lockaby, *Constitutional Challenges to Medical Malpractice Review Boards,* 46 TENN. L. REV. 607, 612 (1979).

However, they do have the power to subpoena witnesses and documents.[85] In addition, most panels allow party statements in either oral or deposition form, the production of medical records and the testimony of expert witnesses.[86] A few states even allow the panels to compel a physical examination of the plaintiff under certain conditions.[87] Finally, and perhaps the most attractive feature of these panels (at least to defendants), the proceedings of these panels are typically confidential.[88]

With regard to the specificity of the findings of these panels, states vary. Although all states require their panels to make a determination regarding liability, the ability of these panels to make further findings varies from state to state.[89] Some states limit the panel's role to determining liability;[90] some allow the panels to determine the existence and extent of damages but prohibit them from assigning a dollar figure to these damages;[91] while some permit the panels to make specific findings with regard to both liability and damages, much like a trial court would.[92] As for the weight given to these findings should a ruling be appealed to the trial court, Maryland (which permits arbitration panels to assign dollar values to damage awards) goes so far as to dictate that the findings of its state's arbitration panel are presumed correct.[93] As a result, the party rejecting an arbitration award carries the burden of proving that the award was somehow

---

[85] *See* Macchiarioli, *supra* note 80, at 190.
[86] *Id.*
[87] *Id. See e.g.* ALASKA STAT. § 09.55.536 (b) (Supp. 2002): DEL. CODE ANN. tit. 18, § 6810 (Supp. 2003); HAW. REV. STAT. § 671-13, para. 4 (Supp. 1988); MASS. GEN. LAWS ch. 231, § 60B, para. 5 (1986).
[88] *See* Macchiarioli, *supra* note 80, at 190.
[89] *See* Lockaby, *supra* note 84, at 612.
[90] *Id.*
[91] *Id.* Alaska, Delaware, Indiana, Lousiana and Virginia are such states. CITE
[92] *Id.* Such as Florida, Hawaii, Maryland and New Hampshire. CITE
[93] MD. CODE ANN., CTS. & JUD. PROC. § 3-2A-06(d) (2004) (Admissibility of award; presumption of correctness: "Unless vacated by the court pursuant to subsection (c), the unmodified arbitration award is admissible as evidence in the judicial proceeding. The award shall be presumed to be correct, and the burden is on the party rejecting it to prove that it is not correct.").

incorrect.[94] However, Maryland courts have been adamant in stating that this presumption of correctness does not otherwise shift the common law burden of proof in general.[95]

2. Constitutional Challenges

Generally, medical malpractice screening/arbitration panels have faced (typically state) constitutional challenges on one or more of the following four grounds: that they violate (a) the right to a jury trial; (b) the right of access to courts; (c) equal protection/due process; and/or (d) separation of powers/impairment of the judicial function. These will be analyzed in turn.

a. Right to a Jury Trial

Most often, the challenge to a jury trial right is raised when the decision of the arbitration panel is admitted into evidence at the trial level.[96] When this occurs, some courts have held that this evidence unduly distorts a jury's decision-making function due to the fear that the jury will be improperly influenced by the panel's decision and allow it to cloud their judgment.[97] The Ohio Supreme Court, for example, declared that although the right to trial by jury still existed under the Ohio arbitration statute, it was no longer a "free and unfettered right as was certainly intended by the framers."[98] For this reason, Ohio's arbitration statute was struck down as unconstitutional.

This approach is, however, in the minority. A majority of courts have held that the right to trial by jury is not impermissibly restricted or denied by the

---

[94] *Id.*
[95] *Newell,* 594 A.2d at 1158.
[96] *See* Macchiarioli, *supra* note 80, at 190.
[97] *See* Lockaby, *supra* note 84, at 628.
[98] Simon v. St. Elizabeth Med. Ctr., 355 N.E.2d 903, 908 (Ohio 1976).

screening/arbitration panel requirement.[99] Indeed, most courts have held that the admissibility of the panel's decision is a permissible application of the legislative prerogative to change the rules of evidence.[100] These courts have rested this conclusion on the tenet that the jury remains the final arbiter of the facts in their totality.[101] Maryland has perhaps gone the furthest in this regard, holding that the admissibility of the panel's decision, along with its accompanying "presumption of correctness," does not violate the state's constitutional guarantee of a right to trial by jury.[102]

b. Right of Access to the Courts

There are generally two types of challenges grounded in the alleged violation of a right to judicial access. The first is typically based on the inherent delay between the time when the allegedly tortious act was committed and the time when the plaintiff is permitted to proceed at the trial court level.[103] This delay is caused, inevitably, by the relevant statutory arbitration/screening panel requirement, which mandates that all claims first pass through this quasi-judicial system before being permitted to proceed to the trial level.[104] This delay has caused great concern to many state supreme courts, which have recognized it as a serious constitutional problem.[105] This is particularly the case when the relevant statute does not specify a time frame in which the panel must render its

[99] *See* Eastin v. Broomfield*,* 570 P.2d 744 (Ariz. 1977); Paro v. Longwood Hosp.*,* 369 N.E. 2d 985 (Mass. 1977); Prendergast v. Nelson, 256 N.W.2d 657 (Neb. 1977); Comiskey v. Arlen, 55 App. Div. 304, 390 (N.Y. App. Div. 1976); Wisconsin *ex rel*. Strykowski v. Wilkie, 261 N.W.2d 434 (Wis. 1978).
[100] See i*d.*
[101] *See id.*
[102] Maryland v. Johnson, 385 A.2d 57, 67-68 (Md. 1978).
[103] *See id.* at 71.
[104] *See id.*
[105] *Id.* at 71 (quoting Martin H. Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications,* 55 Tex. L. Rev. 759, 795-96 (1977).

decision.[106] This statutory construction failure can lead to situations such as the one in Pennsylvania during the 1970's, when it was not uncommon for years to pass from the time of the plaintiff's initial filing without resolution.[107] This resulted in a medical malpractice tort system where 73% of all filed claims were still pending when the state Supreme Court finally declared Pennsylvania's statute unconstitutional.[108] Such delay, or fear of similar delays, has been the basis for the decisions in several states which declared such statutes violative of the right to access the courts.[109] Although the Maryland Supreme Court considered the dangers caused by such delays, it nevertheless held that they were outweighed by competing, legitimate state interests.[110]

The second type of challenge under the right of access to the courts stems from the fees sometimes generated by the arbitration/screening panels.[111] Indeed, a few courts have held that this additional level of litigation poses the risk of imposing financial hardship upon the plaintiff over and above those normally associated with litigation at the trial court level.[112] This is particularly the case when the arbitration/screening panel statute requires the plaintiff to post a bond as a condition precedent to proceeding to trial.[113] The Arizona Supreme Court, for example, held that such a requirement deprived indigent plaintiffs of their right of access to the courts.[114] The court then went even

---

[106] *See* Mattos v. Thompson, 421 A.2d 190, 196 n.5 (1980). *See also* Heller v. Frankston, 475 A.2d 1291, 1295 (Pa. 1984).
[107] *See id.*
[108] *See Mattos*, 421 A.2d at 196 n.5. *See also* Heller v. Frankston, 475 A.2d 1291, 1295 (Pa. 1984) ("Such delays are unconscionable and irreparably rip the fabric of public confidence in the efficiency and effectiveness of our judicial system.")
[109] *See Mattos*, 421 A.2d at 196 n.5; State *ex rel.* Cardinal Glennon Mem'l Hosp. for Children v. Gaertner, 583 S.W.2d 107 (Mo. 1979); Aldana v. Holub, 381 S.2d 1080 (Fla. 1980); Gale v. Provident Hosp., 325 N.W.2d 439 (Mich. Ct. App. 1982).
[110] *Johnson,* 385 A.2d at 71.
[111] *See e.g.,* Eastin v. Broomfield, 570 P.2d 744, 754 (Ariz. 1977).
[112] *Id.*
[113] *Id. See also* Macchiarioli, *supra* note 80, at 190.
[114] *Eastin,* 570 P.2d at 754.

further and held that non-indigent medical malpractice plaintiffs were likewise deprived by imposing a burden on them that was not similarly imposed on other classes of plaintiffs.[115]

However, when the additional fees are not considered a precondition to proceeding at the trial court level, courts have been more willing to adjudge them constitutional. The Maryland statute, for example, requires the parties to pay a fee to the arbitration panel, a fee which, obviously, does not exist in those types of litigation which are not subject to mandatory arbitration prior to filing at the trial court level.[116] Nevertheless, the Maryland Supreme Court held that because payment of these fees is not a precondition to the court proceeding and accompanying jury trial, it is not violative of Maryland's constitutionally protected right of access to the courts.[117] The court rejected the argument that knowledge that these fees will have to be paid at some future point if the suit is lost constitutes an unreasonable obstruction to this right.[118] Although the Maryland Supreme Court appears to generally be the exception to the rule with regard to constitutional challenges in this area, its rulings are helpful in attempting to draw an appropriate line. Statutes that require the posting of bonds or which tie the payment of arbitration fees to the ability of the plaintiff to proceed to the trial level appear to be unconstitutional. However, when the fee requirement is severed from the ability to proceed, it is most likely constitutionally sound.

c. Equal Protection/Due Process

---

[115] *Id.*
[116] MD. CODE ANN., CTS. & JUD. PROC. § 3-2A-05(e) (2002).
[117] *Johnson,* 385 A.2d at 74.
[118] *Id.*

An equal protection/due process challenge rests on the premise that the existence of the medical malpractice arbitration/screening panels results in a tort system which impermissibly discriminates between classes of injured tort victims.[119] Likewise, such a challenge argues that the statutorily created panels confer a benefit upon medical malpractice defendants not available to other defendants, thereby presenting medical malpractice plaintiffs with a greater burden than other plaintiffs.[120] Whether these constitutional challenges are successful, however, depends greatly on the standard of review applied to the court's inquiry.

