# VIRGINIA'S MEDICAL MALPRACTICE CAP: HISTORY, CHALLENGES, AND COMPARATIVE ANALYSIS

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Virginia's medical malpractice recovery cap, codified in 1976 at Virginia Code section 8.01-581.15 is now well-established law but still faces periodic challenges in courts across the Commonwealth and recently in the state legislature. The cap has been tested through the appellate process, where plaintiffs have appealed the constitutionality of reducing jury verdicts that exceeded the cap; and there have been proposals in the General Assembly to limit or significantly change the law's substance. These recent challenges have been unsuccessful but may signal more activity to come

This article discusses the history of Virginia's medical malpractice cap, including a look at the history of the changes to the statute and challenges to its constitutionality. It assesses some of the more recent challenges to the cap as well and outlines rationales for the reasons they have failed. This article also compares Virginia's cap to governing provisions found in other jurisdictions around the country and assesses the impact these caps on damages have on professional liability insurance premiums for healthcare providers and on the healthcare industry as a whole. Finally, it examines what the future challenges and defenses to Code section 8.01-581.15 may look like.

## I. Code Section 8.01-581.15 and Its Legislative History

Virginia's medical malpractice cap was instituted in 1976. It was a reaction to the nationwide medical malpractice "tort crisis" of the mid-1970s.[1] This crisis was marked by large upward trends in the number of medical malpractice claims, the rise in severity and number of paid claims, and a resultant increase in insurance premiums. The crisis prompted state and federal government investigations into the impact on healthcare's economic viability and overall quality.[2] Studies had shown that from 1960 to 1972, the average costs for the next-to-lowest risk rating categories of practice increased 600 percent. The next-to-high-

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1 Jason A. Parson, *Medical Malpractice Damage Caps: Navigating Safe Harbors,* 65(3) Wash. U. L. Rev. 565 (1987).

2 Glen O. Robinson, *The Medical Malpractice Crisis of the 1970's: A Retrospective*, 49(2) L. & Contemp. Probs. 5 (1986) [hereinafter *Medical Malpractice Crisis*].

est risk rating category increased approximately 900 percent.[3] This systemic increase has a significant effect on the greater medical community, including the loss of patient access to many forms of care including obstetrical[4] and specialized surgery.[5] The bigger threat, however, was the withdrawal of insurance carriers from the medical malpractice market altogether. The causes of the increase in malpractice claims are speculative but include the decline in medical standards, the increase in medical technology and sophistication, the increase in supply of lawyers and large contingency fee arrangements, legal reforms that improved prospects for recovery, and changes in the public attitude toward medical care.[6] Despite uncertainty about the cause of the crisis, the need for an effective response was clear. Something had to be done. And while this took various forms, many states, including the Commonwealth of Virginia, responded with tort reform.

Virginia's statute was first codified as Code 1950, section 8-654.8. This law, in effect until 1983, limited medical malpractice damages to $750,000 total, regardless of the number of providers or causes of action. The rationale for the statute was clear. The General Assembly concluded that the increase in medical malpractice claims was directly affecting the premium costs and availability of medical malpractice insurance. It found that without that insurance, healthcare providers could be expected to stop providing medical care in the Commonwealth. A cap on damages was meant to counter that threat and protect the citizens of the Commonwealth by ensuring the availability of medical care.[7]

Studies did show that caps on damages, such as Virginia's, reduced the severity of claims and the total cost of the tort system.[8] But the code continued to adapt. In 1983, the General Assembly increased that limit to $1 million. The General Assembly raised the limit again in 1999 to $1.5 million and put in place a structure for a decade of increases.

In 2010, the Virginia Trial Lawyers Association (VTLA), the Medical Society of Virginia (MSV), and the Virginia Hospital and Healthcare Association (VHHA) engaged in discussions for a long-term solution to the issues surrounding the medical malpractice cap. The entities did agree to maintain an aggregate malpractice cap for twenty years and create long-term predictability and stability for medical liability insurance. The MSV and the VTLA both agreed there would be no legislative efforts to eliminate the total cap, to amend the cap to apply only to noneconomic damages, or to create a second cap with the total

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3 *Id.* at 8.

