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In Search of Savings - Caps on Jury Verdicts are Not a Solution to Health Care Crisis

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In Search of Savings

Caps on jury verdicts are not a solution to health care crisis

by David Morrison

In the past two decades, twenty-eight states have altered their tort laws to limit all or part of the damages a jury may assess against a doctor accused of medical malpractice.[1] Further efforts to create new "caps" or to amend existing caps are pending in several states.[2] Moreover, caps have been integral to several of the recently debated national health care reform proposals.[3] Most recently, caps have been featured prominently in the Republican "Contract with America."[4]

Observers generally acknowledge "waves" of caps on medical malpractice verdicts. Caps first occured in the mid-1970s and featured laws that limited total compensation to a pre-determined amount.[5] The second wave occurred in the mid-1980s and differed from the first only slightly. Specifically, these laws capped only noneconomic damages, punitive damages or both. While the scope of the caps differed, the basic argument in favor of caps was largely the same. Caps proponents argued that malpractice insurance premiums had risen to intolerably high levels and that insurers were losing money or were withdrawing from the region.[6]

Advocates for caps have argued that problems in the insurance market had several, broader consequences. While these advocates tailored each argument to address the perceived needs of various health care crises, they each shared a common motor force: insurance rates. The link between insurance rates and the need for caps takes many forms. In response to claims that health care costs were rising rapidly, they blamed jury verdicts. Jury verdicts, they asserted, were often excessive per se. Thus, according to the advocates, high jury verdicts were the cause of rapidly increasing malpractice insurance premiums.[7] Moreover, they asserted that caps on jury verdicts would result in lower premiums and consequently in lower health care costs. When a perceived decline in health care was discussed, caps supporters again pointed to verdict-driven insurance costs. They claimed that jury verdicts were responsible for large increases in insurance premiums, which drive health care providers out of practice and cause shortages of specific specialties, especially obstetricians.[8] In the mid-1980s, caps proponents introduced the idea of "defensive medicine." This concept was explicitly tied to insurance rates. *The Journal of the American Medical Association* reported that during the 1980s, every $1.00 increase in malpractice insurance costs resulted in a $3.50 increase in costs for additional testing to avoid malpractice.[9] Thus, caps proponents linked caps to insurance rates and promised a better insurance environment only if jury verdicts were artificially restricted.

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Significantly, during these waves, opponents of caps framed their arguments largely in terms of the relationship between caps and insurance. They countered that the cost of medical liability comprised a minuscule fraction of total health care spending so that artificial restrictions on health care provider liability would have a negligible effect on total expenditures. Many questioned even the existence of an insurance "crisis," noting that malpractice insurance remained immensely profitable. Moreover, they noted, malpractice premiums had actually grown at a slower rate than other health care provider costs. The direct and indirect effects of jury verdicts on health care costs and availability are negligible, they claimed, while the cost of caps to victims is unconscionably high. Opponents also argued that caps affect only the most seriously injured. Rather than distributing the reduction in jury verdicts among all malpractice victims, much of the effort focuses on insurance costs and availability.[10]

As the verdict limitations adopted during the first two waves faced constitutional challenges, a sizeable body of case law developed. Many challengers of jury verdicts question who pays for and who benefits from caps. Several cases have been brought by injury victims whose verdicts were reduced by caps. In turn, these claims have raised issues of equal protection,[11] open courts,[12] due process,[13] and the right to a jury trial;[14] usually under state law.[15] In facing one of the challenges, the survival of caps most often hinged on the practical distribution of costs and benefits.

Few courts ruled that caps of any sort were unconstitutional.[16] Most acknowledged circumstances under which legislatures could limit all or part of an injury victim's recovery. But courts were careful about determining exactly what circumstances would allow such limitations. Many courts adopted a balancing test, weighing the cost of limits to victims against projected societal benefits. Only in jurisdictions where courts were convinced that the promised benefits of lower health care costs and increased availability could be reasonably expected as a result of the caps did the new laws pass constitutional challenges.[17] When caps failed, they did so primarily because the insurance "crisis" proved illusory.[18]

Many of the arguments in favor of caps, including rural availability, obstetric availability, and defensive medicine, were explicitly tied to the idea of an "insurance crisis." Courts proved unwilling to accept that there was a crisis at all, or, if such a crisis did exist, that caps on jury verdicts would help to solve the crisis. The argument that caps bore a substantial relation to improving insurance availability, central to the claims made by caps proponents, became untenable as insurers' own analyses of the new laws became public. For example, Florida's caps law, as passed in 1986, require insurers to lower their rates unless they can prove that the Act would be ineffective at lowering costs, rather than requiring the insurers to justify future rate hikes.[19]

Aetna Insurance issued a report finding that the jury verdict limits would have no impact on insurance rates.[20] Perhaps most damning, the Insurance Services Office ("ISO"), an insurer-dominated clearinghouse, issued the results of a survey of over 1,000 insurance executives in 24 states, including 15 that had recently imposed caps.[21] The ISO found that an overwhelming majority believed that caps would have no effect on rates.[22] Combined, these reports reduced many arguments in favor of caps to non sequiturs.