Courts finding a violation of equal protection or due process have invariably done so after a strict scrutiny review.[121] Courts refusing to find an equal protection/due process violation typically base their holdings upon constitutional reviews under the more permissive rational basis standard.[122] And once again, the Maryland Supreme Court proves illustrative in highlighting where the judicial line is most likely drawn.

In analyzing this challenge, the Maryland Supreme Court rejected the Maryland Bar Association's contention that because a fundamental right was involved, strict scrutiny review was mandated.[123] Specifically, the Bar Association asserted that the discriminatory classification described above resulted in an impermissible interference with a plaintiff's right to a jury trial.[124] As this is unquestionably a fundamental right, the Bar Association argued that any equal protection analysis must be done under the strict scrutiny standard.[125] In rejecting this claim, the Court concluded that because it had

---

[119] *See e.g.* Simon v. St. Elizabeth Med. Ctr., 355 N.E.2d 903, 908 (Ohio 1976).
[120] *Id.*
[121] *See Id.*
[122] *Johnson,* 385 A.2d at 77-79.
[123] *Id.* at 77.
[124] *Id.*
[125] *Id.*

already held that Maryland's medical malpractice arbitration panel did not impermissibly infringe on the plaintiff's right to a jury trial, no fundamental rights were affected.[126] In reviewing the equal protection claim under the rational basis standard, the court held that the distinction created by the arbitration statute between medical malpractice claimants and other claimants was reasonably related to the legitimate purpose of the Act - "the protection of the public health and welfare by assuring the availability of malpractice insurance at reasonable rates."[127]

As the Maryland Supreme Court decision highlights, the ultimate determination of an equal protection/due process violation necessarily involves, as a prerequisite, the determination of the right of access to the courts.[128] If that is violated, then it is bootstrapped into the equal protection/due process analysis with the result that strict scrutiny review is mandated.[129] Under that level of review, a constitutional violation is likely to be found as well.[130] If, however, it has been judicially determined that these screening/arbitration panels do not impermissibly infringe upon the right of access to the courts, then it is likely that no fundamental rights will be considered implicated under a subsequent equal protection/due process analysis.[131] This would then permit an equal protection/due process review under the more permissible rational basis standard, resulting in a holding that the panels are constitutionally sound under this analysis as well.[132] Therefore, because of this bootstrapping, although numerous claims have been raised on this basis, equal protection/due process challenges do not appear to be

---

[126] *Id.* at 77-78.
[127] *Johnson*, 385 A.2d at 78-79.
[128] *See id. See also,* Simon v. St. Elizabeth Med. Ctr., 355 N.E.2d 903, 908 (Ohio 1976).
[129] *See e.g.,* Simon v. St. Elizabeth Med. Ctr., 355 N.E.2d 903, 908 (Ohio 1976).
[130] *Id.*
[131] *See e.g., Johnson*, 385 A.2d at 78.
[132] *Id.*

determinative in the overall constitutional analysis of these statutes. Rather, they merely pile on, one way or the other.

d. Separation of Powers/Infringement on the Judicial Function

A constitutional challenge based on separation of powers/infringement on the judicial function argues that by giving the arbitration/screening panel the authority to apply legal principles to malpractice claims, and to make conclusions of law and fact, these statutes impermissibly infringe upon the function of the judiciary, thus violating a state's constitutionally protected separation of powers doctrine.[133] This argument is particularly compelling in states that require a sitting judge to be one member of the panel since the likelihood exists that the judge's decision could be overridden by the other, non-judicial members of the panel, given that a majority vote typically determines the decision of the panel as a whole.[134] The Illinois Supreme Court, for example, rested its ruling declaring Illinois' panel unconstitutional on the tenet that the power to apply the law to the facts was exclusively the function of the judiciary.[135] Even after the struck statute was revised in response to this ruling, it was still held unconstitutional because the makeup of the panel allowed for shared judicial power.[136]

The Maryland Supreme Court found to the contrary.[137] Interestingly, it based its holding on the acknowledgement that "the essence of judicial power is the *final* authority to render and enforce a judgment,"[138] ruling that because the arbitration panel is

---

[133] *See* Richard C. Turkington, *Constitutional Limitations on Tort Reform: Have the State Courts Placed Insurmountable Obstacles in the Path of Legislative Responses to the Perceived Liability Insurance Crisis?* 32 VILL. L. REV. 1299, 1324 (1987).
[134] *See* Wright v. Cent. DuPage Hosp., 347 N.E.2d 736, 739-40 (Ill. 1976).
[135] *Id.* at 739.
[136] Bernier v. Burris, 497 N.E.2d 763, 770-71 (Ill. 1986).
[137] *Johnson*, 385 A.2d at 59.
[138] *Id.* at 64 (emphasis added).

nonbinding, the power of the judiciary is not infringed.[139] Accordingly, because the right of appeal to the trial level exists, the panel's decision can be rejected and is thus not necessarily the final determination of the controversy.[140] The Court found further support for its ruling in the fact that the panel lacks the statutory authority to enforce its judgment.[141] As the power to enforce remained solely with the judiciary, no constitutional violation on this ground was found.[142]

3. Overall Effect on the Combined Ratio

Of course, the analysis of a particular mode of reform cannot end at the determination of constitutionality. Regardless of its constitutionality, a reform is irrelevant if it fails to remedy its targeted societal ill. Unfortunately for the numerous states that have enacted various arbitration/screening panel statutes over the past 30 years, such is the case here. Because these panels not only fail to reduce the combined ratio but, in some instances, actually serve to raise it, they are worthless at best, and exacerbate the medical malpractice insurance problem at worst.

For example, although the Maryland Supreme Court upheld the 1975 Maryland Health Claims Arbitration Act ("HCA") despite the numerous constitutional challenges described above, once the challenges passed and the statute went into effect, Maryland's medical malpractice crisis only became more pronounced.[143] Eight years later, in 1983, the Maryland General Assembly adopted a Senate Joint Resolution declaring that the cost of medical liability insurance had increased "tenfold" since 1975, and requested that the

---

[139] *Id.*
[140] *Id.* at 65.
[141] *Id.*
[142] *Id.* at 65-66.
[143] *See* Witte v. Azarian, 801 A.2d 160, 166 (Md. 2002) ("Although the 1975-76 legislative response seemed to resolve the immediate 'crisis' of insurance availability, opposition remained to the arbitration mechanism, and some concern was expressed that it did little to stem increases in the cost of malpractice insurance.")

Governor appoint a commission to study the problem.[144] Although the appointed commission downplayed the joint resolution and claimed that it had overstated the problem, the commission nevertheless agreed that the HCA was not the cure-all it was touted to be when it was enacted.[145] Subsequent, post-mortem analysis of the HCA sheds light on why it not only failed to achieve its goal but actually made a bad situation worse.

A 1984 study -- commonly referred to as the "Liebmann Report" -- of the HCA found that once the HCA went into effect, judgments against defendants increased significantly.[146] Specifically, under the HCA, Maryland medical malpractice defendants were successful in only 58% of cases, compared to a national rate of 80-90%.[147] Subsequent to the Liebmann Report, the HCA was amended to allow both parties to waive the arbitration hearing and proceed directly to the trial level.[148] Thereafter, a follow-up study found that Maryland medical malpractice defendants won 62% of cases heard by the panels compared to 70% of cases heard by juries.[149]

While the reasons for this discrepancy are unknown, there is some thought that perhaps, contrary to popular assumption, the panels are more pro-plaintiff than are juries, or that the panels, given that two of the three members are comprised of judicial and medical experts, are more apt to find true malpractice.[150] Regardless, this rise in plaintiffs' verdicts does nothing to lower the combined ratio, but rather, raises it

---

[144] *Id.*
[145] *Id.* The Commission noted that while the overall rate of increase in premium rates had not exceeded increases in the general cost of health care, there had been significant physician premium increases in certain specialties. *Id.* "The Commission concluded that there were existing conditions and future dangers that warranted some changes in tort doctrines and the manner in which malpractice claims were processed." *Id.*
[146] *See* Trimble, *supra* note 4, at 902.
[147] *Id.*
[148] *Id.* at 893.
[149] *Id.* at 902.
[150] *Id.* at 902-03.

Although the Liebmann Report found that the HCA panels returned lower verdicts on average than juries ($289,000 vs. $412,000),[151] the increase in the number of plaintiffs' verdicts more than offsets this advantage, at least from the standpoint of the combined ratio.