4 *See* Judy Donlen, Janet S. Puro, *The Impact of the Medical Malpractice Crisis on OB-GYNs and Patients in Southern New Jersey*, N.J. Me. (2003).

5 Am. Med. Ass'n, America's Medical Liability Crisis: A National View (2004).

6 *Medical Malpractice Crisis*, *supra* note 2, at 11–18.

7 *See* Etheridge v. Medical Ctr. Hosps., 237 Va. 87, 93, 376 S.E.2d 525, 527 (1989).

8 *See Medical Malpractice Crisis*, *supra* note 2, at 30.

cap.[9] This was followed by the General Assembly passing the latest iteration. Code section 8.01-581.15 raises the cap on damages in a medical malpractice action by $50,000 each year until July 31, 2031, when it reaches $3 million. Both compensatory damages and punitive damages are covered by the medical malpractice cap.[10] The cap total applies to the total amount recoverable for any injury or death, regardless of the number of different health care providers named in the plaintiff's action.[11]

## II. Challenges to Code Section 8.01-581.15

Damages caps vary widely across the country and some of them have been struck down as unconstitutional, but many states' limits on damages remained protected by both courts and legislatures. Today, Virginia is one of twenty-six states that still have some form of limit on damages in medical malpractice actions.

Virginia's limit on damages has been challenged as unconstitutional on multiple occasions, although the Supreme Court of Virginia has not specifically addressed it in more than twenty years. In the case of *Etheridge v. Medical Center Hospital*,[12] a plaintiff had been awarded a verdict by a jury in the amount of $2,750,000. The trial court reduced the verdict to the medical malpractice cap of $750,000. The Supreme Court of Virginia reviewed the case on appeal. The Court relied upon the presumption that the General Assembly acts constitutionally. It also relied upon—and quoted—the 1975 report conducted by the Bureau of Insurance, submitted to the General Assembly during consideration of the 1976 Act. Regarding all the constitutional challenges, the Court found that the cap on damages did not violate the plaintiff's right to due process, to a jury trial, or to equal protection guarantees of the both the Virginia and United States Constitutions. The Court also found that the cap violated neither the separation of powers doctrine nor prohibitions against special legislation.

In *Boyd v. Bulala*[13] allegations of mismanagement of labor and delivery were raised. The jury awarded million-dollar verdicts for the infant, the mother, and the father, in excess of the existing cap on damages of $750,000. The district court refused to reduce the verdict amounts, finding that doing so would unconstitutionally deny the plaintiffs their right to a jury trial as guaranteed by both the federal and Virginia constitutions. The Fourth Circuit cited the ruling in *Etheridge*, overturned the district court's ruling, and found the cap on damages constitutional.

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[9] MSV and VTLA Achieve Malpractice Cap Agreement, *at* www2.vos.org/legis/MSV_cap_agreement_and_Q_A.pdf.

[10] Bulala v. Boyd, 239 Va. 218, 229, 389 S.E.2d. 670, 675 (1990).

[11] Etheridge v. Medical Ctr. Hosps., 237 Va. 87, 105, 376 S.E.2d 525, 535 (1989).

[12] *Id.*

[13] 877 F.2d 1191 (4th Cir. 1989).

In 1999, the Supreme Court of Virginia again upheld the cap in response to a sweeping challenge raising a host of constitutional issues. The Court held that the medical malpractice cap does not violate a plaintiff's constitutional rights, particularly those relating to the right to a jury trial. In *Pulliam v. Coastal Emergency Services,*[14] the Court adhered to well-established precedent in stating that the common-law right to a trial by jury was never recognized as a right to a full recovery in tort.[15]

Despite the well-established precedent in the Commonwealth of Virginia, challenges to the medical malpractice cap have occasionally been lodged in the lower courts. Two recent challenges to Virginia's medical malpractice cap in the courts and the legislature are examined here.