On the basis of these findings, many courts declared the new caps laws to be unconstitutional. Courts in Alabama and New Hampshire struck caps under equal protection clauses. The Alabama supreme court noted: "[a]lthough there is evidence of a connection between damages caps and the size of malpractice claims filed, the size of claims filed is merely one among a host of factors bearing on the cost of malpractice insurance."[23] "By contrast," the court continued, "the burden imposed on the rights of individuals to receive compensation for serious injuries is direct and concrete."[24] The Texas supreme court found: "it is unreasonable and arbitrary to limit [injury victims'] recovery in a speculative experiment to determine whether or not liability rates will decrease. Texas Constitution article I section 13, guarantees meaningful access to the courts whether or not liability insurance rates are high."[25] In Ohio, the court focused on the state constitution's due process clause, holding: "it is irrational and arbitrary to impose the cost of the intended benefit to the general public solely upon a class consisting of those most severely injured by medical malpractice."[26] Both the Ohio and Texas courts cited data confirming that caps had little or no effect on insurance rates.[27]

In the wake of these decisions, caps proponents have tinkered with their arguments.[28] The idea of a "crisis" remained, but the exact nature of the crisis became fuzzy. Each of the "problems" that made the "crisis" had been linked explicitly to insurance costs. After a series of de-

feats in the courts, proponents began to disassociate the "problems" from the cause. Caps proponents continue to cite problems of rural availability, but generally do not cite insurance rates as the cause. Obstetric availability remains a frequently-cited problem but, here too, insurance rates are no longer blamed as the principle reason that obstetricians leave the practice. Defensive medicine remains a mainstay of caps proponents' arguments but, where the original studies expressed the cost of defensive medicine in terms of changes in insurance premiums, now proponents cite only the aggregate figure. Proponents have repositioned themselves to avoid the legal embarrassment that greeted them during the last wave of caps laws.[29]

This tactical shift on the part of caps proponents could affect the next wave of legal challenges. The new spin on caps is that verdict limits are needed to improve the availability of rural and obstetrical care and to decrease the practice of defensive medicine.[30] The argument for the "need" for caps has taken the place of the "insurance crisis" argument.[31] While it is likely that caps laws will continue to face challenges on grounds of equal protection, due process, and the right to a jury trial, the specific nature of the claim will shift away from insurance costs and onto the general societal impact of caps. Where past legal challenges focused on whether there was a substantial relation between jury verdict caps and insurance rates, future cases may turn on whether there is a substantial relation between caps and availability.

Indeed, courts have suggested framing the question in these terms.[32] In *Wright v Central DuPage Hospital*, Justice Underwood of the Illinois supreme court dissented, noting: "It is quite true that the $500,000 limitation upon recovery bears most heavily upon the severely injured person. A stronger case for the limitation would exist if it permitted unrestricted recovery of actual expenses, for it is conceivable, as the majority emphasizes, that with today's inflated costs, total expenses of treatment and care could exceed the allowable recovery. *To be weighed against that rather remote possibility, however, is the vital interest, if not the absolute necessity, of society in having adequate health care available at reasonable cost. To the admittedly imprecise extent that the recovery limitation here in question contributes to that goal, far more persons are benefited than in any other area in which similar litigation occurs.*"[33]

While largely a case of old wine in new bottles, this transition nonetheless necessitates a reformulation of the debate. Of course, not all decisions striking caps were the result of caps proponents' inability to prove a link between caps and insurance costs.[34] But many did, and in these states, caps opponents may have to rework their arguments. Moreover, the bulk of academic studies of the effects of jury verdict caps generally reflect the focus on insurance. These studies focus on either doctors' insurance costs or the impact of caps on claims severity and frequency: how much insurers pay out, and how often.[35]

This article attempts to address this transition by examining empirical evidence of the effect of caps on jury verdicts on the general population.

This article attempts to address this transition by examining empirical evidence of the effect of caps on jury verdicts on the general population. Specifically, those who are not injured by malpractice. The article will examine aspects of health care costs and availability in Indiana, which has a cap on the total compensation a jury may issue; and Illinois, which puts no restrictions on medical malpractice jury verdicts.[36] Furthermore, this article focuses specifically on differences in aggregate and per capita health care spending; aggregate and per capita physician services spending; the availability of different specialties of doctors; aggregate insurance levels and growth; and profitability of malpractice liability insurance from 1980 to 1991.

Illinois and Indiana are ideally suited for such a comparison. These states share over 200 miles of border, but their medical malpractice laws are worlds apart. During the period from 1980 to 1991, Illinois put no limit on any part of medical malpractice jury awards. Conversely, In-

diana limited the total award both economically and non-economically.[37] Illinois made those even partly responsible for the specific instance of medical malpractice liable for the total verdict; whereas Indiana limited each party's liability to his estimated share of blame. No other set of neighboring states illustrates so dramatic a disparity in medical malpractice laws.[38]

Likewise, Illinois' and Indiana's health care systems recently faced similar "crises." Legislators in both states adopted caps on total victim compensation in 1975, but, while the Indiana courts upheld caps, Illinois courts struck caps down.[39] This article examines empirical data focusing on the years when Indiana had a cap and Illinois did not. It quantifies the consequences of these two decisions. Were the arguments in favor of caps true, Illinois' health care costs should have risen significantly in comparison with costs in Indiana. Greater availability of physician services including obstetrical care could also be expected. Moreover, while the number of hospital beds should seemingly increase, the costs of these beds should decrease. In addition, most Indiana residents should have seen some benefit from the restrictions paid for by victims.