Upon reflection, the findings of the Liebmann Report should not have come as a surprise. It simply found that members of the HCA panels behaved in a manner typical of arbitration panels in most forms of litigation. At the very core of the nature of arbitration is the desire to prevent further litigation. As a result, arbitrators naturally feel an urge to dispense a ruling which gives each side something and minimizes the likelihood of appeal. This may explain why, in the case of the HCA, panels found more often for plaintiffs but dispensed lower awards.[152] In the area of medical malpractice litigation, this approach is doubly dangerous because reduced litigation costs serve to lower the bar and encourage additional claims. This results in a medical malpractice litigation framework which not only fails to address the problem directly, but exacerbates it indirectly.

Specifically, reduced litigation costs through the use of arbitration only encourages more claims to be filed overall because, under an arbitration scheme, litigation costs for plaintiffs are significantly lowered along with the increased probability that they are likely to receive a favorable decision from the panel. This likewise encourages the filing of a greater percentage of dubious claims because under an arbitration system, litigation is cheaper, quicker and more likely to result in a plaintiff's verdict than under a jury system. Numerous claims that previously would not have been

[151] *Id.* at 903.
[152] Trimble, *supra* note 4, at 902-03.

filed due to the high cost and low probability of a jury award are subject to reassessment under this system. Although the vast majority of these doubtful claims ultimately and inevitably would result in defense verdicts regardless of the legal system under which they were tried, their sheer number has a devastating effect on an insurer's combined ratio because, as stated earlier, from an insurer's perspective, it makes no inherent difference whether money is spent on indemnity or defense dollars. Evidence of the deleterious effect of wasted defense costs comes from a study which found that Maryland's largest medical malpractice insurer spent almost half of its 1986 legal expenditures on cases closed without payment.[153]

In sum, regardless of their constitutionality, although arbitration/screening panels may very well lessen the likelihood of a substantial plaintiff's verdict, they nonetheless ultimately prove irrelevant at best to the combined ratio because, as a tradeoff, they tend to find for plaintiffs substantially more frequently then do juries. Moreover, the combination of reduced litigation costs for plaintiffs and a greater likelihood of success only encourages the filing of numerous doubtful claims that never would have been filed in the absence of such a system. This very likely explains why the creation of the HCA ultimately served to intensify Maryland's medical malpractice crisis. Thus, contrary to expectations, screening/arbitration panels do not lead to lower premiums and may very well lead to higher ones.

B. Verdict "Capping" and Multipliers

Without question, the most popular forms of malpractice tort reform (or the ones most loudly called for) are the verdict cap on non-economic damage awards and/or the punitive damage cap or multiplier. These types of reform are easily grasped by the public

[153] *Id.* at 910 (regarding the Medical Mutual Liability Insurance Society of Maryland).

and appear, at first glance, to make inherent sense when presented in conjunction with some seemingly convincing statistics regarding large jury awards. However, as this section shows, because, percentage-wise, so few cases ultimately go to a plaintiff's verdict, such caps and multipliers are, for the most part, directly irrelevant to the problem. Moreover, because the overwhelming majority of cases that settle out of court do so for amounts below the level of most caps, they are of little indirect relevance as well. However, these caps do exact an enormous social cost.

1. The Perceived Justification for Caps and Multipliers

In an effort to promote caps on jury awards, supporters point to various statistics. For example, nationally, the size of median malpractice awards between 1996-2000 rose 110%.[154] In 2000, the median jury verdict reached $1 million, which represented a 43% increase over the 1999 figure of $700,000.[155] Such increases also, it is argued, result in higher settlement demands and negotiated settlements.[156] Based on statistics such as these, the popular perception is that million dollar verdicts are now the norm in malpractice litigation.[157] In Philadelphia, the epicenter of the medical malpractice reform debate, the call for some form of capping (despite the fact that capping is prohibited under Pennsylvania's constitution) is growing increasingly louder due to what is perceived to be a malpractice litigation environment out of control, with runaway jury verdicts threatening to shut down southeastern Pennsylvania's medical community.[158] This argument was later buttressed by the White House when in January, 2003, President

[154] *See iii Hot Topics*, *supra* note 1.
[155] *Id.*
[156] *Id.*
[157] *See id. See also* Goldstein, *supra* note 43. In the Goldstein article, Randall R. Bovbjerg of the Urban Institute, who examined medical malpractice in Pennsylvania as part of a Pew Charitable Trust project, stated: "Philadelphia has far more winners as a proportion than elsewhere, and the million-dollar case is not uncommon. It is the norm for jury verdicts in favor of plaintiffs." *Id.*
[158] *See id.*

Bush, citing Pennsylvania's malpractice crisis, singled out exploding jury verdicts as the cause and a nationwide cap the cure.[159]

As a result of such talk, caps, in one form or another, have become quite popular. Currently, 27 states have legislated caps on punitive damage awards with caps on non-economic damages similarly popular.[160] The various forms of capping will be discussed in turn.

2. Punitive Damage Caps

a. Generally

Currently, twelve states have either "flat caps," which set absolute limits on the amount of punitive damages awarded, or "multipliers," which set a maximum punitive damage award as a multiple of the amount of compensatory or actual damages awarded.[161] For example, Nevada's multiplier formula simply provides a cap at three times compensatory damages if they are equal or greater than $100,000, or $300,000 if the compensatory damages are less than $100,000.[162] North Dakota's multiplier formula caps punitive damages at twice the compensatory damages award or $250,000, whichever is greater.[163] Similarly, Indiana's formula caps punitive damages at $50,000 or three times the compensatory damages award, whichever is greater.[164]

By way of contrast, the formulas used by Kansas and Oklahoma are more complicated. The Kansas statute provides that an award for punitive damages may not exceed the lesser of the defendant's gross income, $5 million, or 1.5 times the amount of

---

[159] *Supra* note 2. Bush's plan would supersede state laws and cap noneconomic damages at $250,000 and punitive damages to twice actual losses, up to a cap of $250,000.
[160] Troy L. Cady, Note, *Disadvantaging the Disadvantaged: The Discriminatory Effects of Punitive Damage Caps,* 25 HOFSTRA L. REV. 1005, 1026-27 (1997).
[161] *Id.* at 1027.
[162] NEV. REV. STAT. § 42.005(1) (2002).
[163] N.D. CENT. CODE § 32-03.2-11 (4) (2002).
[164] IND. CODE ANN. § 34-51-3-4 (2002).

profit which the defendant gained or is expected to gain from the wrong.[165] Under Oklahoma law, the determination of the punitive damages cap depends on the *mens rea* involved.[166] Therefore, in cases involving recklessness, a punitive damages award may not exceed the greater of $100,000 or actual damages.[167] However, where the defendant acted intentionally or with malice, a punitive damages award may reach $500,000 or twice the actual damages, whichever is greater, or an amount equal to the increased financial benefit to the defendant that resulted directly from the injury-producing conduct.[168]

Finally, at the extreme end of the spectrum are New Hampshire and Illinois, which prohibit the recovery of punitive damages altogether in medical malpractice actions.[169]

b. Constitutionality of Punitive Damage Flat Caps or Multipliers

The overwhelming majority of punitive-damage flat cap or multiplier statutes have withstood constitutional challenge. Only Alabama and Ohio courts have stricken them on a constitutional basis, with both courts holding that such statutes impermissibly infringe on the state constitutionally protected right to trial by jury.[170] Subsequent to the decision of the Ohio Supreme Court, the Ohio legislature modified its statute by removing the offending language (which stated that punitive damages were to be limited by the discretion of the court) and replacing it with a multiplier provision similar to Nevada and Indiana's, which limited punitive damage awards to the lesser of three times

[165] KAN. STAT. ANN. §§ 60-3701 (e)-(f) (2002).
[166] OKLA. STAT. ANN. tit. 23, §9.1 (B)-(D) (2003).
[167] *Id*. § 9.1 (B).
[168] *Id.* at § 9.1 (C).
[169] N.H. REV. STAT. ANN. § 507:16 (2003); 735 ILL. COMP. STAT. 5/2-1115 (2003).
[170] *See* Henderson v. Ala. Power Co., 627 S.2d 878, 887 (Ala. 1993); Zoppo v. Homestead Ins. Co., 644 N.E.2d 397, 399 (Ohio 1994).

compensatory damages or $100,000.[171] The Ohio Supreme Court struck this provision as well,[172] resulting in the statutory abandonment of punitive damage caps in Ohio.[173] The Supreme Court of Alabama, focusing on the historical role of the jury in the determination of punitive damages, concluded that since, at the time of drafting of the state constitutionally protected right of trial by jury in 1901 juries were entrusted with the role of determining punitive damages claims, there could be no limitation of this right without necessarily infringing on this constitutional right.[174]

c. Other Forms of Punitive-Damage Award Limitations

Caps and multipliers are by no means the sole methods of limiting punitive damage awards. A majority of states, either in conjunction with a cap or multiplier or standing alone, have statutorily heightened the requisite burden of proof for the recovery of punitive damages. 33 states require a showing of clear and convincing evidence before punitive damages may be awarded.[175] Colorado goes even further and adopts a criminal proceeding standard, requiring proof beyond a reasonable doubt for the recovery of punitive damages.[176]

Another method designed by some states to reduce the incentive of plaintiffs to claim punitive damages is to require that a percentage of any medical malpractice punitive damage award be paid to sources other than the plaintiff. A number of states have created funds that are statutorily required to receive anywhere from 25-75% of such