### A. RECENT COURT CHALLENGE TO THE CAP

Just this year, the United States District Court for the Western District of Virginia, Harrisonburg Division, refused to issue declaratory relief finding that Code section 8.01-581.15 is unconstitutional.[16] In this matter, a minor (represented by next friends), alleged medical malpractice against the defendant pediatricians for failure to diagnose a spinal cord injury, leading to chronic health and developmental issues. The plaintiff settled the matter with some defendants for the full medical malpractice cap (at that time) of $2 million. Despite recovery of the full amount of the cap applicable at the time, the plaintiff sought to recover from the remaining defendants by continuing with its suit against them. The plaintiff also sought a declaratory judgment that he could recover above the cap limit. The Commonwealth intervened and, along with the remaining defendant, argued that declaratory judgment was inappropriate unless and until liability was found against that defendant.

In denying the plaintiff's motion for declaratory relief, the court noted the strong statutory precedent of finding Code section 8.01-581.15 constitutional. The plaintiff argued three United States Supreme Court cases that he claimed showed a shift—or elaboration—on constitutional principles that supported his arguments for unconstitutionality.[17] The plaintiff also cited cases from Maryland and Ohio to support the argument that declaratory relief was appropriate and ripe.[18] However, the court was persuaded more by the defendants' argument that several jurisdictions, including Texas, Florida, Tennessee, and Montana, had all deemed that the issue was not ripe until liability was found and a jury had awarded damages.

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14 257 Va. 1, 509 S.E.2d 307 (1999).

15 *See id.* at 14.

16 J.S. v. Winchester Pediatric Clinic, P.C, Civil No. 5:19-CV-0097.

17 The plaintiff cited *Ramos v. Louisiana*, 140 S. Ct. 1390 (2020); *Timbs v. Indiana*, 139 S. Ct. 682 (2019); and *McDonald v. Chicago*, 561 U.S. 742 (2010).

18 The plaintiff cited *Franklin v. Mazda Motor Corp.*, 704 F. Supp. 1325 (D. Md. 1989); *Simms v. Holiday Inns, Inc.,* 746 F. Supp. 596 (D. Md. 1990); and *Arbino v. Johnson & Johnson*, No. 3:06CV40010, 2006 WL 1720538 (N.D. Ohio June 20, 2006).

While the court did not directly address constitutionality of the cap, it denied a plaintiff an avenue for relief on the issue that some jurisdictions have allowed.

### B. RECENT LEGISLATIVE CHALLENGE TO THE CAP

Also this year, Senate Bill 1107 was introduced. It would modify Virginia's medical malpractice cap and was originally drafted to eliminate entirely the cap on damages.[19] The version ultimately presented to the Senate Judiciary Committee left the cap in place but carved out an exception that would allow damages to be awarded by a court or jury in excess of the cap if the fact finder "determine[d] that there is (i) substantial or permanent loss or impairment of a bodily function, (ii) brain injury, (iii) substantial disfigurement, or (iv) any other special circumstance in the case that warrants a finding that imposition of such a limitation would deprive the plaintiff of just compensation for the injuries sustained."[20]

The proposed bill was meant to address cases where plaintiff's medical bills and economic damages exceeded the applicable cap amount. Despite its being proposed as a form of narrow relief, this draft exception was far reaching. Its interpretation could have been stretched enough to effectively eliminate the cap in most medical malpractice cases. The rationale for the bill was grounded in arguments similar to appellate challenges to Code section 8.01-581.15; namely, that plaintiffs' rights to a trial by jury were being deprived by the statute. If a jury's award was retroactively limited after an award in excess of the cap, then a plaintiff was being deprived of a jury's findings regarding an award for damages. The bill was sent back to the Civil Sub-Committee of the Senate Judiciary for discussion. The bill failed in the subcommittee, where the vote was 5 to 1. The focus of this effort was to address the circumstance of a catastrophic damages case where special damages exceed the cap, and the perceived injustice of applying the cap limitation in that circumstance. An interesting alternative discussed but not formally proposed during the subcommittee hearing was the possibility of a program similar to the Virginia Birth-Related Neurological Injury Compensation Program (hereinafter "the Birth Injury Fund"), to take certain high-exposure claims out of the traditional tort system and provide an alternative damages approach.