Table 1: Health Care Spending Per Capita Annual Rate of Change

	Indiana	Illinois	Nation
1982	+12.48%	+8.69%	+11.7%
1983	+7.40%	+6.48%	+8.7%
1984	+6.18%	+6.34%	+7.7%
1985	+8.44%	+7.62%	+8.8%
1986	+6.67%	+4.68%	+7.3%
1987	+8.17%	+6.34%	+8.4%
1988	+8.63%	+7.26%	+9.1%
1989	+8.27%	+6.71%	+8.4%
1990	+10.13%	+8.77%	+9.8%
1991	+10.24%	+7.66%	+9.1%

Table 1a: Five Year Average 1987-1991

Total	+47.92%	+37.21%	+41.7%
Average Annual	+9.29%	+7.34%	+9.0%

Source: Health Care Finance Administration, Office of the Actuary

Table 2: Physician Services Spending Per Capita

	Indiana	Illinois	Nation
1980	165	187	199
1981	187	211	227
1982	213	224	249
1983	220	248	276
1984	247	275	307
1985	297	322	354
1986	321	344	387
1987	364	379	429
1988	399	413	478
1989	433	435	516
1990	485	476	564
1991	515	496	598

Table 2a: Rate of Growth 1980-1991

Total	212.12%	165.24%	200.50%
Average Annual	10.9%	9.3%	10.5%

Source: Health Care Finance Administration, Office of the Actuary

Health Care Spending: Greater Growth with Caps than Without[40]

Exploding health care spending is among the principle reasons cited for current reform debate. Between 1980 and 1991 aggregate[41] health care spending in the United States grew nearly three-fold, from $226 billion to $676 billion, a 199% increase.[42] Far outstripping growth in Gross Domestic Product ("GDP"), health care consumed nearly 12% of the nation's economy. This number is up from 8.4% in 1980.[43] Efforts to slow this explosion have shaped the current reform debate. Some claim that lawsuits and unbridled jury verdicts have contributed to this explosion. Thus, they contend, only by limiting recovery can government hope to slow health care spending.

Neither Indiana nor Illinois was immune to the forces that pushed health care spending higher during the 1908s; but these states experienced dramatically different growth rates. Illinois' health care spending increased from $8.8

billion in 1980 to $21.2 billion in 1991, an increase of 138.6%. During that time, even without caps on jury verdicts, Illinois grew significantly slower than the national average. Relative to economic output, Illinois health care spending grew moderately when compared to the nation as a whole. In 1980, health care took 8.8% of Illinois' Gross State Product ("GSP"), slightly more than the national average. But by 1986, health care was taking a smaller-than-average share of GSP at 9.5% compared to the national average of 9.8%. By 1991, health care represented just 10% of GSP compared to 11.9% nationally. The absence of caps obviously had no inflationary impact on health care spending.

Table 3: Health Care Spending as a Percent of Household Income

	Indiana	Illinois
1981	6.94%	7.33%
1982	7.47%	7.71%
1983	7.95%	7.92%
1984	7.67%	7.70%
1985	7.96%	7.90%
1986	8.04%	7.87%
1987	8.34%	8.00%
1988	8.60%	8.07%
1989	8.79%	8.06%
1990	9.30%	8.36%
1991	10.11%	8.87%

Table 3a: Five Year Average 1987-1991

Total	9.07%	8.30%
Average Annual Increase	4.46%	2.36%

Source: Based on figures from the Health Care Finance Administration, Office of the Actuary.

By contrast, Indiana's aggregate growth nearly equalled the national pace. From $3.3 billion in 1980, Indiana's health care spending grew 192.6% to $9.7 billion. Indiana's economy was not as equipped to pay these increases. Its economy grew 16% slower than the national economy as a whole. Indiana's health care spending ballooned from 8.1% in 1980 to 12.2% in 1991. In this respect, Indiana surpassed Illinois by 1986 and the nation by 1990. Despite its severe limitation on medical malpractice victim recovery, Indiana saw significantly greater growth in health care spending.

Even in the area of physician services spending, which would seem to be most sensitive to reductions in medical malpractice liability, Indiana did not grow any slower than Illinois or the nation. Across the United States, physician services spending grew 235.6%, from $45 billion in 1980 to $151 billion in 1991. Indiana did slightly better, growing 220%, from $904 million to $2.9 billion. But here, too, Illinois, without limits on victim compensation, experienced the slowest growth. Illinois' physician services spending grew just 169%, from $2.1 billion to $5.7 billion.

