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Beyond Damages Caps: Behavioral, Economic, and Legal Pathways to Reforming Medical Malpractice Liability

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BEYOND DAMAGES CAPS: BEHAVIORAL, ECONOMIC, AND LEGAL PATHWAYS TO REFORMING MEDICAL MALPRACTICE LIABILITY

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Abstract: Medical malpractice reform in the United States has long centered on statutory damages caps intended to control liability costs, stabilize insurance markets, and preserve access to healthcare. This paper evaluates the legal and economic performance of damages caps and argues that their effects are more limited than often assumed. Using case law, national malpractice data, and economic scholarship, the analysis shows that malpractice claim frequency has declined substantially since the 1990s, while system costs are increasingly driven by a small number of high-severity cases. In this context, damages caps modestly reduce certain payouts but do not consistently lower insurance premiums, significantly reduce defensive medicine, or address broader drivers of healthcare spending. Their legal durability also varies widely across states due to differing constitutional frameworks. The paper concludes that these caps function primarily as a redistributive mechanism rather than a comprehensive reform, ultimately proposing alternative strategies—including behavioral interventions, structured disclosure programs, and tiered damages frameworks—to improve safety, compensation, and system efficiency.

I. Problem

Medical malpractice lies at the intersection of law, economics, and public policy. State and federal statutes shape how society values human life, compensates injured patients, deters professional negligence, and allocates the financial burdens of modern healthcare. Each year, preventable medical errors lead to serious injuries and deaths, while physicians and hospitals operate in an environment of rising costs, increasingly complex care, insurance reimbursement pressures, and concerns about litigation. America's civil justice system is intended to balance

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accountability with fairness, yet stakeholders increasingly question whether traditional tort principles can effectively achieve these goals in a complex and rapidly evolving healthcare economy.

The ultimate goal of medical malpractice law has always been to ensure that injured patients receive just compensation. Yet as total settlement payouts climb dramatically—from $3.6 billion in 2010 to $5.1 billion in 2024—the system faces a more complex question: how can it preserve fair compensation and meaningful deterrence without bankrupting physicians and hospitals, driving up malpractice premiums, discouraging risky but necessary care, expanding administrative burdens meant solely to avoid liability, and inviting greater legal exposure as opportunistic attorneys pursue ever-larger awards?[2] This tension has led many states to enact tort reform measures—generally caps on non-economic or total damages—designed to stabilize liability risk, control premiums, and reduce overall costs. Supporters argue that caps reduce unpredictable—and potentially irrational—jury awards, lower premiums, and help retain physicians in high-risk specialties. Critics counter that caps arbitrarily limit recovery for the most severely injured patients and undermine tort law's core compensatory and corrective-justice functions.

From an economic perspective, malpractice liability influences physician behavior, insurance markets, and healthcare spending. Broad estimates place the systemwide cost of malpractice, including defensive medicine, administrative expenses, and indemnity payments, at approximately $56 billion annually, representing 2.4% of national healthcare expenditures.[3] Some studies suggest that caps modestly reduce premiums and certain forms of defensive

[2] Division of Practitioner Data Bank, Bureau of Health Workforce, Health Resources and Services Administration, *Data Analysis Tool*, https://www.npdb.hrsa.gov/analysistool.
[3] Michelle M. Mello, Amitabh Chandra, Atul A. Gawande, and David M. Studdert, "National Costs of the Medical Liability System," *Health Affairs* 29, no. 9 (2010): 1569–77, https://doi.org/10.1377/hlthaff.2009.0807.

medicine; others find minimal long-term effects or emphasize that most malpractice-related costs arise from structural features of healthcare rather than litigation frequency. The mixed nature of the data illustrates a key difficulty: evaluating the actual impact of tort reform requires reconciling conflicting evidence and recognizing the limitations of economic measurement in a system as fragmented as American healthcare.

The legal landscape is equally unsettled. Damages caps have faced persistent constitutional challenges, with courts in different states reaching sharply divergent conclusions about the limits of legislative authority. Some courts uphold caps as permissible economic regulation, while others strike them down as violations of equal protection, the right to a jury trial, or separation-of-powers principles. These disputes highlight larger institutional questions about which branch of government is best positioned to regulate civil liability, and whether tort reform encroaches on the traditional role of juries in determining damages.

Public policy considerations further complicate the debate. Tort reform affects patient safety incentives, the distribution of healthcare resources, and access to justice. Critics argue that caps disproportionately burden children, the elderly, and individuals with limited earning potential, whose harms are often primarily non-economic. Proponents respond that without caps, liability pressures may worsen physician shortages or discourage providers from practicing in underserved communities. These competing concerns demonstrate why malpractice reform has remained politically salient across decades and why no consensus solution has emerged.