The 2021 effort to amend Code section 8.01-581.15 was set against the backdrop of the ongoing COVID crisis with its devastating impact on public health and healthcare economics, which no doubt influenced the debate. Whether future challenges to the cap might find more traction remains an interesting question. The most compelling specific case examples used by those who wish to challenge or change the cap are those cases with enormous special damages in excess of the cap. Addressing those claims specifically through a no-fault excess

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[19] S.B. 1107, 2021 Gen. Assem. Reg. Sess. (Va. 2021), *available at* https://lis.virginia.gov/cgi-bin/legp604.exe?211+ful+SB1107+pdf.

[20] *Id.* (as amended before presentation to Judiciary: https://lis.virginia.gov/cgi-bin/legp604.exe?211+ful+SB1107S1+pdf).

fund or other cap structure amendment might be an area where future legislative efforts focus.

## III. A Jurisdictional Perspective on Medical Malpractice Caps and No Caps

Statutory limits on the recovery of medical malpractice damages exist in a slim majority of states across the country.[21] These caps are usually distinguished by their respective applicability to economic and noneconomic damages. Economic damages are traditionally defined as liquidated financial losses such as medical expenses (both past and future) and loss of future earning capacity.[22] Noneconomic damages cover intangible, nonliquidated losses such as pain and suffering and mental anguish.[23] There are further distinguishing factors in states with caps on noneconomic damages, which may have significant impact on the effectiveness of a cap, as explained by the American Medical Association's 2021 update on medical malpractice liability reform.

> For example, some states have a hard cap on noneconomic damages while others have a soft cap on noneconomic damages. A hard cap, like the $250,000 cap found in California's MICRA, is not subject to exceptions, does not adjust over time and applies irrespective of the number of defendants or plaintiffs. By contrast, a "soft" cap may be subject to (1) numerous exceptions for various injuries or legal findings, (2) annual increases (e.g., indexed for inflation), (3) increases based on a set schedule, or (4) individual application to every defendant or plaintiff, thereby allowing several caps for a single claim. Recognizing the limitations of a soft cap, several states, such as Alaska, Mississippi, and Missouri, have enacted legislation to strengthen their caps. Likewise, Nevada voters adopted a ballot initiative in 2004 to replace a cap riddled with exceptions with a hard cap of $350,000 on noneconomic damages. A cap on noneconomic damages that is set too high will also have a limited effect. For example, prior to modifying legislation in 2003, West Virginia had a $1 million cap on noneconomic damages, which was too high to be effective.[24]

Virginia damages in tort are traditionally distinguished between general and special damages.[25]

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21 *See infra* Table 1.

22 *See* Sue Ganske, *Noneconomic Damages Caps in Wrongful Death Medical Malpractice Cases—Are They Constitutional?*, 14 Fla. St. U. Bus. Rev. 31, 32 (2015).

23 *See id.*

24 American Medical Association, *Medical Liability Reform Now!*, at 13, 2021 Update (2021).

25 *See* Craig D. Johnston, Va. Prac. Trial Handbook § 35:4 (2021).

> General damages are those which are the probable and necessary result of the injury, or which are presumed or implied by law to be the result of the wrongdoer's action . . . . Special damages are those damages which actually result from the wrong, but which are not presumed or implied . . . . Special damages must be specially pleaded and proven.[26]

### A. MEDICAL MALPRACTICE CAPS ACROSS THE COUNTRY

Many states have statutory limits on noneconomic damages, but caps limiting the recovery of economic special damages are less common.[27] When analyzing the different applications of medical malpractice caps across the country it is important to keep in mind that special damages, which are required to be specifically pled and proven under Virginia law, have been and remain the target of most medical malpractice reform.[28] A comprehensive index of medical malpractice caps in the fifty states is provided here.

TABLE 1[29]

| *State* | *Cap/No Cap and economic/ noneconomic distinguishing factors* | *Cap Amount* |
|---|---|---|
| Alabama | No Cap (Unconstitutional)[30] | |
| Alaska | Yes – noneconomic damages | $250,000 – $400,000 |
| Arizona | No Cap | |
| Arkansas | No Cap | |
| California | Yes – noneconomic damages | $250,000 |
| Colorado | Yes – total cap + noneconomic cap | $1 million and $300,000 |
| Connecticut | No Cap | |

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26 *Id.* (citing AM. JUR. 2D, *Damages* §§ 37, 38, 40).