---

[171] OHIO REV. CODE ANN. § 2315.21 (1999).
[172] *State ex rel. Ohio Acad. of Trial Lawyers v. Sheward,* 715 N.E.2d 1062, 1090-91 (Ohio 1999).
[173] OHIO REV. CODE ANN. § 2315.21(B)(1) (1999).
[174] *See Henderson*, 627 S.2d at 884-92. The court held that it would be improper for the legislature to substitute itself for the jury and fix "an arbitrary, predetermined limit of [punitive damages]. . . 'which the jury itself is the appointed constitutional tribunal to award.'" *Id.* at 891 (citing Barry v. Edmunds. 6 S.Ct. 501, 509 (1886)).
[175] *See* Cady, *supra* note 160, at 1027 n. 116; *see, e.g.,* OHIO REV. CODE ANN. § 2315.21(C)(2) (2002).
[176] COLO. REV. STAT. ANN. § 13-25-127(2) (2004).

awards, with some states' fund proceeds earmarked for medical purposes while others are paid into the state treasury.[177]

The constitutionality of these types of statutes varies from state to state. In Colorado, a statute requiring that one-third of punitive damage awards be paid into the state treasury was struck down as unconstitutional under the takings clause of both the U.S. and Colorado constitutions.[178] Georgia, on the other hand, upheld a similar statute in the face of an identical constitutional challenge.[179] Moreover, the Florida Supreme Court refused to consider constitutional challenges of any sort with regard to limitations on punitive damage awards because of its view that since punitive damages are based entirely on public policy considerations, the legislature is empowered to regulate them in whatever way it deems fit.[180] Finally, the Iowa Supreme Court upheld perhaps the most restrictive of these statutes, one which required 75% of all punitive damage awards to be paid into a civil reparation fund.[181] The court reasoned that since plaintiffs do not have a vested right in punitive damages prior to the entry of judgment, the statute cannot violate any constitutional rights.[182]

3. Caps on Non-Economic Damages

a. 'Hard' and 'Floating' Non-Economic Damage Caps

Statutorily imposed caps on non-economic damages typically range from $250,000-$1 million, with most states adopting a "hard" or inflexible cap. Others, however, have floating caps that accommodate changing economic conditions throughout

---

[177] *See* Sandra N. Hurd & Frances E. Zollers, *State Punitive Damages Statutes: A Proposed Alternative,* 20 J. LEGIS. 191, 196 (1994).
[178] Kirk v. Denver Publ'g Co., 818 P.2d 262, 272 (Colo. 1991).
[179] Georgia v. Moseley, 436 S.E.2d 632 (Ga. 1993) (upholding GA. CODE ANN. § 51-12-5.1(2003)).
[180] Gordon v. Florida, 608 S.2d 800, 801 (Fla. 1992).
[181] *Shepherd Components, Inc. v. Brice Petrides-Donohue & Assoc., Inc.,* 473 N.W.2d 612 (Iowa 1991) (upholding IOWA CODE § 668A.1(2)(b) (1989)).
[182] *Id.* at 619.

Deleted: 400

the years. Idaho's cap, for example, is set at $250,000 but may be increased or decreased in accordance with the percentage change in the average annual wage.[183] In Virginia, a statutorily created 1988 $750,000 cap was raised to $1.5 million in 1999 and will continue to increase in $50,000 yearly increments until 2008 when it will increase in increments of $75,000.[184] The proposed nationwide cap, however, as outlined by President Bush in January, 2003, would set a $250,000 hard cap on non-economic damages.[185] In addition, punitive damage awards would be limited to a multiplier of twice actual losses up to an additional $250,000 cap.[186]

b. Constitutional Challenges to Non-Economic Damage Caps

Although the constitutionality of hard and floating caps on non-economic damages varies from state to state, most courts have found them to be constitutional. As with punitive damages challenges, the majority of constitutional challenges here focus on state, rather than federal, constitutional issues.[187] Various challenges have been raised under state equal protection and/or due process clauses, the separation of powers doctrine, the state right to remedy provision and/or trial by jury provisions, with most such challenges ultimately denied.[188]

---

[183] IDAHO CODE § 6-1603 (2003).
[184] VA. CODE ANN. § 8.01-581.15 (2002).
[185] *Supra* notes 2, 159.
[186] *Id.*
[187] *See infra* note 188.
[188] The foolowing cases contain **successful** state equal protection challenges: Moore v. Mobile Infirmary Ass'n, 592 So.2d 156, 170-71 (Ala. 1991) (opinion of Adams, J., with three Justices concurring, one Justice concurring in result, and one Justice expressing no opinion) (invalidating ALA. CODE § 6-5-544(b)(2003)); Carson v. Maurer, 424 A.2d 825, 836-38 (N.H. 1980) (invalidating N.H. REV. STAT. ANN. § 507-C (2003)). The following is a list of cases in which **unsuccessful** state equal protection challenges were asserted: Fein v. Permanente Med. Group, 695 P.2d 665, 682-84 (Cal. 1985) (upholding CAL. CIV. CODE § 3333.2 (2003)); Scholz v. Metro. Pathologists, P.C., 851 P.2d 901, 906-07 (Colo. 1993) (upholding COLO. REV. STAT. § 13-64-302 (2002)); Butler v. Flint Goodrich Hosp. of Dillard Univ., 607 So.2d 517, 522 (La. 1992) (upholding LA. REV. STAT. ANN. § 40:12.99.42 (2002)); Murphy v. Edmunds, 601 A.2d 102, 114-16 (Md. 1992) (upholding MD. CODE ANN., CTS. & JUD. PROC. § 11-108 (2003)); Adams v. Children's Mercy Hosp., 832 S.W.2d 898, 903-06 (Mo. 1992) (upholding MO. REV. STAT. § 58.210 (2001)); Wright v.

4. Capping and the Combined Ratio

Although for the most part passing constitutional muster, these caps and multipliers, regardless of their form, must then achieve their goal of lowering health care costs. Unfortunately, as this section shows, because they are largely irrelevant to such costs, and therefore irrelevant to the combined ratio, they do not. Moreover, they exact enormous unwanted societal costs.

As a preliminary matter, it must be noted that because all caps, regardless of their form, reduce jury verdict awards only and have no direct connection to cases which settle out of court, they affect an extremely small percentage of the medical malpractice cases filed annually. From 1985-1999, only 6.7% of all medical malpractice cases filed nationally went to verdict.[189] Further, only 1.3% reached a *plaintiff's* verdict--the only type directly affected by capping and multiplier statutes.[190] Thus, the capping and multiplier statutes have no direct effect on approximately 99% of all medical malpractice

Colleton County Sch. Dist., 391 S.E.2d 564, 570 (S.C. 1990) (upholding S.C. CODE ANN. § 15-78-120 (2002)); Rose v. Doctors Hosp., 801 S.W.2d 841, 846 (Tex. 1990); Pulliam v. Coastal Emergency Serv. Of Richmond, Inc., 509 S.E.2d 307, 318 (Va. 1999) (upholding VA. CODE ANN. § 8.01-581.15 (2002)); Robinson v. Charleston Area Med. Ctr., Inc., 414 S.E.2d 877, 887-88 (W. Va.. 1991) (upholding W. VA. CODE § 55-7B-8 (2002)); Guzman v. St. Francis Hosp., Inc., 623 N.W.2d 776, 788-90 (Wis. Ct. App. 2000) (upholding WIS. STAT. § 893.55 (2002)). One case held a state due process challenge **successful**. Morris v. Savoy, 576 N.E.2d 765, 770-71 (Ohio 1991) (invalidating OHIO REV. CODE ANN. § 2307.43 (2003)). Other cases, however, have held state due process challenges **unsuccessful**. *Fein*, 695 P.2d at 385; *Scholz*, 851 P.2d at 907; Samsel v. Wheeler Transp. Serv., Inc. 789 P.2d 541, 558 (Kan. 1990) (upholding KAN. STAT. ANN. § 60-19a-01 (2001)); *Pulliam*, 509 S.E.2d at 318; *Robinson*, 414 S.E.2d at 888; *Guzman*, 623 N.W.2d at 788-90. One court has held a state right to trial by jury challenges **successful**. *Moore*, 592 So.2d at 164. However, other cases have held state right to trial by jury challenges **unsuccessful**. Kirkland v. Blaine County Med. Ctr., 4 P.3d 1115, 1120 (Idaho 2000) (upholding IDAHO CODE § 6-1603 (*Year)); *Samsel*, 789 P.2d at 558; *Murphy*, 601 A.2d at 117-18; *Wright*, 391 S.E.2d at 569-70; *Pulliam*, 509 S.E.2d at 314-15; *Gruzman*, 623 N.W.2d at 784-85. The following cases have held state separation of powers challenges **unsuccessful**: *Kirkland*, 4 P.3d at 1122; *Wright*, 391 S.E.2d at 570; *Pulliam*, 509 S.E.2d at 319; *Guzman*, 623 N.W.2d at 787. The following cases held state right to remedy or open courts challenges **unsuccessful**: *Adams*, 832 S.W.2d at 906; *Wright*, 391 S.E.2d at 570; *Rose*, 801 S.W.2d at 845; *Gruzman*, 623 N.W.2d at 787.

[189] *See iii Hot Topics, supra* note 1.