Given these overlapping legal, economic, and policy dynamics, the core problem is not merely whether damages caps succeed or fail in isolation, but whether the broader malpractice system effectively balances compensation, deterrence, and healthcare affordability. Tort reform has sought to address genuine challenges, yet its outcomes remain contested, and its trade-offs

are unevenly distributed among patients, physicians, and insurers. Understanding these tensions is essential to evaluating whether existing reforms are justified and to identifying alternative approaches that better align with the goals of fairness, efficiency, and institutional legitimacy in medical liability.

II. History

IIa. Origins of Malpractice

Writings on medical responsibility can be traced back to Ancient Egypt, where Hammurabi's Code ordered that "if the doctor has treated a gentleman…and has caused [him] to die, or has opened an abscess of the eye for a gentleman…and has caused the loss of [his] eye, one shall cut off his hands."[4] This law was adopted in Rome, and by 1200 CE, Roman law had become the law of Europe. In 1066, English common law was established, and court records show a direct line of malpractice decisions extending to the present.[5] Due to British influence, medical malpractice suits first appeared in the US with regularity beginning in the 1800s.[6] Before the 1960s, however, legal claims for medical malpractice were rare and had little impact on the practice of medicine.[7]

IIb. 1970s

The origins of contemporary malpractice reform trace back to the early 1970s, when the United States experienced what became known as the first medical malpractice insurance crisis.[8]

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[4] B. S. Bal, "An Introduction to Medical Malpractice in the United States," *Clinical Orthopaedics and Related Research* 467, no. 2 (2008): 339, https://doi.org/10.1007/s11999-008-0636-2.
[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] Glen O. Robinson, "The Medical Malpractice Crisis of the 1970's: A Retrospective," *Law and Contemporary Problems* 49, no. 2 (1986): 5–35, https://doi.org/10.2307/1191413.

Several insurers withdrew from the market or drastically raised premiums, citing unexpectedly high claims costs and volatility in jury verdicts.[9] Physicians in high-risk specialties, particularly obstetrics and emergency medicine, reported dramatic premium spikes and, in some cases, threatened to stop delivering babies or leave certain states altogether.[10] Policymakers feared that escalating liability pressures would reduce access to essential medical services.

In response, numerous states enacted the first generation of tort reforms. California's Medical Injury Compensation Reform Act of 1975 (MICRA) became the most influential model.[11] MICRA imposed a $250,000 cap on non-economic damages, limited attorney contingency fees, allowed periodic payments of future damages, and introduced other modifications intended to stabilize insurance markets.[12] At the time, legislators explicitly framed these reforms as emergency measures designed to contain spiraling costs and preserve the availability of care.[13] MICRA quickly became the template for national reform efforts, and California's experience would shape debates for decades as malpractice attorneys attempted to work around the law.[14]

IIc. 2003

During the early 2000s, individual cases began to illustrate the stakes of tort reform more vividly than abstract policy debates. One of the most notable was *Gourley v. Methodist Health*

[9] Ibid.
[10] Ibid.
[11] R. Marcelis, "Medical Injury Compensation Reform Act of 1975: Looking Back, Looking Forward, an Interview with Tort Reform Attorney, Fred Hiestand, General Counsel of Civil Justice Association of California," *UC Davis Business Law Journal* 11 (2012).
[12] Ibid.
[13] Ibid.
[14] A second wave of reforms emerged in the 1980s and 1990s, as states sought to replicate MICRA's approach in response to renewed premium increases and concerns about defensive medicine. Many states enacted caps—primarily on non-economic damages—and early constitutional challenges began to surface. Although this era expanded the geographic reach of tort reform, it did not fundamentally alter the structure of malpractice liability. Instead, it laid the groundwork for the more consequential debates and judicial conflicts that would emerge in the early 2000s.

System (2003), a Nebraska Supreme Court decision involving a child who suffered severe brain injuries at birth due to medical negligence.[15] A jury awarded $5.6 million in damages to cover lifelong care and suffering,[16] but Nebraska's statutory cap on total damages required the court to reduce the award to $1.25 million.[17]

The *Gourley* decision crystallized the tensions at the heart of malpractice reform. To supporters of caps, the case demonstrated the necessity of predictable liability limits to preserve stable insurance markets and protect healthcare providers from financial ruin. To critics, *Gourley* represented the injustice inherent in blanket statutory caps, as the award was insufficient to cover the lifelong care the child would require. The Nebraska Supreme Court ultimately upheld the statutory cap, emphasizing the legislature's prerogative to address perceived crises in healthcare access and insurance costs.[18] Yet the case also highlighted a deeper normative question: whether legislatures should override jury determinations to achieve economic stability, and whether such limits erode the compensatory function at the core of tort law.