27 *See generally id.,* (discussing the rarity of caps on economic damages specifically in wrongful death medical malpractice cases); *see infra* Table 1.

28 *See generally* Nancy L. Zisk, *The Limitations of Legislatively Imposed Damages Caps: Proposing a Better Way to Control the Costs of Medical Malpractice*, 30 SEATTLE U. L. REV. 119, at 124 (2006) (detailing the efforts to enact medical malpractice damages limitations across the country beginning in 2003 with 41 states introducing legislation that either proposed or changed caps on noneconomic damages for medical malpractice awards, which by 2005 were enacted by approximately 20 states).

29 *See Medical Malpractice Damage Caps*, MED. MALPRACTICE CT., *at* https://malpracticecenter.com/legal/damage-caps/ (last visited April 12, 2021) (providing a comprehensive list of states that have enacted statutory damages caps and their respective statutory citations).

30 Moore v. Mobile Infirmary Ass'n, 592 So. 2d 156 (Ala. 1991); Mobile Infirmary Med. Ctr. v. Hodgen, 884 So. 2d 801 (Ala. 2003).

| *State* | *Cap/No Cap and economic/ noneconomic distinguishing factors* | *Cap Amount* |
|---|---|---|
| Delaware | No Cap | |
| D.C. | No Cap | |
| Florida | No Cap (Unconstitutional)[31] | |
| Georgia | No Cap (Unconstitutional)[32] | |
| Hawaii | Yes – Pain and suffering only | $375,000 |
| Idaho | Yes – noneconomic damages | $250,000 |
| Illinois | No Cap (Unconstitutional)[33] | |
| Indiana | Yes – total cap | $1,250,000 total cap – providers pay max $250,000 |
| Iowa | Yes – noneconomic damages | $250,000 |
| Kansas | No Cap | |
| Kentucky | No Cap | |
| Louisiana | Yes – total cap | $500,000 total + future expenses, providers pay max $100,000 |
| Maine | No Cap | |
| Maryland | Yes – noneconomic damages | $815,000 personal injury – wrongful death is maxed at 125 % of the cap |
| Massachusetts | Yes – noneconomic damages | $500,000 |
| Michigan | Yes – noneconomic damages | $455,000 – $812,500 |
| Minnesota | No Cap | |
| Mississippi | Yes – "Pain and suffering" only | $500,000 |
| Missouri | Yes – noneconomic damages | $420,749 – $736,331 |
| Montana | Yes – noneconomic damages | $250,000 |
| Nebraska | Yes – total cap | $2,250,000 |
| Nevada | Yes – total cap | $350,000 |

31 N. Broward Hosp. Dist. v. Kalitan, 219 So. 3d 49, 56 (Fla. 2017).

32 P.C. v. Nestlehutt, Case No. S09A1432 (Ga. 2010).

33 Lebron v. Gottlieb Mem'l Hosp., 237 Ill. 2d 217 (2010).

| *State* | *Cap/No Cap and economic/ noneconomic distinguishing factors* | *Cap Amount* |
|---|---|---|
| New Hampshire | No Cap (Unconstitutional)[34] | |
| New Jersey | No Cap | |
| New Mexico | Yes – total cap | $600,000 – providers pay max $200,000 |
| New York | No Cap | |
| North Carolina | Yes – noneconomic damages | $545,144 |
| North Dakota | Yes – noneconomic damages | $500,000 (under review by courts) |
| Ohio | Yes – noneconomic damages | $500,000/case – no cap for wrongful death |
| Oklahoma | No Cap (Unconstitutional)[35] | |
| Oregon | No Cap (Unconstitutional)[36] | |
| Pennsylvania | No Cap | |
| Rhode Island | No Cap | |
| South Carolina | Yes – noneconomic damages | $350,000; multiple defendants = $1,050,000 |
| South Dakota | Yes – noneconomic damages | $500,000 |
| Tennessee | Yes – noneconomic damages | $750,000–$1 million[37] |
| Texas | Yes – noneconomic damages | $250,000/provider; $500,000 total |
| Utah | No Cap (Unconstitutional)[38] | |
| Vermont | No Cap | |
| Virginia | Yes – total cap | $2,350,000; increases by year until $3 million in 2031 |