Similar trends are evident when physician services spending is examined in relation to population trends. Per capita physician services spending grew 200% nationally, from $199 to $598. Indiana grew 212%, from $165 to $515, while Illinois grew just 165%, from $187 to $496. Despite the fact that Indiana was 11% below Illinois' average in

Table 4: Doctors Per 10,000 Capita

	Indiana	Illinois
1980	9.5	11.7
1981	9.9	12.4
1982	10.4	12.7
1983	10.9	13.1
1984	11.1	13.5
1985	11.3	13.9
1986	11.2	13.9
1987	11.5	14.1
1988	11.7	14.3
1989	12.0	14.8
1990	12.3	14.8
1991	12.6	15.2

Table 4a: Five Year Average 1987-1991

Average	12.0	14.4

Source: Health Care Finance Administration, Office of the Actuary

1980, it surpassed Illinois by 1990 and stood 3.8% above Illinois' average in 1991. As table 2 indicates, both states were below the national average.

Doctors per Capita: Comparable Growth in Both States

In 1980, the United States had 12.4 doctors per 10,000 capita.[44] By 1991, the number of doctors per 10,000 capita had grown 26.6%, to 15.7. In aggregate, the number of doctors grew by 115,744; a 41% increase. Illinois and Indiana both grew at faster rates. In Illinois, the number of doctors grew from 11.7 per 10,000 capita to 15.2; a 30% increase. Indiana grew slightly faster, but the difference is not statistically significant. In Indiana, the number of doctors per 10,000 capita grew from 9.5 to 12.6, or a 32.6% increase.

Another purported general benefit that proponents of jury verdict restrictions claim is increased availability of medical services. Just over half a million Americans live in counties without a physician in active patient care, and many more live in areas underserved by one or more medical specialties.[45] Caps supporters have argued that malpractice lawsuits are one of the reasons that doctors choose not to practice in rural areas and that limits on injury victims' rights will help to correct this problem.

Indiana's ability to provide health care to rural residents is not markedly different from Illinois'. Both states did a better job than did most other states. In 1986, both states had one county without an active physician in patient care. In Indiana, 0.10% of the population lived in the county without a physician, while only 0.05% did so in Illinois. By 1991, Illinois had two counties without a physician, 0.15% of its population, while Indiana was unchanged. Both states were well below the national average of 0.20% of population in counties without an active physician.[46]

Growth in obstetrical availability followed similar patterns. Nationally, the number of obstetricians and gynecologists grew 30.4% to 34,000.[47] Illinois' figures grew from 11.7 per 100,000 capita to 13.7, a 17.5% increase. In aggregate, Illinois grew from 1,300 to 1,600. Indiana grew 26.9%, from 380 to 480 or 7.0 per 100,000 capita to 8.6, a 22.9% increase.[48]

Table 5: Hospital Room Costs at Selected Hospitals in Illinois and Indiana

Large Cities (population between 100,000 and 140,000)

Springfield, Ill. (pop. 105,227)

Name	Basic Room	Emergency Room	Delivery Room
Doctor's Hospital	$334	$73	na
St. John's Hospital	nr	nr	nr
Memorial Medical	nr	nr	nr

Evansville, Ind. (pop. 126,272)

Name	Basic Room	Emergency Room	Delivery Room
Deaconess Hosp.	$360	$38	$650
St. Mary's	$360	$60	$360
Welborn Memorial	$354	$86	$390
Illinois Average:	$334	$73	nr
Indiana Average:	$358	$61	$467

Source: Phone survey conducted in March and April, 1994. The designation "na" means that the hospital does not provide that service. The designation "nr" means that the hospital did not respond to the survey. Interview by Kim Simmons and Trelinda Pitchford.

Hospital Costs: No Appreciable Difference

The Prospective Payment Assessment Commission ("ProPAC") recently tabulated average medicare hospital inpatient cost per discharge in 1991 for all fifty states. According to this report, the average charge in Illinois was $4,625 while Indiana was slightly higher at $4,675. Medicare costs may not be typical of all health care costs to consumers; however, the ProPAC report suggests that Indiana's health care costs are not substantially lower than Illinois'.

Table 6: Hospital Room Costs at Selected Hospitals in Illinois and Indiana

Medium Cities (population between 50,000 and 60,000)

Name/City	Basic Room	Emergency Room	Delivery Room
Skokie, Ill. (pop. 59,432)			
Rush North Shore	$49	$100	(range)
Bloomington, Ill. (pop. 51,972)			
St. Joseph's	nr	nr	nr
Bromenn Lifecare	$329	$59	$472
Anderson, Ind. (pop. 57,483)			
Community Hospital	$311	$50	$460
St. John's	$330	(range)	$330
Bloomington, Ind. (pop. 60,633)			
Bloomington Hosp.	$470	$81	$470
Terre Haute, Ind. (pop. 57,483)			
Terre Haute Hosp.	$325	$66	$340
Union Hosp.	$355	(range)	$400
Illinois Average:	$412	$79	$472
Indiana Average:	$358	$66	$400

Source: Phone survey conducted in March and April, 1994. The designation "na" means that the hospital does not provide that service. The designation "nr" means that the hospital did not respond to the survey. The designation "(range)" means that the hospital gave several changes for the facility, depending on various factors. Interview by Kim Simmons and Trelinda Pitchford.

To determine what people actually pay for health care, twenty hospitals in both states were surveyed to determine the charges for basic rooms, emergency rooms and delivery rooms. Costs for rooms in Illinois and Indiana are similar. Even though Illinois' citizens per capita personal income is 20% higher than Indiana's, and even though Illinois lacks the medical malpractice restrictions that Indiana has, Illinois resident pay about the same for health care.