While *Gourley* worked its way through the courts, a third wave of tort reform emerged, again driven by rising malpractice premiums and concerns from medical associations that high-risk specialties were becoming unsustainable. Texas's 2003 reforms, which included a $250,000 cap on non-economic damages for physicians, hospitals, and nursing homes, were widely promoted by tort reform advocates as a success story.[19] Texas reported improved insurer participation, greater perceived stability in the liability market, and renewed physician interest in

[15] *Gourley v. Methodist Health System*, 265 Neb. 918 (Neb. 2003).
[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] Jamee Cotton, "How Much Are You Worth?: Why the Texas Supreme Court Took Tort Reform Too Far in Limiting the Admissibility of Certain Medical Expenses During Trial," *Texas Tech Law Review* 45 (2013): 565.

practicing in the state, though academic analyses reached more mixed conclusions regarding long-term effects.[20]

IId. 2010-2025

The period from 2010 to the present has been marked by constitutional fragmentation, legislative recalibration, and growing experimentation with alternatives to traditional caps. During this time, the legal landscape surrounding malpractice reform became increasingly uneven as state supreme courts reached sharply divergent conclusions about the validity of damages caps. In 2010, the Illinois Supreme Court struck down its non-economic damages cap in *Lebron v. Gottlieb Memorial Hospital*, holding that the statute violated the state constitution's separation-of-powers doctrine.[21] Florida followed suit several years later: in 2014, its Supreme Court invalidated caps in wrongful-death malpractice cases in *Estate of McCall v. United States*, and in 2017, extended that reasoning to personal-injury malpractice actions in *North Broward Hospital District v. Kalitan*.[22] By contrast, many other states continued to uphold their cap regimes, often applying lenient rational-basis review rather than strict scrutiny. This emerging patchwork underscored that malpractice reform is deeply intertwined with each state's constitutional structure and institutional philosophy. Where courts regarded the jury's fact-finding role as indispensable, caps proved vulnerable; where legislatures enjoyed broad authority over economic regulation, caps were more readily sustained. Today, thirty states use some form of cap.[23]

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[20] Ibid.; Beyond 2003, the 2000-2010 era also witnessed growing scrutiny of the empirical claims underlying tort reform. Economic studies reached divergent conclusions about whether caps reduced premiums, defensive medicine, or healthcare spending. The academic debate became increasingly nuanced, laying the groundwork for the more sophisticated analyses seen today.

[21] *Lebron v. Gottlieb Memorial Hospital*, 930 N.E.2d 895 (Ill. 2010).

[22] *Estate of McCall v. United States*, 134 So. 3d 894 (Fla. 2014); *North Broward Hospital District v. Kalitan*, 219 So. 3d 49 (Fla. 2017).

[23] Center for Justice & Democracy, "Fact Sheet: Caps on Compensatory Damages: A State Law Summary," September 29, 2025, https://centerjd.org/content/fact-sheet-caps-compensatory-damages-state-law-summary.

Over the past few years, states have revisited the substance of their malpractice frameworks in response to new empirical evidence, evolving political dynamics, and shifts in public attitudes toward compensation. The most consequential example is California's 2022 enactment of AB 35, the first major revision to MICRA since 1975. AB 35 increased the non-economic damages cap for both personal-injury and wrongful-death malpractice claims and provided for gradual future increases, reflecting the recognition that MICRA's fixed nominal cap had become outdated and insufficient for catastrophic injury cases.[24] Yet the reform preserved MICRA's broader architecture, signaling that legislators remained committed to balancing compensation concerns with the stability valued by insurers and providers.

At the national level, policymakers and scholars have increasingly explored alternatives to traditional caps, including "safe harbor" rules tied to evidence-based clinical guidelines, specialized health courts, early-offer mechanisms, and enhanced patient-safety initiatives. These approaches reflect a growing understanding that the malpractice system must balance multiple objectives, and that no single reform can address all the system's deficiencies.

The history of medical malpractice reform thus reveals a recurring pattern: periods of perceived crisis prompt legislative intervention; courts either validate or constrain those efforts; and stakeholders debate the empirical outcomes with varying conclusions. Throughout this evolution, the core tensions remain unresolved: how to adequately compensate injured patients, deter negligence effectively, and maintain a healthcare system that is both affordable and accessible.

III. Analysis

IIIa. Legal Performance of Damages Caps

[24] *California Assembly Bill No. 35*, ch. 17 (2022).