34 Carson v. Maurer, 12 N.H. 925 (1980).

35 Beason v. I.E. Miller Servs., Inc., 2019 Okla. 28 (2019).

36 Horton v. Oregon Health & Sci. Univ., 359 Or. 168 (2016).

37 *See* TENN. CODE. ANN. § 29-39-102 (2020) (defining catastrophic injury as including a spinal cord injury resulting in paraplegia or quadriplegia amputation of two (2) hands, two (2) feet or one (1) of each; third degree burns over forty percent (40%) or more of the body as a whole or third degree burns up to forty percent (40%) percent or more of the face; or wrongful death of a parent leaving a surviving minor child or children for whom the deceased parent had lawful rights of custody or visitation).

38 Smith v. United States, 2015 Utah 68 (1986).

| *State* | *Cap/No Cap and economic/ noneconomic distinguishing factors* | *Cap Amount* |
|---|---|---|
| Washington | No Cap (Unconstitutional)[39] | |
| West Virginia | Yes – noneconomic damages | $250,000; $500,000 (catastrophic)[40] |
| Wisconsin | Yes – noneconomic damages | $750,000 |
| Wyoming | No Cap | |

Some states have constitutional prohibitions on damages caps.[41] Understanding the benefits derived from Virginia's protective combination of the medical malpractice cap and special damages pleading and proof requirements can help Virginia practitioners defend future constitutional challenges to the cap.

### B. MEDICAL MALPRACTICE DAMAGES CAPS AND MEDICAL MALPRACTICE INSURANCE PREMIUMS; EXAMINING NATIONAL AND VIRGINIA-SPECIFIC TRENDS

As shown above, medical malpractice insurance premiums began rising dramatically across the United States in the 1970s, and they have continued to rise over time.[42]

> In 2002, malpractice insurance rates for physicians nationwide rose approximately twenty percent, but this average figure obscures a very wide range. States like California that enjoy effective legal reforms have seen rates increase only a few percent per year in this interval, while states lacking such reforms have seen increases in excess of one hundred percent for specialists in high-risk areas of medicine.[43]

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[39] Sofie v. Fibreboard Corp., 112 Wash. 2d 636 (1989).

[40] "The plaintiff may recover compensatory damages for noneconomic loss in excess of the limitation described in subsection (a) of this section, but not in excess of $500,000 for each occurrence, regardless of the number of plaintiffs or the number of defendants or, in the case of wrongful death, regardless of the number of distributees, where the damages for noneconomic losses suffered by the plaintiff were for: (1) Wrongful death; (2) permanent and substantial physical deformity, loss of use of a limb or loss of a bodily organ system; or (3) permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself or herself and perform life-sustaining activities." W. VA. CODE § 55-7B-8 (2020).

[41] *See supra* Table 1; *see also* Sue Ganske, *Noneconomic Damages Caps in Wrongful Death Medical Malpractice Cases—Are they Constitutional?*, 14 FLA. ST. U. BUS. REV. 31, at 34 (2015) ("States such as Arizona, Arkansas, Kentucky, Pennsylvania, and Wyoming have prohibitions in their state constitutions on certain damages caps. In addition, the Ohio and Oklahoma Constitutions expressly prohibit limiting damages in wrongful death cases.") (internal citations omitted).

[42] *See generally* David A. Matsa, *Does Malpractice Liability Keep the Doctor Away? Evidence from Tort Reform Damage Caps*, J. LEGAL STD. 36(52), S143-S182 (2007).

[43] Richard E. Anderson, *Effective Legal Reform and the Malpractice Insurance Crisis*, 5 YALE J. HEALTH POL'Y, L. & ETHICS 341, at 344 (2005) [hereinafter Anderson, *Effective Legal Reform*].