[190] *Id.* The article notes that of the 6.7% of medical malpractice cases which ultimately went to verdict between 1985-99, only 19.1% of these were decided in favor of the plaintiff. **NOTE: *iii Hot Topics* was updated last month – this information is no longer there. Do you have this article on file???**

Deleted: Equal Protection challenges: **Successful**: *Moore v. Mobile Infirmary Association,* 592, S.2d 156 (1991) (invalidating Ala. Code §6-5-544(b)); *Carson v. Mauer,* 424 A.2d 825 (N.H. 1980 (invalidating N.H. Rev. Stat. Ann. §507-C). **Unsuccessful**: *Fein v. Permanente Medical Group,* 695 P.2d 665 (Cal. 1985) (upholding Cal. Civ. Code § 3333.2 (2003); *Guzman v. St. Francis Hosp., Inc.,* 623 N.W.2d 776 (Wis. Ct. App. 200) (upholding Wis. Stat. §893.55 (2002)); *Murphy v. Edmonds,* 601 A.2d 102 (Md. 1992) (upholding Md. Code Ann. Cts. & Jud. Proc. §1-108)); *Adams v. Children's Mercy Hosp.,* 832 S.W.2d 898 (Mo. 1992) (upholding Mo. Rev. Stat. §58.210 (2001)); *Rose v. Doctor's Hospital,* 801 S.W.2d 841 (Tex. 1990); *Butler v. Flint Goodrich Hospital of Dillard University,* 607 S.2d 517 (La. 1992) (upholding La. Rev. Stat. §42:1299.42 (2002)); *Scholz v. Metropolitan Pathologists, P.C.,* 851 P.2d 901 (Colo. 1993) (upholding Colo. Rev. Stat. §13-64-302 (2002)); *Pulliam v. Coastal Emergency Services of Richmond, Inc.,* 509 S.E.2d 307 (Va. 1989) (upholding Va. Code Ann. §8.01-581.15 (2002)); *Wright v. Colleton County School District,* 391 S.E.2d 564 (S.C. 1990) (upholding S.C. Code Ann. §15-78-10 *et. seq.* (2002)); *Robinson v. Charleston Area Med. Ctr., Inc.,* 414 S.E.2d 406 (W.Va. 2001) (upholding W. Va. Code §55-7B-8 (2002)). Due Process challenges: **Successful:** *Morris,* 576 N.E.2d 765. **Unsuccessful:** *Samsel v. Wheeler Transport Serv., Inc.,* 789 P.2d 541 (Kan. 1990) (upholding Kan. Stat. Ann. §60-19a-01 (2001)); *Fein,* 695 P.2d 665; *Guzman,* 623 N.W.2d 776; *Scholz,* 851 P.2d 901; *Pulliam,* 509 S.E.2d 307; *Robinson,* 414 S.E.2d 406. Right to Trial by Jury challenges: **Successful:** *Moore,* 592, S.2d 156. **Unsuccessful:** *Samsel,* 789 P.2d 541; *Wright,* 391 S.E.2d 564; *Guzman,* 623 N.W.2d 776; *Murphy,* 601 A.2d 102; *Kirkland v. Blaine County Medical Center,* 4 P.3d 1115 (Idaho 2000); *Pulliam,* 509 S.E.2d 307. Separation of Powers challenges: **Unsuccessful:** *Wright,* 391 S.E.2d 564; *Guzman,* 623 N.W.2d 776; *Pulliam,* 509 S.E.2d 307; *Kirkland,* 4 P.3d 1115. Right to Remedy/Open Courts challenges: **Unsuccessful:** *Wright,* 391 S.E.2d 564; *Guzman,* 623 N.W.2d 776; *Adams,* 832 S.W.2d 898; *Rose,* 801 S.W.2d 841.

Deleted:

cases filed. Although it can be argued that caps have an indirect effect on settled cases and serve to drive down settlement demands and the dollar amounts of negotiated settlements, further inquiry into the mechanics of most such settlements reveals that these caps are largely irrelevant in this area as well. As such, and with pun intended, the "trickle down" theory holds little water.

Specifically, the average payout per medical malpractice claim closed with some sort of payment (via jury verdict or negotiated settlement) from 1991-2000 was roughly $120,000.[191] It is important to note that this number includes the highly publicized "runaway" jury awards (which in many cases are later and without media fanfare significantly reduced), along with the more numerous negotiated settlements.[192] Moreover, this number has remained roughly consistent throughout the decade, though jumping approximately $14,000 in 1994 and another $16,000 in 1997, years in which the economy was strong, which therefore did not result in sharply spiked premiums.[193] Despite these increases, the average payout per claim closed with payment in 2000 was still only $126,270, approximately 50% below the threshold of even the most restrictive caps.[194] As a result, even a cap set as low as $250,000 (the proposed level of the nationwide cap) will likely have a negligible effect at best on the vast majority of settled claims.

Deleted: and

[191] *See* Joanne Doroshow, *Medical Malpractice Closed Claims Data*, *at* http://www.centerjd.org/press/release/011114.htm) (last visited March 6, 2004) (electronic news release of the Center for Justice and Democracy, Nov. 14, 2001). Accompanying the news release is a spreadsheet highlighting closed claim data for the years 1991-2000. Pursuant to the information provided in this spreadsheet, the average payout per claim closed with payment by year is as follows: 1991: $100,172; 1992: $105,219; 1993: $104,751; 1994: $118,682; 1995: $124,978; 1996: $119,296; 1997: $135487; 1998: $139,542; 1999: $114,460; 2000: $126,270.

[192] *See id.*

[193] *See id.*

[194] *See supra* notes 161-186 and accompanying text. Research done in conjunction with the preparation of this article indicates that the most restrictive caps, such as California's, regardless of whether they are caps of punitive or noneconomic damages, are set at $250,000.

In sum, capping is ineffective mainly because it affects, either directly or indirectly, an insubstantial number of medical malpractice cases. Although the caps do serve to eliminate the occasional runaway verdict, this benefit is largely subsumed in light of the sheer volume of malpractice cases filed. Because the vast majority of cases settle for amounts significantly less than even the most restrictive cap, their presence is largely ceremonial, with this becoming even more so as the level of the cap rises. Moreover, these caps have absolutely no affect on the costs associated with the large number of cases filed which ultimately are dismissed or dropped without an indemnity payment and which, as stated above, represent the largest area of economic waste in the medical malpractice arena. Because both indemnity dollars and expense dollars count equally in the eyes of the combined ratio, the misguided focus and resultant small benefit on the loss side is more than outweighed by the costs on the expense side.

5. The Societal Costs of Capping

Despite the small percentage of cases affected by the various forms of capping, these statutes nevertheless exact significant unwanted societal costs. This becomes evident when those cases affected by caps (either directly via a limitation on the jury's verdict or indirectly via a negotiated settlement reduced due to the presence of a cap) are examined more closely. Upon such examination, it is clear that the small benefit to the loss (and, consequently, the combined) ratio comes at too high a cost and is therefore socially unacceptable.

As the level of the cap rises, so does the selectivity of the cases singled out to bear the brunt (albeit unsuccessfully) of reform. However, as these cases inherently represent

the clearest cases of liability and/or the most grievous damages suffered,[195] it is contrary to common sense notions of justice and fairness to place the laboring oar of reform in their hands. Although there is no question that runaway verdicts occur on occasion, the preceding section showed that payouts over the past decade have not increased significantly in either numbers or dollar amounts.[196] Rather, and contrary to popular opinion, despite the occasional large verdict, malpractice payouts have remained steady.[197] Therefore, on the whole, medical malpractice payouts to claimants are in response to the same factors which motivate payouts in other areas of litigation (i.e., the higher the payout, the more pronounced the liability and greater the damages). As a result, capping only serves to compel the most grievously injured at the hands of the most clearly negligent and/or reckless to bear the brunt of reform.

Moreover, assuming capping were successful, the beneficiaries of this system, from the perspective of potential medical malpractice plaintiffs, are the ones who are the cause of the problem, i.e., those who file doubtful claims in the hope of a quick, cheap settlement. Because meritless and questionable suits are not impacted by capping, the incentive to file them is not reduced with the result being that the insurer's expense costs (and consequently combined ratio) remain high.

From the perspective of the physician, capping is likewise undesirable in that such a system protects the most clearly negligent doctors at the expense of the non-negligent. Those who commit the most grievous mistakes and cause the most significant injuries are

---

[195] Given that there has not been an explosion in medical malpractice indemnity payouts through the 1990's and early 2000's which would indicate the possible involvement of other factors, it is reasonable to assume that the amount of a particular verdict or settlement in this area of the law is as reliable an indicator of the nature of the error and/or harm inflicted in that particular case as it is in any other area of litigation.
[196] *See supra* notes 189-194.
[197] *Id.*

protected through a limitation of their liability while no protection is offered to those who practice good medicine. Rather, those physicians practicing in accordance with the acceptable standard of care are no less susceptible to meritless claims which, while likely to eventually be dropped or dismissed, nevertheless subject them to months or years of stressful litigation and mounting expense costs (which consequently, result in increased insurance premiums in the aggregate). As a corollary, the incentive to practice good medicine is likewise reduced in such an environment given that bad medicine is protected while good medicine is not. In sum, because a capping system protects bad medical decisions, punishes the most grievously injured, and provides no protection of appropriate medical decisions by doing nothing to dissuade doubtful claims, capping is damaging from a policy standpoint and socially unacceptable.