Damages caps operate at the intersection of legislative authority and traditional judicial functions. Their performance depends not only on statutory design but also on constitutional durability, institutional fit, and the extent to which they preserve or constrain the jury's fact-finding role. Law reviews across the country have observed that state courts diverge sharply on these questions, reflecting constitutional traditions that differ more fundamentally than the statutes they review.[25]

Courts that uphold damages caps tend to emphasize the legislature's authority to regulate civil remedies in response to perceived systemic concerns. *Arbino v. Johnson & Johnson* (2007) illustrates this approach. Here, the Ohio Supreme Court reasoned that modifying non-economic damages to stabilize the liability insurance market was a legitimate exercise of policymaking power and reviewed the statute under a deferential, rational-basis standard.[26] This form of deference reflects an institutional judgment that legislatures, rather than courts, are better positioned to weigh complex economic tradeoffs. This reasoning, however, presumes a relatively direct connection between damages caps and improved insurance stability—a premise that empirical studies evaluate with mixed results. NYU law professor Catherine Sharkey's analysis suggests that focusing solely on payout suppression understates the broader systemic effects of caps, including changes in insurer behavior, plaintiff selection, and the overall litigation environment.[27] A significant part of her analysis is the finding of a crossover effect where caps on noneconomic damages (like pain and suffering) lead plaintiffs' attorneys to more vigorously pursue, and juries to award, larger economic damages (like lost wages and medical expenses), which are often uncapped.[28] From this perspective, the argument that caps inherently promote

[25] Catherine M. Sharkey, "Unintended Consequences of Medical Malpractice Damages Caps," *New York University Law Review* 80 (2005): 391.
[26] *Arbino v. Johnson & Johnson*, 116 Ohio St. 3d 468 (Ohio 2007).
[27] Sharkey, "Unintended Consequences of Medical Malpractice Damages Caps," 403.
[28] Sharkey, "Unintended Consequences of Medical Malpractice Damages Caps," 405.

predictability may rely on a partial account of how malpractice systems operate. This highlights a central tension: although standardization may further legislative policy goals, it can also constrain the individualized assessment of harm traditionally entrusted to juries.

Courts that strike down damages caps adopt the opposite institutional perspective, viewing tort remedies as part of the judiciary's core constitutional function. The Illinois Supreme Court's decision in *Best v. Taylor Machine Works* (1997) demonstrates this ideology. The court invalidated a $500,000 non-economic damages cap on separation-of-powers grounds, reasoning that a uniform statutory limit prevents juries from performing their role of assessing individualized harm.[29] Rather than deferring to legislative policymaking, the court emphasized the judiciary's obligation to preserve the integrity of the adjudicative process.[30] Jeffrey Parness' commentary on *Best* in the *Penn State Law Review* notes that this approach reflects a deeper constitutional commitment: the jury's fact-finding authority is a structural guarantee resistant to across-the-board legislative modification.[31] The Florida Supreme Court adopted a related logic in *McCall,* striking down malpractice caps on equal protection grounds. In the court's view, caps impose disproportionate burdens on the most severely injured plaintiffs, flattening distinctions among cases that tort law is designed to evaluate individually.[32] These decisions reveal skepticism toward the standardization project inherent in damages caps and reflect a constitutional philosophy that prioritizes individualized adjudication over systemic uniformity.

Cases applying total-damages caps reveal additional institutional tensions. As previously mentioned, in *Gourley*, the Nebraska Supreme Court upheld a statutory ceiling on all damages, reducing a jury's multimillion-dollar verdict to the legislative maximum. While the court found

[29] *Best v. Taylor Machine Works*, 179 Ill. 2d 367 (Ill. 1997).
[30] Ibid.
[31] Jeffrey A. Parness, "State Damage Caps and Separation of Powers," *Penn State Law Review* 116 (2011–2012): 145.
[32] *McCall v. US*, 9.

that the legislature acted reasonably to address insurance concerns, some Stanford scholars have observed that total caps intensify the tradeoff between predictability and individualized compensation, particularly in catastrophic injury cases.[33] Such caps shift significant discretion from juries to legislatures and courts, prompting questions about which institution is best situated to evaluate the magnitude of non-economic harm.

The recent case law and scholarly analysis indicate that a stable national legal consensus on damages caps is unlikely to emerge. States that conceptualize tort law as a domain for legislative experimentation, such as Ohio, tend to uphold caps; states that embed individualized adjudication and jury authority within structural constitutional protections, such as Illinois and Florida, tend to invalidate them. As Studdert and Mello note in the *New England Journal of Medicine*, this divergence is rooted in constitutional design rather than empirical disagreement.[34]

Accordingly, the legal performance of damages caps cannot be assessed in the abstract: their stability, function, and doctrinal coherence depend on institutional environments that are neither uniform nor converging. This structural fragmentation ensures that caps will remain legally contested and jurisdiction-specific for the foreseeable future.