Representing cities with a population between 100,000 and 140,000, three hospitals each in Springfield, Ill. and Evansville, Ind. were surveyed. Although all of the Evansville hospitals responded to our survey; only one in Springfield did. The results suggest that residents of large cities pay slightly more for a basic room in Indiana and slightly less for an emergency room treatment. Survey results do not allow comparison of costs for a delivery room.

For medium cities with a population between 50,000 and 60,000, one hospital in Skokie, Ill., two in Bloomington, Ill., one in Bloomington, Ind., two in Anderson, Ind., and two in Terre Haute, Ind., were surveyed. One hospital in Bloomington, Ill. did not respond. We found that costs for a basic room, for an emergency room, and for a delivery room were all slightly higher in Illinois. The differences were all within the difference in per capita income, however, and so may not represent a difference in real cost.

For small towns with a population between 10,000 and 14,000, the survey included one hospital in each of the following: Effingham, Canton, Pontiac and Morris in Illinois; Madison, Bedford, Peru, Jasper and Warsaw in Indiana. All hospitals responded to the survey. We found that costs for a basic room, for an emergency room, and for a delivery room were all slightly lower in Illinois.

Health care costs and availability are just two factors present in the debate over jury verdict restrictions. Other factors include the cost of insurance to doctors and the cost to insurers of paying claims. The remainder of this section will examine the experiences of health care providers and insurers under the two legal regimes.

Insurers Benefit Through Higher Profits

Insurers have realized significant gains from Indiana's medical malpractice restrictions. While premiums are significantly lower, payments to victims are lower still, so that Indiana profit margins represent a larger share of the insurance dollar. In Illinois, money set aside to pay victims, termed "adjusted losses" by insurers, declined at an average annual rate of 10% between 1987 and 1991. In Indiana adjusted losses fell at an average annual rate of 54.89%. Indiana's rate of decline was nearly five times the rate in Illinois.

On a per patient basis, the decline in adjusted loss is equally significant, and once again, Indiana saw greater

Table 7: Hospital Room Costs at Selected Hospitals in Illinois and Indiana

Small Towns (population between 10,000 and 14,000)

Name/City	Basic Room	Emergency Room	Delivery Room
Canton, Ill. (pop. 13,922)			
Graham Hosp.	$390	$78	$390
Effingham, Ill. (pop. 11,851)			
St. Anthony's	$290	$45	$445
Morris, Ill. (pop. 10,270)			
Morris Hosp.	$410	$74	$675
Pontiac, Ill. (pop. 11,428)			
St. James'	$280	$35	$300
Bedford, Ind. (pop. 13,817)			
Bedford Med. Cntr.	$375	$49	$841
Jasper, Ind. (pop. 10,030)			
Memorial Hosp.	$290	$95	$290
Madison, Ind. (pop. 12,006)			
The King's Daughter's	$358	(range)	$609
Peru, Ind. (pop. 12,843)			
Dukes Memorial	$334	$59	$334
Warsaw, Ind. (pop. 10,968)			
Kosciusko Community	$370	nr	$320
Illinois Average:	$343	$58	$453
Indiana Average:	$345	$68	$479

Source: Phone survey conducted in March and April, 1994. The designation "nr" means that the hospital did not respond to the survey. The designation "(range)" means that the hospital gave several changes for the facility, depending on various factors. Interview by Kim Simmons and Trelinda Pitchford.

declines than did Illinois. Illinois' adjusted loss per patient fell 21.2% between 1987 and 1991. In Indiana, adjusted losses per patient fell 61.3% overall. Indiana's decline occurred at nearly three times the rate of Illinois' decline.

In both states, over the period of 1985-1992, medical malpractice was the single most profitable line of property/casualty insurance when measured as a percent of premium. But insurers in Indiana took a larger share of premium in profit. In Illinois, medical malpractice insurance earned an aggregate profit of just over twice the profits earned in all property/casualty insurance (22.6% of premium in medical malpractice versus 11.0% in all lines). Indiana's experience was even higher. Indiana's medical malpractice insurers earned aggregate profits of 48.5% of premium, compared to 3.6% in all lines; medical malpractice insurance turned a profit of more than 13 times the average line of property/casualty insurance. Most significantly, Indiana's profit was twice the rate of Illinois'.[49]

Table 8: Medical Malpractice Insurance Adjusted Losses (Aggregate) Annual Rate of Change

	Indiana	Illinois
1982	+63.37%	+30.89%
1983	-73.34%	-60.73%
1984	+0.64%	+36.10%
1985	+59.21%	+42.12%
1986	-2.30%	-31.90%
1987	-42.42%	-74.14%
1988	+12.13%	+42.60%
1989	-303.92%	-63.63%
1990	+64.09%	+20.96%
1991	-4.30%	+21.71%

Table 10a: Five Year Average 1987-1991

Total	-24.79%	+72.05%
Average Annual	-54.88%	-10.50%

Source: Adjusted losses are the insurers estimate of what it will cost to pay claims to victims of medical malpractice. These figures also include dividend payments to policyholders. Based on figures from *Best's Review.*