Finally, recent evidence indicates that public awareness of the most recent medical malpractice crisis may have succeeded in lowering the amounts of verdicts and settlements more effectively than any form of capping. In Pennsylvania, an uncapped state, the number and dollar amounts of jury verdicts decreased dramatically in 2002, with the number of million dollar verdicts decreasing 50% from 2000.[198] Moreover, the total amount awarded by Pennsylvania juries in 2002 was approximately $93 million as compared with $415 million in 2000.[199] Whatever impact capping has on an insurer's

[198] *See* Goldstein, *supra* note 43. Through August, 2002, there had been 13 jury awards of $1 million or greater in Pennsylvania compared with 44 such verdicts in 2000. *See also* Telephone Interview with Josh Goldstein, Philadelphia Inquirer Staff Writer (September 2, 2003) (wherein this information was updated with statistics gathered from Pennsylvania's Medical Care Availability and Reduction of Error Fund (MCARE Fund)). According to the MCARE data, there were 22 jury awards of $1 million or greater in Pennsylvania in 2002, a 50% drop from 2000. *See id.*

[199] *See* Goldstein, *supra* note 43. According to Goldstein's article of September 22, 2002, Pennsylvania juries awarded $415 million to plaintiffs in 2000 compared with $69 million through August, 2002. The 2002 jury verdict information was updated by Mr. Goldstein in a telephone interview conducted on September 2, 2003 with data gathered from the MCARE Fund. The final total for 2002 was approximately $93 million.

loss ratio, it is doubtful that it has had more of an impact than juries acting on their own in the absence of a cap. Whether Pennsylvania juries in 2002 were in fact more sensitive to large verdicts due to increased media attention paid to them and the perceived crisis is unknown at present. Anecdotally, however, the dramatic drop points to the preferred method of capping: in the jury deliberation room where the facts and damages of each individual case can be analyzed by those most familiar with the evidence

C. Certificates of Merit

1. Generally

The most recent reform technique is what is commonly referred to as the "certificate (or "affidavit") of merit," whereby a medical malpractice plaintiff is required to file a certificate (either before, in conjunction with or shortly after the filing of the complaint) that certifies, typically by way of an attached expert report, that the claim is meritorious. Currently, approximately 15 states mandate some variation of this filing.[200] New Jersey's statute is typical in that it was enacted with the express purpose of requiring "plaintiffs in malpractice cases to make a threshold showing that their claim is meritorious, in order that meritless lawsuits readily could be identified at an early stage of litigation."[201] The certificate, therefore, provides malpractice defendants with somewhat of a shield, enabling them to ward off frivolous suits quickly and inexpensively.[202]

The certificate of merit requirement appears to succeed where other methods of reform have failed. Maryland adopted its certificate of merit requirement after its

---

[200] *See* Witte v. Azarian, 801 A.2d 160, 168 (Md. 2002). Discussing the qualifications required of experts in those states operating under certificate of merit statutes. *See id.* at 168-69.
[201] In re Hall, 688 A.2d 81, 87 (N.J. 1997).
[202] *See* DeLuna v. St. Elizabeth's Hosp., 588 N.E.2d 1139, 1142 (Ill. 1992) (noting that the purpose of Illinois' certificate of merit statute was to "reduce the number of frivolous suits that are filed and to eliminate such actions at an early stage, before the expenses of litigation have mounted.")

previous method, the arbitration system, produced little fruit and actually, as stated above, made matters worse.[203] In 1987, the year after the certificate of merit requirement was adopted in Maryland, medical malpractice filing rates dropped in the state by 36%.[204] As such, it has been hailed as the single best deterrent to the filing of frivolous claims in Maryland.[205] Its worth relative to its predecessor, the HCA, is evident in the fact that while the arbitration method is still an option in Maryland, it is no longer required and both parties may waive it if they so choose.[206] The certificate of merit, however, is mandated regardless of the form of litigation.[207] These certificates or affidavits have proven increasingly popular such that some states now require them in product liability litigation as well.[208]

2. Method and Process

Certificate of merit requirements vary among the states. In Maryland, medical malpractice litigation is commenced with the filing of the complaint.[209] The complaint, however, will be dismissed with prejudice unless, within 90 days of the filing of the complaint, the plaintiff files a certificate of a qualified expert attesting that the defendant's conduct constituted a departure from the standard of care and that the departure was the proximate cause of the alleged injury.[210]

---

[203] *See supra* notes 143-145 and accompanying text.
[204] *See* Trimble, *supra* note 4, at 907.
[205] *Id.* "The single most effective mechanism for discouraging claimants may be the certificate of merit."
[206] MD. CODE ANN., CTS. & JUD. PROC. § 3-2A-06B (2003). *See also* Witte v. Arizona, 801 A.2d 160, 162 (Md. 2002).
[207] MD. CODE ANN., CTS. & JUD. PROC. § 3-2A-04(b)(2003).
[208] *See* Jeffrey A. Parness & Amy Leonetti, *Expert Opinion Pleading: Any Merit to Special Certificates of Merit?,* 1997 BYU L. REV. 537, 554-55 (1997).
[209] *See Witte,* 801 A.2d at 167.
[210] *See id.*

In other states, the certificate must be filed in conjunction with the complaint.[211] For example, in Illinois, the affidavit must give the name and address of the health care professional consulted, and must, along with the resulting expert report, be filed with the complaint.[212] Moreover, Illinois requires the filing of separate reports for each defendant,[213] and failure to comply with any of these requirements results in the dismissal of the action.[214] There is some leeway, however, as although the affidavit and expert report are ordinarily required to be filed commensurate with the complaint, extensions of time are granted when, despite a good faith effort on behalf of the plaintiff, the defendant refuses to produce relevant medical records or when statute of limitations considerations require the plaintiff to file his/her complaint without the accompanying affidavit.[215] In such situations, the plaintiff then has an additional ninety days to file the affidavit and accompanying report and the defendant is excused from responding to the complaint until the affidavit has been filed.[216] Finally, if allegations contained within the affidavit are found to be untrue, either the plaintiff, her attorney or both may be compelled to pay the other party's reasonable expenses and attorney's fees.[217]

Yet another variation regarding the timing of the certificates comes from New Jersey.[218] Its certification statute requires plaintiffs to file an affidavit of "an appropriate licensed person" in any malpractice claim.[219] This affidavit must be filed within 60 days of the filing of the defendant's answer and must state that there is a reasonable

---

[211] *See, e.g.,* DeLuna v. St. Elizabeth's Hosp., 588 N.E.2d 1139, 1141 (Ill. 1992).
[212] *See* Alford v. Phipps, 523 N.E.2d 563, 567 (Ill. App. Ct. 1988).
[213] *See id.* at 568.
[214] *See DeLuna,* 588 N.E.2d at 1141.
[215] *See* Parness, *supra* note 208, at 557.
[216] *See* James M. Cutchin, Comment, *The 1995 Illinois Civil Justice Reform Act: Has the Baby Been Thrown Out with the Bath Water?,* 20 S. ILL. U. L.J. 117, 124 (1995).
[217] *See* Parness, *supra* note 208, at 557.
[218] N.J. STAT. ANN. § 2A:53A-27 (West Supp. 1999).
[219] *Id.*

probability that the defendant's conduct "fell outside acceptable professional or occupational standards or treatment practices."[220] Similar to the Illinois statute, if the defendant fails to cooperate with the discovery required for the affidavit, the plaintiff is excused from the certification requirement[221] but must file a sworn statement that the defendant failed to provide "information having a substantial bearing on the preparation of the affidavit."[222] However, in the absence of such misconduct on the defendant's behalf, failure to comply with the requirements is considered failure to state a cause of action.[223]

Florida's certification process is a bit more complicated.[224] First, the plaintiff must file a "notification of intent to initiate medical malpractice litigation".[225] However, this cannot be filed until the plaintiff has completed his/her investigation into the matter.[226] The results of this investigation form the substance of the notification of intent, which must state that the defendant was negligent and that this negligence was the cause of his/her injury.[227] A "verified written medical expert opinion" must be filed in conjunction with the notification, corroborating the grounds for the claim.[228] Once these documents have been filed, the defendant must then commence its investigation prior to responding.[229] If, after investigating, the defendant chooses to contest the claim, it must

---

[220] *Id.*
[221] *Id.* § 2A:53A-28.
[222] *Id.*
[223] *Id.* § 2A:53A-29. Georgia's certificate of merit statute is substantially similar to that of New Jersey's. *See* GA. CODE ANN. § 9-11-9.1 (1987). *See also* Robert D. Brussack, *Georgia's Professional Malpractice Affidavit Requirement,* 31 GA. L. REV. 1031, 1032-33 (1997).
[224] *See* FLA. STAT. ANN. § 766.203 (West Supp. 1997).
[225] *Id.*
[226] *Id.*
[227] *Id.*
[228] *Id.*
[229] *Id.* § 766.203(3).

submit a written expert report as well.[230] Such report must be completed by a medical expert and state that "reasonable grounds for lack of negligent injury exist."[231] Significantly, if this expert has had any previous opinion disqualified, he must specify the opinion and the relevant court and case number.[232] The filing on behalf of the defendant completes the first step of Florida's certification process.