IIIb. Economic Performance

Economic assessments of medical malpractice reforms must begin with the fundamental question of whether the system faces a volume-driven crisis. National data suggest it does not. As shown below, malpractice payment reports submitted to the National Practitioner Data Bank

[33] Christopher N. Kelly and Michelle M. Mello, "Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation," *Stanford Journal of Law, Medicine & Ethics* 33, no. 3 (2005): 515–534.
[34] David M. Studdert, Michelle M. Mello, and Troyen A. Brennan, "Medical Malpractice," *New England Journal of Medicine* 350, no. 3 (2004): 283–292.

peaked in the early 1990s at nearly 20,000 annually and have since entered a decades-long decline.[35] By the early 2020s, annual payment reports had fallen to roughly half their 1990s levels.

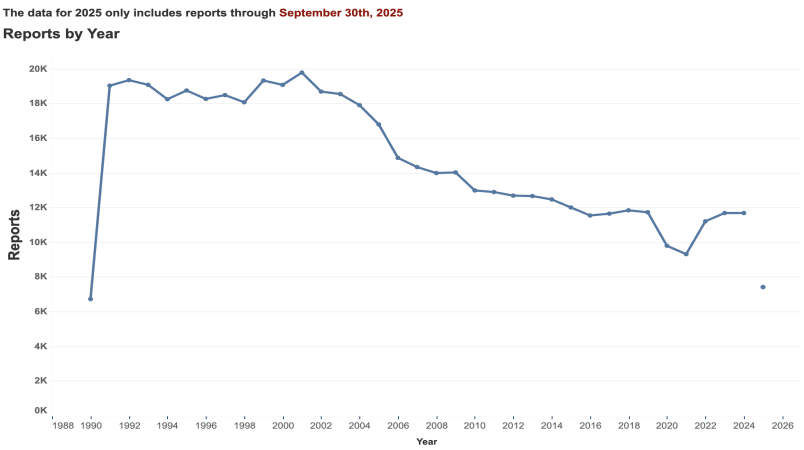

Figure 1:
NPDB Medical Malpractice Payment Reports over Time

This sustained contraction complicates arguments that malpractice litigation remains excessively frequent or that high filing rates drive contemporary instability in insurance markets. A shrinking pool of paid claims indicates that reforms designed to reduce claim volume—such as procedural hurdles or screening panels—address a problem that has been diminishing for more than twenty years. The economic pressures of the current malpractice environment arise from different sources, prompting a reevaluation of what damages caps meaningfully achieve.

National trends can mask specialty-level variation, but the long-run decline is consistent across medical fields. Table 1 (adapted from a 2017 *JAMA* study) shows that paid-claim rates per 1000-physician-years fell sharply between 1992 and 2014 in virtually every specialty, including those historically considered high-risk.[36] Neurosurgery, obstetrics and gynecology, general surgery, orthopedics, and emergency medicine all experienced declines of 40-60%. Even low-risk specialties, including pediatrics and dermatology, saw steep reductions.

[35] Division of Practitioner Data Bank, Bureau of Health Workforce, Health Resources and Services Administration, *Data Analysis Tool*, https://www.npdb.hrsa.gov/analysistool.
[36]Adam C. Schaffer et al., "Rates and Characteristics of Paid Malpractice Claims Among U.S. Physicians by Specialty, 1992–2014," *JAMA Internal Medicine* 177, no. 5 (2017): 710–718, https://doi.org/10.1001/jamainternmed.2017.0155.

Table 1: Rates of Paid Medical Malpractice Claims per 1,000 Physician-Years by Specialty, 1992–2014.

Specialty	Rate of Paid Medical Malpractice Claims					Difference in Mean Rate From Period 1 to Period 4	Percentage Change[a]
	1992-2014 (All Periods)	1992-1996 (Period 1)	1997-2002 (Period 2)	2003-2008 (Period 3)	2009-2014 (Period 4)		
All specialties	14.1	20.1	17.5	13.2	8.9	−11.2	−55.7
Anesthesiology	11.7	15.4	13.7	10.8	8.6	−6.8	−44.2
Cardiology	15.9	15.6	18.0	16.6	13.5	−2.1	−13.5
Colon and rectal surgery	34.1	38.3	39.3	35.1	27.6	−10.7	−27.9
Dermatology	11.6	17.3	15.2	10.6	6.2	−11.1	−64.2
Emergency medicine	18.8	24.3	24.4	18.6	13.0	−11.3	−46.5
Family medicine	14.3	22.3	18.4	13.0	8.2	−14.1	−63.2
Gastroenterology	15.8	18.5	18.0	16.5	12.1	−6.4	−34.6
General practice	21.9	29.0	23.2	16.7	12.6	−16.4	−56.6
General surgery	30.0	34.4	34.3	29.9	22.2	−12.2	−35.5
Internal medicine	7.1	8.9	8.5	7.1	4.8	−4.1	−46.1
Neurology	9.5	13.1	12.0	9.4	5.8	−7.3	−55.7

These parallel declines reinforce a central economic insight: contemporary malpractice risk is not driven by the sheer number of claims, but by the financial impact of a relatively small subset of high-severity cases. This shift places increased importance on payout magnitude and variance. Insurers can no longer rely on frequency smoothing—spreading risk over many moderate claims—and instead must absorb the financial shock of rare but extremely costly catastrophic injuries. This is the environment in which damages caps are intended to function economically.