Table 9: Medical Malpractice Insurance Adjusted Losses Per Patient Annual Rate of Change

	Indiana	Illinois
1982	+56.80%	+21.73%
1983	-69.84%	-39.62%
1984	+6.54%	+35.33%
1985	+58.30%	+39.98%
1986	-5.41%	-41.30%
1987	-45.83%	-80.73%
1988	-0.09%	+38.32%
1989	-317.44%	-67.27%
1990	+59.87%	+15.97%
1991	-5.87%	+19.02%

Table 11a: Five Year Average 1987-1991

Total	-43.61%	+42.44%
Average Annual	-61.87%	-14.94%

Source: We calculated adjusted losses using figures from *Best's Review.* We applied these figures to the combined total of hospital admissions and outpatients. Patient figures are from Health Care Finance Administration, Office of the Actuary.

Discussion

Tremendous growth in health care expenditures has strained state budgets and led policymakers to search for sensible ways to contain costs. Many legislators have been tempted by claims that artificial restrictions on health care provider liability could help to contain total health care spending. This argument assumes that health care cost and availability are fairly elastic relative to liability costs; that a diminution in liability will result in a similar decline in health care spending and an increase in health care availability.

Experience in Indiana fails to bear out this theory. Indiana's medical malpractice laws have produced no savings for Indiana health care consumers. While Indiana medical malpractice insurers are far more profitable than their Illinois counterparts, the savings from restrictive medical malpractice laws have not trickled down to Indiana's health care consumers. Despite the fact that Indiana insurers pay smaller benefits to medical malpractice victims, Indiana residents pay more for doctors' services than Illinois residents. Indiana's health care spending per capita grew at a rate 20% faster than Illinois'. Furthermore, Indiana's spending on physician services per capita grew at a rate 17% faster than Illinois', and Indiana residents now spend more for doctors' services, per capita, than Illinois residents. In sum, as a percentage of household income, health care costs grew almost twice as fast in Indiana as in Illinois.

Instead, Indiana's experience suggests that most of the benefits of caps on jury verdicts accrue not to consumers but principally to insurers within the health care system. Insurance companies earned dramatically higher profits in Indiana than in Illinois. In both states, medical malpractice was the single most profitable line of property/casualty insurance, yet Indiana was more than twice as

Table 10: Medical Malpractice Insurance Insurer Profits As a Percent of Premium

	Indiana	Illinois
1985	18.7	-20.9
1986	26.6	23.9
1987	42.8	52.2
1988	42.8	31.2
1989	84.1	34.8
1990	43.3	29.1
1991	52.6	6.2
1992	64.7	11.2
Total	48.5	22.6
Average Annual	46.9	21.0

Source: National Association of Insurance Commissioners, *Report on Profitability*

profitable. Insurance companies retained the savings generated by jury verdict restrictions allowing no identifiable benefits to trickle through to consumers.

Conclusion

Laws which restrict jury verdicts in medical malpractice cases have not lowered health care spending or increased health care availability. Indiana's malpractice legislation has not produced any cost savings for Indiana's health care consumers, nor has it demonstrably increased the number of doctors in the state. In fact, Indiana's laws have penalized those most injured by medical malpractice with no tangible benefit to Indiana residents.

More broadly, the practical experience in states that have imposed limits on jury verdicts does not support the contention that consumers receive a quid pro quo in exchange for curtailed legal remedies. Injury victims pay substantial amounts under caps, but the benefits provided in exchange are slight indeed. The benefits claimed by caps supporters including lower growth in health care costs, increased availability of specialties of care, and increased availability in underserved areas, have not borne out. Instead, Indiana residents have seen substantially faster growth in health care costs than have Illinois residents and continue to have substantially fewer doctors per capita, even in obstetrics.

ENDNOTES

[1] OFFICE OF TECHNOLOGY ASSESSMENT, *Impact of Legal Reform on Medical Malpractice Costs*, Sept. 1993, at 26-27, 34-37 (charting which states imposed verdict caps and when).

[2] Brian Cox, *Clinton Med. Mal. Reform Challenged*, NAT'L UNDERWRITER, Nov. 8, 1993, at 3; Edwin Chen, *Clinton Malpractice Plan Angers Doctors, Lawyers*, CHIC. SUN-TIMES, Sept. 9, 1993, at C2.

[3] *Id.* President Clinton decided not to seek financial limits on claims of damages for pain and suffering in malpractice cases. *Id.*

[4] Common Sense Legal Reform Act, HOUSE REPUBLICAN CONF. LEGIS. DIG., Sept. 27, 1994 at 37. For example, the Bill sponsors argue that uniform product liability laws should be established to limit punitive damages to three times the actual harm. *Id.* at 38.

[5] Howard Alan Learner, *Restrictive Medical Malpractice Compensation Schemes: A Constitutional "Quid Pro Quo" Analysis to Safeguard Individual Liberties*, 18 HARV. J. ON LEGIS. 143, 148-51 (1981).

[6] Johnson v. St. Vincent Hosp. Inc., 404 N.E.2d 585, 594 (Ind. 1980).

[7] *See* Reynolds, *infra* note 9.