Insurance premiums are driven by the frequency and severity of claims filed against physicians.[44] The more claims filed against insured physicians, the more pay-outs insurers must make, thus raising the price of insurance.[45] When this trend continues, it is easy to see how the tort crisis of the 1970s can be repeated. The threat of insurer's leaving the medical malpractice marketplace would be a serious threat, leading to a serious impact on the ability of the citizens of this Commonwealth to obtain health care.

Whether medical malpractice damages caps bring down malpractice insurance premiums is debated by some researchers and is a point of constant contention between plaintiff and health care sides of the tort reform debate.[46] There is strong evidence supporting the argument that medical malpractice damages caps lower malpractice insurance claims over time. Medical malpractice caps have also been shown to decrease malpractice insurance premiums since the 1990s.[47] California stands out as a case study, thanks in large part to the relative age of California's medical malpractice cap. In 1975 the California legislature passed the Medical Injury Compensation Reform Act,[48] which establishes a cap of $250,000 for noneconomic damages in medical malpractice actions.[49] This law "has reduced California's malpractice premiums by forty percent in constant dollars since 1975."[50] This has kept California malpractice insurance premiums at an increase of less than one-third the national rate.[51]

The connection between medical malpractice caps and the reduction in malpractice insurance payouts is shown in states both with and without caps.

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44 *See, e.g.* U.S. Gen. Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, at 16 (June 2003), *at* https://www.govinfo.gov/content/pkg/GAOREPORTS-GAO-04-128T/html/GAOREPORTS-GAO-04-128T.htm (last visited April 12, 2021).

45 *Id.* at 43. ("losses on medical malpractice claims appear to be the primary driver of increased premium rates in the long term. Such losses are by far the largest component of insurer costs, and in the long run, premium rates are set at a level designed to cover anticipated costs.")

46 *See* Bryston C. Gallegos, *A More Balanced Prescription: Reconciling Medical Malpractice Reform with Fundamental Principals of Tort Law*, 55 GON. L. REV. 105 (2019); *see also* Kevin J. Gfell, *The Constitutional and Economic Implications of a National Cap on Non-Economic Damages in Medical Malpractice Actions*, 37 IND. L. REV. 773 (2004).

47 *See* U.S. Congress, Office of the Technology Assessment, *Impact of Legal Reforms on Medical Malpractice Costs*, OTA-BPH-H-1 19 (Oct. 1993) (discussing results of six independent studies: E.K. Adams & S. Zuckerman, *Variation in the Growth and Incidence of Medical Malpractice Claims*, 9 J. HEALTH POL. POL'Y & L. 475, 475–88 (1984); D. K. Barker, *The Effects of Tort Reform on Medical Malpractice Insurance Markets: An Empirical Analysis*, 17 J. HEALTH POL. POL'Y & L. 143, 143–61 (1992); G. Blackmon & R. Zeckhauser, *State Tort Reform Legislation: Assessing Our Control of Risks*, TORT L. & PUB. INT. (New York W.W. Norton & Co., 1991); P.M. Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 L. & CONTEMP. PROBS. 57, 57–84 (1986); F.A. Sloan *et al.*, *Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis*, 14 J. HEALTH POL. POL'Y & L. 663, 663–89 (1989); S. Zuckerman *et al., Effects of Tort Reforms and Other Factors on Medical Malpractice*, 27 INQUIRY 167, 167–82 (1990)).

48 CAL. CIV. CODE §§ 3333.1 [Preempted by Goncalves By and Through Goncalves v. Rady Children's Hospital San Diego, 865 F.3d 1237 (9th Cir. 2017)].

49 *See id.*

50 Anderson, *Effective Legal Reform*, *supra* note 42, at 351.

51 *Id.* at 351 (citing U.S. Dep't of Health & Human Servs., *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System*, 19 (July 2002)).