The question, however, is how well caps actually perform this stabilizing function. The empirical literature indicates that many of the claimed economic benefits of caps are overstated or contingent on assumptions that do not hold consistently. For example, caps are frequently justified on the grounds that they reduce malpractice insurance premiums. Yet GAO analyses show that premium spikes correspond more closely to cyclical patterns in the insurance industry—investment downturns, reduced reinsurance availability, and shifting underwriting

standards—than to changes in malpractice claim frequency or severity.[37] This evidence does not merely weaken the premium-reduction claim but raises a deeper point: to the extent premiums move independently of tort reforms, caps may be addressing the wrong variable altogether. If the primary drivers of premium instability lie outside the liability system, lawmakers may be using a legal instrument to treat what is essentially a financial market phenomenon.

Even when studies detect premium reductions in cap states, the effect is often small relative to overall market variation. This raises a second question: is the observed premium stability attributable to the cap itself, or to selection effects, insurer market structure, or broader economic conditions? Because many states adopt caps during politically salient "crisis periods," it is difficult to disentangle the effect of the reform from that of the cycle that triggered it. The empirical record, therefore, supports a narrower and more cautious claim: caps may contribute to premium stabilization under certain conditions, but they are neither a necessary nor sufficient cause of sustained premium moderation.

Defensive medicine also illustrates how the economic rationale for caps can be overstated. Early studies—most notably by Kessler and McClellan—found that liability reforms were associated with reductions in spending for certain Medicare patient groups.[38] Yet subsequent research has struggled to replicate these results across specialties, time periods, or broader patient populations. Continued studies consistently find minor or statistically insignificant effects, and surveys indicate that physicians report practicing defensively even in states with strict caps on damages.[39] This suggests that liability pressure is only one factor

[37] U.S. Government Accountability Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702 (Washington, DC: U.S. Government Printing Office, 2003), https://www.govinfo.gov/app/details/GAOREPORTS-GAO-03-702.
[38] Daniel Kessler and Mark McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics* 111, no. 2 (1996): 353–390, https://doi.org/10.2307/2946682.
[39] Michelle M. Mello and Troyen A. Brennan, "Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform," *Texas Law Review* 80 (2002): 1595–1637.

shaping clinical behavior, interacting with institutional practice norms, reimbursement incentives, and patient expectations. The Congressional Budget Office estimated that even a comprehensive package of tort reforms would reduce national health spending by approximately 0.5 percent, a figure that substantially narrows the economic significance of defensive medicine as a justification for caps.[40] The weight of the evidence thus indicates that while caps may marginally reduce some defensive practices, they do not meaningfully alter overall healthcare spending patterns.

The rise in claim severity, however, offers a more targeted, though still limited, economic justification for caps. Data from the National Association of Insurance Commissioners show that while the number of paid claims has declined, average indemnity payments have steadily increased, driven by the growing cost of medical care and the disproportionate economic weight of catastrophic injuries.[41] This concentration of financial exposure in a small set of high-severity cases introduces volatility that insurers struggle to price effectively. Damages caps theoretically mitigate this risk by constraining the upper tail of non-economic damages, thereby reducing volatility in total payouts. But this mechanism has structural limits: caps restrict only non-economic damages, while economic damages, especially lifetime medical costs, continue to rise sharply.[42] In states with long-static caps that fail to adjust for inflation, such as California under the pre-2022 MICRA regime, this mismatch becomes especially pronounced. Caps substantially reduce compensation for non-economic loss without materially addressing the escalating economic damages component that drives overall severity. Economically, this

[40] Congressional Budget Office, "Limiting Tort Liability for Medical Malpractice," January 8, 2004, https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/49xx/doc4968/01-08-medicalmalpractice.pdf.
[41] National Association of Insurance Commissioners, *U.S. Health Insurance Industry Analysis Report* (2024).
[42] Rishi Khera et al., "Lifetime Healthcare Expenses across Demographic and Cardiovascular Risk Groups," *American Journal of Preventive Cardiology* 14 (2023): 100493.

produces an uneven tradeoff: predictability may improve for insurers, but not necessarily in the areas most responsible for rising costs.