[8] *See generally* The National Commission to Prevent Infant Mortality, *Malpractice and Liability: An Obstetrical Crisis*, Jan. 1988; Nira Kaplan, *Law Delivers Relief for Obstetricians*, JEFFERSON CITY (MO.) POST-TRIB., June 23, 1987, at 17. Some obstetricians in Missouri, for example, argue that rising medical malpractice rates have forced them to stop providing free services for poor people living in rural areas because their malpractice insurance has gone up as much as 350% in three years. *Id.*

[9] R.A. Reynolds, et al., *The Cost of Medical Professional Liability*, 257 JAMA 2776 (1987). Subsequent research has cast significant doubt on the extent of the so called defensive medicine. The Physician Payment Review Commission concluded that "studies that use physicians estimates of the amount of defensive medicine they practice [like the AMA estimates in Reynolds] are not sufficiently reliable to make quantitative estimates" of its true extent or cost. *See* Physician Payment Review Commission, *1991 Annual Report to Congress*, at 374 n.8. More recently, the congressional Office of Technology Assessment issued a report calling into serious question the AMA estimates of defensive medicine. OFFICE OF TECHNOLOGY ASSESSMENT, *Defensive Medicine and Medical Malpractice*, June 1994, at 154-59.

[10] *See, e.g., Bring Back Insurance Sanity*, L.A. TIMES, Aug. 21, 1986, Metro, at 2.

[11] *See generally* Moore v. Mobile Infirmary Ass'n, 592 So. 2d 156 (Ala. 1991); Brannigan v. Usitalo, 587 A.2d 1232 (N.H. 1991); Sofie v. Fibreboard Corp., 771 P.2d 711 (Wash. 1989); Carson v. Maurer, 424 A.2d 825 (N.H. 1980); Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978); Wright v. Central DuPage Hosp., 347 N.E.2d 736 (Ill. 1976).

[12] Lucas v. United States, 757 S.W.2d 687 (Tex. 1988).

[13] Morris v. Savoy, 576 N.E.2d 765 (Ohio 1991).

[14] *See generally Brannigan*, 587 A.2d 1232; *Sofie*, 771 P.2d 711; Condemarin v. University Hosp., 775 P.2d 348 (Utah 1988); Smith v. Department of Ins., 507 So. 2d 1080 (Fla. 1987); Tenold v. Weyerhauser, 873 P.2d 413 (Or. App. 1994).

[15] *But see* Boyd v. Bulala, 672 F. Supp. 915 (W.D. Va. 1987). The federal court held that caps laws are violative of the separation of powers.

[16] In states where the law was challenged under state constitutional provisions

that "the right to trial by jury shall remain inviolate," courts came closest to declaring that all caps would be unconstitutional. *See generally Moore*, 592 So. 2d 156; *Sofie*, 771 P.2d 711; *Tenold*, 873 P.2d at 413.

[17] Generally, these jurisdictions eschewed close analysis of the relationship between caps and insurance rates, asserting only that the legislature had a reasonable basis for believing that such a relationship existed. *See, e.g.*, Samsel v. Wheeler Trans. Servs., 789 P.2d 541, 543 (Kan. 1990); *See also* Fein v. Permanente Medical Group, 965 P.2d 665, 679-82 (Cal. 1985).

[18] In Boucher v. Sayeed, 459 A.2d 87 (R.I. 1983), the Rhode Island supreme court struck a caps law on the ground that the "crisis" in insurance justified only temporary action; when the crisis ended, so too ended the justification for caps. *Id. See also Lucas*, 757 S.W.2d at 691 (striking a Texas caps law and noting the absence of a provable correlation between caps and insurance rates).

[19] Harvey Rosenfield, SILENT VIOLENCE, SILENT DEATH: THE HIDDEN EPIDEMIC OF MEDICAL MALPRACTICE 69 (1994).

[20] *Id.*.

[21] *Id.*

[22] *Id.*

[23] *Moore*, 592 So. 2d at 168-69.

[24] *Id.*

[25] *Lucas*, 757 S.W.2d at 691.

[26] *Morris*, 576 N.E.2d at 771 (quoting Nervos v. Pritchard, No. CA-6560 (Oh. Ct. App. filed June 10, 1985)).

[27] *See supra* notes 10-14 for additional decisions striking caps.

[28] In addition to the shift described below, a second partly unrelated shift has also taken place in response to court decisions. This article focuses on the practical effect of caps, but many court challenges focused on the scope of the caps. Several states that capped only medical malpractice verdicts saw their laws struck on the grounds that limiting verdicts for medical malpractice victims alone created an arbitrary and unreasonable distinction between types of injury victims based on cause of injury. Caps proponents responded by improving coordination, and in some places by creating new coalitions among doctors who supported medical malpractice caps and businesses who supported products liability caps. The formation of this new coalition deserves greater attention, but is beyond the scope of this article.

[29] *See, e.g., The Battle for Tort Reform Continues* (editorial), ILL. MED., Nov. 19, 1993, at 6. David G. Savage, *Doctors Seek Remedy for Lawsuits*, CHIC. SUN-TIMES, Oct. 5, 1993, at 26.

[30] Mike Flaherty, *Senate Puts Price Tag on Pain*, WALL ST. J., March 9, 1995, at 1.