> It is reliably estimated by entities such as the U.S. Congressional Budget Office, the U.S. Department of Health and Human Services, Milliman and Robertson, the Florida Governor's Select Task Force on Healthcare Professional Liability Insurance, and the American Academy of Actuaries that passage of reforms similar to MICRA in states currently lacking such statutes would result in premium savings of twenty-five to thirty percent annually [in malpractice insurance premiums].
>
> Not only is there convincing evidence that these reforms are effective when enacted, we have, unfortunately, compelling evidence of the damage that occurs when these reforms are withdrawn. The state of Ohio enacted MICRA-like statutes in 1975. Malpractice insurance rates in the state fell steadily from 1975 until the law was challenged in 1982, and the Ohio Supreme Court found the statutes to be unconstitutional. Thereafter, malpractice insurance rates resumed their climb. Not surprisingly, Ohio is one of the states the AMA has declared to be in "crisis" and is again debating the need for legal reforms.
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> Similarly, Oregon capped non-economic damages in 1987. In 1987, the Oregon Supreme Court nullified the law. By 2001, the cost of malpractice claims in the state had increased from a base of $15 million in 1998 to $60 million, an increase of 400% and has continued to rise since.[52]

The positive effect of malpractice caps on malpractice insurance premiums has remained constant over the past decade.[53] "An overview of the [medical malpractice cap] data suggests that the period between 2009 and 2018 was one of increasing stability in medical liability premiums. In 2009, 57.8 percent of premiums were the same as those reported for 2008."[54] In 2018, the percent of premiums remained the same as the year prior reached 82 percent.[55]

### C. VIRGINIA'S MEDICAL MALPRACTICE CAP AND VIRGINIA MEDICAL MALPRACTICE INSURANCE PREMIUMS

The insurance market appears to be hardening and medical malpractice insurance premiums saw a slight uptick in Virginia over 2020.[56] But overall, only 1.3 percent of Virginia medical malpractice insurance premiums increased 10 per-

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[52] Richard E. Anderson, *Effective Legal Reform and the Malpractice Insurance Crisis*, 5 YALE J. HEALTH POL'Y, L. & ETHICS 341, at 351 (2005) (internal citations omitted ).

[53] *See* Jose R. Guardado, *Medical Professional Liability Insurance Premiums: An Overview of the Market from 2009 to 2018*, AMA ECO. & HEALTH POL'Y RES. 2019-1 (2019).

[54] *Id.* at 3.

[55] *Id.*

[56] *See* American Medical Ass'n., *AMA issues analysis of medical liability insurance premiums*, *at* https://www.ama-assn.org/press-center/press-releases/ama-issues-analysis-medical-liability-insurance-premiums (2021) (last visited April 12, 2021).

cent or more.[57] This should not, however, be misconstrued as evidence that Virginia's medical malpractice cap is any less effective at lowering malpractice insurance premiums than its counterparts throughout the country. Perhaps this is best attributed to the nature of the yearly increasing cap on damages. But a complete abrogation of Virginia's statute would clearly show a much greater impact. And as those premiums increase, the Medical Society of Virginia argues the costs and expenses to healthcare providers to cover those increases will mean a greater burden on the patient.[58]

## IV. The Future Challenges and Defenses to Code Section 8.01-581.15

As we have seen, the recent challenges to the medical malpractice cap, both through the appellate process, and through the General Assembly, have been unsuccessful. As these challenges continue, Virginia precedent and legislative intent have yet to be overturned, undermined, or proven outdated. The recent challenges to the cap show that the courts are reluctant to entertain new ways of challenging the statute's constitutionality, and the legislature is unwilling to act without a great deal more information on how such a change would affect the healthcare industry. Our Commonwealth remains in the majority of states that have medical malpractice caps. It also has the largest cap of all states that still limit damages. That is not to say that, given all these factors, proponents of Code section 8.01-581.15 should remain confident that the cap remain untouched. Medical malpractice defense attorneys should continue to educate themselves and understand the importance of the statute's legislative and appellate history, the impact the statute has on the healthcare industry, and the importance of this statute to the availability of healthcare to the citizens of the Commonwealth of Virginia.

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57 *See id.*

58 *Medical Malpractice Damages Cap*, *at* https://www.msv.org/advocacy/issues/medical-malpractice-damages-cap.