Cross-state analyses also reveal the constraints of caps as a systemic reform. Using Avraham's Database of State Tort Law Reforms, multiple studies find that non-economic caps reliably reduce mean payouts.[43] Yet these reductions have not translated into consistent improvements in physician supply, particularly in high-risk specialties such as obstetrics or neurosurgery. Workforce data from the Association of American Medical Colleges show no stable correlation between the presence of caps and specialist distribution once population, market demand, and regional healthcare infrastructure are accounted for.[44] This disconnect suggests that the economic effects of caps may be primarily redistributive—shifting financial risk away from insurers and providers and onto severely injured plaintiffs—rather than transformative at the system level. They reduce the size of payouts but do not address broader structural issues, such as escalating healthcare costs, regional provider shortages, or insurance-cycle volatility.

Therefore, the economic evidence supports a restrained conclusion: damages caps function effectively in narrow, context-dependent ways, principally by reducing certain categories of payouts and, in some cases, moderating short-term volatility in insurer losses. But beyond this limited domain, they do not reliably reduce premiums, meaningfully curtail defensive medicine, or address the primary drivers of healthcare spending. Their economic performance is therefore real but partial. Caps mitigate a shrinking subset of malpractice-system

[43] Ronen Avraham, "Database of State Tort Law Reforms (7.1)," University of Texas School of Law, Law and Economics Research Paper No. e555 (October 26, 2021), https://doi.org/10.2139/ssrn.90271.
[44] GlobalData Plc, *The Complexities of Physician Supply and Demand: Projections From 2021 to 2036* (Washington, DC: Association of American Medical Colleges, 2024).

pressures, namely severity-driven tail risk, while leaving other inefficiencies of the healthcare and insurance markets largely intact.

IIIc. Distributional and Ethical Tensions

Even if damages caps achieve some degree of economic predictability, they introduce substantial distributional consequences that shape who bears the costs of malpractice injuries. Caps function as a mechanism for allocating losses across plaintiffs, providers, insurers, and society at large. Because caps apply only to non-economic damages, their impact falls most heavily on plaintiffs whose harms are not readily quantified in lost wages or future medical expenses. This includes children, elderly individuals, stay-at-home caregivers, and low-income workers—groups whose economic losses tend to be modest relative to the severity of their injuries. Scholars of medical malpractice reform have emphasized that caps tend to compress recoveries most sharply for claimants whose compensable losses are dominated by pain, suffering, and loss of function rather than foregone earnings.[45] Caps thus redistribute risk downward, away from institutional actors such as insurers and hospital systems and toward those who experience catastrophic injuries.

These distributional dynamics generate further concerns regarding deterrence. Tort law traditionally assumes that providers internalize the expected costs of negligent behavior; liability encourages investment in safety. Yet when caps reduce exposure in the most severe cases, the expected cost of malpractice becomes less sensitive to catastrophic harm. Hyman argues that this can blunt marginal deterrence by flattening the liability function: the difference in legal consequences between moderate and severe negligence narrows.[46] Although empirical studies do

[45] Randall R. Bovbjerg, "Commentary: Malpractice Reform in Policy Perspective," *The Milbank Quarterly* 85, no. 2 (2007): 297–305, https://doi.org/10.1111/j.1468-0009.2007.00488.x.
[46] David A. Hyman, "Commentary: Medical Malpractice and the Tort System: What Do We Know and What (If Anything) Should We Do About It?" *Texas Law Review* 80 (2002): 1639–1655.

not definitively establish that caps weaken safety incentives, the theoretical concern is structurally significant. A liability system that undervalues the largest harms may distort provider incentives even if average payouts decline. This tension between predictability for insurers and deterrence for patients is central to understanding why courts in states such as Florida and Illinois ground their constitutional decisions partly in concerns about individualized adjudication and protection for the most seriously injured.

Ethical tensions arise from these distributional patterns, although they can be articulated without appealing to normative preferences. Tort law historically embodies an individualized conception of justice: each plaintiff's harm is assessed on its own terms, and compensation reflects the magnitude of that harm. Caps, by design, replace individualized assessment with a uniform ceiling. This shift raises the ethical question of whether the state may prioritize systemwide cost control over case-specific compensation. Sharkey describes this as the conflict between aggregate welfare optimization and particularized justice, a conflict embedded in the very structure of caps rather than in political preferences.[47] Courts that strike down caps frequently rely on this reasoning, emphasizing that uniform statutory limits obscure relevant distinctions among injuries and plaintiffs. In this sense, the ethical tension is not whether caps are "fair," but rather what theory of fairness the malpractice system should operationalize: one centered on predictability and systemwide affordability, or one centered on individualized redress.