[31] David Callender, *Malpractice Limits Pit Docs v. Lawyers*, THE [MADISON WIS.] CAP. TIMES, Jan. 20, 1995, at 3A. *See also supra* note 28.

[32] *See generally Fein*, 695 P.2d 665; *Samsel*, 789 P.2d 541.

[33] *Wright*, 347 N.E.2d at 746 (Underwood, J., dissenting) (emphasis added). Alternatively, the majority held unconstitutional a cap on total recovery. *Id.*

[34] Courts have struck caps as violative of state constitutional provisions relating to open courts. *Smith*, 507 So. 2d 1080. *See also Tenold*, 873 P.2d 413 (striking caps as violative of Oregon's constitutional right to a jury trial and forcing the court to re-examine a fact found by the jury); *Sofie*, 771 P.2d at 711 (striking caps as violative of the Washington state constitutional equal protection and jury trial provisions); *Condemarin*, 775 P.2d at 348 (striking caps as violative of the Utah state constituion jury trial provision); *Arneson*, 270 N.W.2d at 125 (striking caps as violative of North Dakota's constitution equal protection clause); *Wright*, 347 N.E.2d at 736 (striking caps as violative of Illinois' constitution equal protection, full remedy, and special privileges clauses).

[35] *See, e.g.*, William Grongein & Eleanor DeArman Kinney, *Controlling Large Malpractice Claims: The Unexpected Impact of Damage Caps*, 16 J. HEALTH POLS. POL'Y & L. 441 (1991); Deborah R. Hensler, et. al., *Trends in Tort Litigation: The Story Behind the Statistics*, RAND Institute for Civil Justice (June 1993); Eleanor D. Kinney, et al., *Indiana's Malpractice Act: Results of a Three Year Study*, 24 IND. L. REV. 1276 (1991); Frank A. Sloan and Chee Ruey Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?* 24 LAW & SOC'Y REV. 997 (1990); Mark I. Taragin, et al., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims*, 117 ANNALS INTERNAL MED. 780 (1992); Neil Vidmar, *Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases* 43 DUKE L.J. 217 (1993). The RAND Corporation's Institute for Civil Justice describes the recent debate on trends in tort litigation in three ways: (1) how much litigation there is; (2) whether jury awards are stable or out of control; (3) how much litigation costs and who gets the money. *Id.* at 21. *See also* Mary Grossman, et al., *An Empirical Analysis of Closed Medical Malpractice Insurance Claims: The Wisconsin Health Care Liability Insurance Plan, 1976-1988*, (American Bar Foundation Working Paper No. 9209); Congressional Budget Office, *Economic Implications of Rising Health Care Costs*, Oct. 1992, at 27 (noting that because malpractice premiums contribute little to the nation's overall healthcare cost, physicians would unlikely change their practice pattern in response); Sarah Glazer, *Whatever happened to the malpractice insurance crisis?*, WASH. POST, July 9, 1991.

[36] In March, 1995, Illinois Governor Jim Edgar signed a measure that imposes sweeping restrictions on injury victims' rights, including their right to full compensation. This new law was not in effect during the period under study.

[37] The Act set the cap at $500,000. It was amended in 1987 to raise the cap to $750,000 for claims arising after January 1, 1990. The total liability of individual doctors is limited to $100,000. *See* IND. CODE § 16-9.5-1-1 to 10-5 (1988).

[38] There are other differences between the two states: Indiana has a mandatory pre-trial review panel, Illinois does not. Illinois has experimented with restrictions on medical malpractice recovery. In 1975, Illinois, like Indiana, imposed a cap on a victim's total recovery but, unlike Indiana, Illinois law did not survive a constitutional challenge. A decade later, in 1985, Illinois adopted a package of new restrictions on medical malpractice claims. Many of these also failed constitutional muster. *See* M. Carroll Thomas, *Why Tort Reform*

Doesn't Reduce Malpractice Premiums, MED. ECON., Oct. 19, 1987, at 23-28.

[39] *See Johnson*, 404 N.E.2d 585; *Wright*, 347 N.E.2d 736.

[40] Per 100,000 capita, the increase was 17.3%, to 13.4.

[41] The discussion to follow examines the most common yardstick of health care spending, the gross total amount. A common derivative, per capita health care spending, shows trends similar to those found in aggregate spending. That is to say, population trends do not explain the discrepancy between Illinois and Indiana.

[42] *State Health Care Expenditures*, HEALTH CARE FINANCE ADMIN. 1980-1991 (1993).

[43] Gross Domestic Product, Gross State Product, and aggregate health care spending figures are listed in the appendix.

[44] The term "doctor" in this context refers to doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s") working in patient care in a non-federal hospital. The figures exclude doctors in teaching and research, and those employed at Veterans Affairs and other federally-operated hospitals.

[45] *Physician Characteristics and Distribution in the U.S.*, AM. MED. ASS'N (1993).

[46] *Physician Characteristics and Distribution in the U.S.*, AM. MED. ASS'N (1986 and 1992).

[47] Per 100,000 capita, the increase was 17.3%, to 13.4.

[48] *Id.*

[49] Profit figures are from the National Association of Insurance Commissioners, *Report on Profitability by Line by State* (1992).