The second step in Florida's certification process occurs only if the claim fails to settle within 90 days after the notice of intent is filed by the plaintiff.[233] In that case, the plaintiff must then file a certificate of counsel with the initial pleading.[234] The certificate must state that there was a "reasonable investigation" that gave claimant or his counsel "a good faith belief that grounds exist" for the action.[235] If the court finds that the certificate was not completed in good faith and that the claim was not founded in the law, the court "shall award" costs and attorney's fees against the counsel and "shall submit the matter…for disciplinary review of the attorney."[236]

Michigan likewise institutes a two-step certification process.[237] Initially, the plaintiff is required to serve the potential defendant with written notice of the claim 182 days prior to filing.[238] The notice must contain the "factual basis for the claim," the "applicable standard of practice or care," the manner of the breach, the conduct that should have been taken by the defendant, the manner in which the proximate cause arises, and the names of all other health professionals and health facilities who have been

---

[230] *Id.*
[231] FLA. STAT. ANN. § 766.203(3) (West Supp. 1997).
[232] *Id.* § 766.203(4).
[233] *Id.* § 766.106(3)(a).
[234] *Id.* § 766.104(1).
[235] *Id.*
[236] *Id.*
[237] MICH. COMP. LAWS. ANN. § 600.29121(1) (2001).
[238] *Id.* § 600.2912b(1).

notified.[239] If at any time during this 182-day period the potential defendant informs the plaintiff of its intent not to settle, the plaintiff may then commence litigation.[240]

The second step occurs once the notice period has ended and the defendant has failed to notify the plaintiff of an intent not to settle.[241] In this scenario, the plaintiff may file an action but must attach an "affidavit of merit signed by a health professional."[242] In it, the expert must: certify that he/she has reviewed the notice and relevant medical records; indicate the applicable standard of care; demonstrate how the standard of care should have been met; and show that the breach was the proximate cause of the plaintiff's injury.[243] Similar to New Jersey's certification statute, if the Michigan defendant does not provide the plaintiff with access to the relevant medical records, the plaintiff may be granted an extension to complete and file the affidavit.[244]

3. Restrictions on Medical Experts

In an effort to reduce the likelihood of professional and/or generic medical experts, some jurisdictions have placed significant limitations on the qualifications of medical experts retained in conjunction with the certification process. For example, the Illinois "Healing Art Malpractice" statute requires the court to consider four factors in the determination of expert qualification:

(a) whether the witness is board certified or board eligible in the same medical specialties as the defendant…;
(b) whether the witness has devoted 75% of his or her time to the practice of medicine, teaching or University based research in relation to the medical care and type of treatment at issue…;

[239] *Id.* § 600.2912b(4)(a)-(f).
[240] *Id.* § 600.2912b(9).
[241] *Id.*
[242] MICH. COMP. LAWS. ANN. § 600.29121d(1) (2001).
[243] *Id.* § 600.2912d(1)(a)-(d).
[244] *Id.* at 600.2912d(3). This is similar to Georgia's provisions as well. *See supra* note 223.

(c) whether the witness is licensed…in the same profession as the defendant; and

(d) whether, in the case against a nonspecialist, the witness can demonstrate a sufficient familiarity with the standard of care practiced in this State.[245]

Maryland has a similar, but ultimately more restrictive, provision, forbidding an attesting expert from spending "annually more than 20% of the expert's professional [time in] activities that directly involve testimony in personal injury claims."[246] This feature is unique in that while other jurisdictions, such as Illinois above, require medical experts to have certain specific qualifications, no other jurisdiction ties an expert's ability to certify a claim solely and directly to the percentage of time he/she spends testifying in personal injury claims.[247]

4. Constitutional Challenges to the Certificate of Merit

a. Denial of Access to the Courts

Perhaps the most apparent challenge to the certificate of merit is rooted in the theory that these certificate of merit statutes are constitutionally infirm because the expert report requirement, either before or in conjunction with the pleadings stage, effectively bars plaintiffs from access to the courts.[248] However, these challenges typically fall short as many courts hold that certificates do not add an additional burden on the plaintiff.[249] Rather, because plaintiffs are required in the overwhelming majority of medical malpractice cases to produce an expert report at some point even without the certificate of

[245] 735 ILL. COMP. STAT. ANN. 5/8-2501 (1993).
[246] MD. CODE ANN. CTS. & JUD. PROC. § 3-2A-04(b)(4) (2003).
[247] *See* Witte v. Azarian, 801 A.2d 160, 168 (Md. 2002).
[248] *See, e.g.,* DeLuna v. St. Elizabeth's Hosp., 588 N.E.2d 1139, 1145 (Ill. 1992).
[249] *Id.* at 1146.

merit requirement, the acceleration of this process is not seen as constitutionally suspect.[250]

b. Equal Protection/Due Process

Like the constitutional challenges under these clauses with respect to other methods of medical malpractice reform, an equal protection/due process challenge to certification statutes is based on the theory that they result in disparate treatment of medical malpractice plaintiffs as compared with plaintiffs who file suit in other areas of the law.[251] And once again, the level of scrutiny given to such challenges largely determines their success.

For example, although the New Hampshire Supreme Court concluded that strict scrutiny was inappropriate given that no fundamental rights were involved (having rejected plaintiff's claim that the right to recover for personal injuries constituted such a right), it nevertheless held that intermediate scrutiny was required given that the rights involved (namely, the right to recover damages) were "sufficiently important to require that the restrictions imposed on those rights be subjected to a more rigorous judicial scrutiny than allowed under the rational basis test."[252] Under this heightened scrutiny, the court held that New Hampshire's certification statute, which mandated that no suit could be filed until the expiration of a sixty day period within which the defendant could review the plaintiff's notice of claim and supporting documentation, was unreasonable.[253] The court noted the statute's legislative history as indicating that the purpose of the certification process was to provide defendants with warning of pending expensive

[250] *Id.* *See also* Pearlstein v. Malunney, 500 So.2d 585 (Fla. Dist. Ct. App. 1986); Lindberg v. Hosp. Corp. of Am., 545 So.2d 1384 (Fla. Dist. Ct. App. 1989).
[251] *See, e.g.,* Carson v. Maurer, 424 A.2d 825 (N.H. 1980).
[252] *Id.* at 830.
[253] *Id.* at 834-35.

litigation and to enable them to evaluate and consider the possibility of settlement in order to avoid these costs.[254] However, the court determined that this did not "fairly and substantially" relate to any legitimate legislative objective, as even without the certification process the defendant still had ample time to review the claim prior to trial, and thus the statute only served to postpone the time until a malpractice victim could expect to recover for his injuries.[255] Although the New Hampshire Supreme Court sorely underestimated malpractice pre-trial costs, its decision is representative of rulings based on equal protection/due process challenges under the microscope of heightened review.

By contrast, the Illinois Supreme Court expressly rejected the reasoning of their judicial brethren in New Hampshire, and concluded that rational basis review was appropriate.[256] Applying the identical rationale used by the Maryland Supreme Court in analyzing an equal protection challenge to Maryland's arbitration panel,[257] the Illinois court concluded that because it had previously ruled that the certification statute does not impermissibly burden a litigant's fundamental right of access to the courts, there were no fundamental rights involved in the context of an equal protection analysis.[258] Accordingly, the court held that Illinois' certification statute was rationally related to the legitimate legislative purpose of reducing the number of frivolous malpractice actions that may otherwise be filed.[259] Rational basis review was likewise performed in the Florida and New Jersey supreme courts with similar results.[260]

c. Separation of Powers

---

[254] *Id.* at 834.
[255] *Id.*
[256] DeLuna v. St. Elizabeth's Hosp., 588 N.E.2d 1139, 1142-43 (Ill. 1992).
[257] *See supra* notes 123-27 and accompanying text.
[258] *DeLuna*, 588 N.E.2d at 1152-43.
[259] *Id.* at 1147. *See also* Bloom v. Guth, 517 N.E.2d 1154, 1156 (Ill. App. Ct. 1988).
[260] *See* Pearlstein v. Malunney, 500 So.2d 585 (Fla. 1987); Lindberg v. Hosp. Corp. of Am., 545 So.2d 1384 (Fla. 1989); Barreiro v. Morais, 723 A.2d 1244 (N.J. 1999).

A final constitutional challenge to state certification statutes takes the form of one based on a violation of the separation of powers doctrine. Under this challenge, plaintiffs typically allege that the prerequisite medical "stamp of approval" of a medical malpractice claim impermissibly confers upon health care professionals a judicial role.[261] As only the judiciary is constitutionally empowered to deny an individual access to the court system, it is alleged that such certification requirements result in an impermissible blending of the judicial and witness roles.[262]

The Illinois Supreme Court rejected this claim, however, holding that the certification process requires medical experts to do nothing more or different than they would otherwise be called upon to do later on at trial.[263] Because the certification process merely accelerates the time by which the expert report needs to be obtained, the court held it to be constitutionally sound.[264] Importantly, the court noted the distinction between roles when it stated that the while the certification statute required an advisory opinion of a medical expert to be attached to the plaintiff's complaint, it was the sole function of the judiciary to take this report into account in determining the overall sufficiency of the complaint.[265] Accordingly, the judge alone has power to dismiss the plaintiff's cause of action.[266]

Further, the Illinois Supreme Court noted that the medical expert is merely providing the opinion of a layman and not a legal professional.[267] As such, certification

---

[261] *See, e.g., DeLuna,* 588 N.E.2d at 1143.
[262] *Id.*
[263] *Id.* at 1144.
[264] *Id.*
[265] *See* McAlister v. Schick, 588 N.E.2d 1151, 1154-55 (Ill. 1992).
[266] *Id.*
[267] *Id.* at 1156-57.

is of the *underlying claim* and not of the legal cause of action.[268] Because the power to certify the legal cause of action remained in the sole dominion of the judiciary, the Illinois certification requirement did not result in an impermissible sharing of judicial power.[269] This was contrasted with the function of a medical malpractice screening panel which was held to violate Illinois' Separation of Powers doctrine because that panel was empowered to make conclusions and interpretations of law.[270]

An important distinction to Illinois Supreme Court, and other courts which found that screening/arbitration panels violate the Separation of Powers doctrine but certification requirements do not, is the fact that plaintiffs are free to select an expert of their choosing under most certification statutes.[271] In fact, the Illinois Supreme Court strongly hinted that its ruling might very well be different were this not the case.[272]

Finally, at least one state -- Ohio -- invalidated a certification statute under the Separation of Powers doctrine under the theory that the procedural requirements contained therein impermissibly conflicted with its rules of civil procedure.[273] The court ruled that because the state supreme court was empowered by the state constitution to promulgate rules of civil procedure which govern civil matters, any conflicting procedural rule must therefore violate the Separation of Powers doctrine.[274] As Ohio's rules of civil procedure stated that pleadings need not be verified or accompanied by affidavit, a certification requirement mandating that all medical malpractice complaints

---

[268] *Id.*
[269] *Id.*
[270] *See* Garland v. Kauten, 567 N.E.2d 707, 709 (Ill. App. Ct. 1991).
[271] *See infra* note 272.
[272] DeLuna v. St. Elizabeth's Hosp., 588 N.E.2d 1139, 1144 (Ill. 1992). "[T]he statute permits the plaintiff to select his own health professional in obtaining the required certification, and we need not consider here whether our result would be the same if the statute designated a specific person or *panel* to perform that function." *Id.* (emphasis added).
[273] Hiatt v. S. Health Facilities, Inc., 626 N.E.2d 71 (Ohio 1994).
[274] *Id.* at 73.

be accompanied by an affidavit signed by the plaintiff's attorney was clearly violative of this rule and therefore, unconstitutional.[275]

5. Certificates of Merit and the Combined Ratio

Unlike the arbitration/screening panel and capping methods of malpractice reform, certificate of merit requirements do in fact achieve their goal of reducing malpractice costs because they exert a tangible effect on an insurer's combined ratio. This is because certificates of merit target and, more importantly (unlike arbitration/screening panel requirements) impact the area of greatest economic waste, namely expenses incurred in defending meritless medical malpractice cases. In addition, and crucially, certificate of merit requirements do not affect those cases which ultimately settle or go to verdict, thus avoiding the negative societal impact associated with capping statutes.

As discussed earlier, medical-malpractice defense costs represent, comparatively, the largest percentage of an insurer's incurred losses: roughly 40% as opposed to 13% in all lines of insurance.[276] In other words, malpractice insurers typically spend 40 cents of every dollar on defense costs as compared with only 13 cents spent by insurers in all lines. This 27 cent difference can be attributed to, in part, the higher costs associated with defending complex medical malpractice claims, but can also be attributed to the fact that roughly 62% of all medical malpractice cases filed are eventually dismissed or dropped without payment.[277] As a result, medical malpractice insurers typically spend, percentage-wise, significantly more on defense costs than do insurers of other lines of

[275] *Id.*
[276] *See supra* notes 69-70 and accompanying text.
[277] *See iii Hot Topics, supra* note 1. Between 1985-99, 62.3% of all medical malpractice cases were dropped or dismissed in favor of the defendant. *Id.*

business and, in fact, spend more money defending claims than on all other administrative costs combined.[278] Therefore, the most effective mode of reform will necessarily be the one which effectively reduces the percentage of meritless claims filed. This, in turn, results in a reduction of defense costs. Because defense and indemnity costs are weighted equally in the calculation of the insurer's combined ratio, a reduction of defense costs impacts the combined ratio with equal force as a reduction of indemnity costs. As previously discussed, there is no inherent reason to target indemnity costs for reform, particularly when it is in the area of defense costs where significant economic waste abounds.

Given the staggering amount of money spent on the defense of ultimately meritless claims (as evidenced by research conducted on Maryland's malpractice litigation environment which found that in 1986 the state's largest insurer spent almost half of all legal expenditures on cases eventually closed without payment),[279] and the corresponding large percentage of them, a successful method of reform will naturally be one which effectively eliminates meritless suits from the legal system as quickly as possible. The arbitration/screening panel system attempts to do this but ultimately fails because by lowering the costs of litigation to plaintiffs, it unfortunately and, unexpectedly, only encourages an even greater number of meritless suits. As a result, and as evidenced by Maryland's HCA reform attempt in the 1980's, while certain, specific cases are eliminated from the trial system on a micro level, a malpractice litigation boom will likely result on a macro level as plaintiffs are encouraged to file

[278] *See* Trimble, *supra* note 4, at 910.
[279] *Id.*

doubtful claims due to lower costs and a greater likelihood of success at the arbitration level.

By contrast, certificates of merit do not lower the costs of litigation to plaintiffs. As stated by numerous courts in the context of responding to constitutional challenges to these statutes, the certificate and attached expert report requirements require plaintiffs to undertake the same burden and expense as before, albeit at an earlier stage of litigation.[280] Thus, the unwanted side effects which emerged with regard to the arbitration/screening panel requirements have been eliminated. Importantly, certificate of merit statutes succeed where others fail because they reduce litigation costs to defendants only. As demonstrated by the failure of arbitration/screening panel reform, reducing costs on both sides results in giving back on one side all of the gains made on the other.

Perhaps the most attractive aspect of certificate of merit statutes is that they succeed in reducing the percentage and costs associated with litigating meritless claims without affecting the amount paid to legitimately injured plaintiffs in indemnity payouts. In short, they succeed in reducing the combined ratio without the deleterious social effects present in capping statutes. Although certificate of merit requirements do not lower litigation costs to plaintiffs, they do not raise them either. Therefore, the legitimate plaintiff is ultimately unaffected by them. The only individuals who feel the sting of these requirements are those who present doubtful claims and who should be deterred from the malpractice litigation system in any event – the meritless plaintiffs. Their lingering presence is what drives the combined ratio of malpractice insurers up to levels which cause these recurring crises whenever the bond market weakens. The quick elimination of these unwanted players in the tort system will result in a lowering of the

[280] *See supra* notes 261-70 and accompanying text.

combined ratio to levels which, although likely to still be higher than in other lines of business due to the high costs associated with litigating complex medical malpractice cases, will be lowered to a point where the cyclical crises will be less severe than is presently the case.

V. Conclusion

Regardless of the area of law, in order to properly shape an effective method of reform the cause must first be properly identified. While it is tempting to jump to conclusions regarding the cause of the recurring medical malpractice crises, further analysis reveals that most of the popularly held assumptions are in fact incorrect. Therefore, it should come as no surprise that tort reform in this area has largely failed. Contrary to the widely held belief, there has never been a malpractice "crisis" insofar as that term implies that malpractice litigation is the root cause of spiking physician premiums. Rather, due to the nature of the investment strategy of the insurance industry, these spikes naturally and precisely correlate to the rise and fall of the bond market.

However, contrary to those economists who conclude that given this economic link, tort reform of any sort is irrelevant to the solution, an analysis of the calculation and effect of the combined ratio on an insurer's profit margin during weak bond markets shows that reform which seeks to lower this ratio will be effective in reducing the impact of the market during these inevitable cyclical downswings. Unlike the arbitration/screening panel and "capping" methods of reform, certificate of merit requirements not only target the area which is most responsible for raising malpractice insurers' combined ratios, they effectively act to reduce this area of waste.

Unfortunately, those states which have enacted certificate of merit statutes have not enjoyed their full benefit because such statutes are typically one of several methods of reform enacted within the jurisdiction. As a result, the economic benefits derived from the certificate of merit statutes are diluted by other, less effective modes of reform, some of which (as with arbitration/screening panels) unintentionally encourage the filing of doubtful claims and offset the economic benefits to insurers.[281] This may explain why Maryland was unable to sustain the sharp decline in filing rates the year after implementation of its certificate of merit statute.[282] Because its highly ineffective arbitration statute remained in effect, prospective plaintiffs who were most likely discouraged from filing due to the higher initial costs associated with the acceleration of the expert report requirement were eventually drawn back into the system by reduced costs in other areas and the greater likelihood of a plaintiff's verdict. As the Maryland example demonstrates, less, at least in the context of medical malpractice litigation reform, is often more. However, given that it is typically difficult to "unring the bell" and discard the ineffective methods of reform that survive, it is unlikely that those jurisdictions which add the effective certificate of merit requirement to the heap of failed experiments which preceded it will realize many of its benefits.

[281] *See supra* notes 143-53 and accompanying text.
[282] *See* Trimble, *supra* note 4, at 907. In 1987, the year after the certificate of merit requirement went into effect, the medical malpractice filing rate declined approximately 36% from the previous year. *Id.* By 1996, however, filing rates had nearly returned to their pre-certificate levels. *Id.*