The distributional consequences also extend beyond plaintiffs. Caps can shift costs to public programs such as Medicaid or Medicare when injured patients receive inadequate tort recoveries to fund long-term care.[48] This creates a secondary redistribution: taxpayers absorb

[47] Sharkey, "Unintended Consequences of Medical Malpractice Damages Caps," 421.
[48] Jennifer Arlen, "Contracting over Liability: Medical Malpractice and the Cost of Choice," *University of Pennsylvania Law Review* 158, no. 4 (2010): 957–1023, http://www.jstor.org/stable/20698352.

costs that would otherwise be borne by negligent providers or their insurers. These spillovers introduce another institutional tension. Legislatures often justify caps as a means of preserving healthcare access by stabilizing provider premiums, yet the downstream transfer of long-term care costs to public systems complicates that calculus. The economic efficiency of caps, then, depends not only on reduced payouts but also on the externalities arising from shifting injury costs to the social insurance system.

Finally, distributional and ethical tensions converge in states that impose caps even in cases of egregious malpractice or catastrophic lifelong injury. In such circumstances, the statutory ceiling may bear little relationship to the harm suffered, creating a divergence between legal compensation and social expectations of accountability. While this paper takes no position on which model is morally preferable, these tensions highlight that caps are not merely technical adjustments to the tort system. They represent institutional choices about how the burdens of medical injury should be allocated, and what values the malpractice system is designed to prioritize.

IV. Conclusion and Implications

IVa. Reform Recommendations

The preceding analysis suggests that damages caps, though politically durable in many jurisdictions, address only a narrow portion of the malpractice system's challenges. A more constructive approach is to view malpractice reform as a problem of institutional design rather than merely a matter of legal doctrine. Behavioral economics provides a helpful framework for this shift. As Thaler and Sunstein's book *Nudge: Improving Decisions About Health, Wealth, and Happiness* emphasizes, outcomes can be transformed by reorganizing environments so that better

choices become more accessible, more salient, and more natural.[49] These principles of liberal paternalism, applied successfully in settings as varied as lunch lines and airport restrooms, can be repurposed for medical liability policy, where complexity, time pressure, and asymmetric information routinely distort decision-making.

One promising area for reform lies in the structure of clinical decision-making itself. Errors often arise not from a lack of knowledge but from predictable cognitive overload. Hospitals could redesign clinical environments to steer physicians toward safer practices: reorganizing electronic records so that crucial information is more prominent, embedding evidence-based guidelines as the natural default pathway, and reducing the number of steps required to follow best practices. These interventions mirror the Schiphol airport strategy of placing the fly in urinals to improve accuracy: a minor change in presentation produces a disproportionately large effect on behavior.[50] Implementing these reforms would require collaboration among hospital leadership, specialty organizations, and technology vendors, as well as state support for institutions that lack the resources to reconfigure their systems. The strength of this approach is its ability to reduce malpractice risk by lowering error rates themselves, thereby targeting the upstream origins of claims. Its weakness is the uneven capacity of hospitals to adopt these changes and the risk that poorly designed defaults could unintentionally narrow clinical discretion.

A second reform focuses on how adverse events are handled once they occur. Traditional disclosure and early-resolution programs often falter because they require physicians to initiate emotionally fraught conversations and require patients to navigate unfamiliar processes. Behavioral insights suggest that participation increases when the pathway is clear and structured,

[49] Richard H. Thaler and Cass R. Sunstein, *Nudge: Improving Decisions About Health, Wealth, and Happiness* (New Haven: Yale University Press, 2008), 3.
[50] Ibid., 4.

like eating healthy in a lunch line that pushes salad rather than junk food.[51] Making disclosure the presumptive first step could normalize early communication. Providing patients with automatically generated, visually straightforward explanations of their options would reduce uncertainty at a time when many feel overwhelmed and are then persuaded to sue by litigious attorneys. The strength of such a model lies in its capacity to resolve disputes before they escalate, thereby improving patient trust and reducing litigation risk. Its weakness is largely cultural: institutions may resist adopting a process that appears to be an implicit admission of fault, and without broad uptake, the effects may remain limited.

A third set of reforms concerns the structure of damages limits themselves. If political or constitutional realities make the elimination of caps unlikely in some states, the design of caps can still be improved.[52] A uniform ceiling treats vastly different injuries in the same way, producing the distributional distortions identified earlier. A tiered cap, i.e., one higher for catastrophic injuries, could preserve some predictability while reducing the most regressive effects. Such a model would resemble the cafeteria strategy of placing healthier items at the front of the line: the overall menu remains unchanged, but the arrangement encourages more balanced outcomes.[53] Implementing a tiered system would require legislative action, actuarial modeling, and clear statutory definitions of injury categories. The strength of this approach is that it addresses both fairness and stability; its weakness lies in the administrative complexity of defining severity levels and drawing a line for what injuries qualify as "catastrophic."

Reforms could also target the informational asymmetries that shape who brings malpractice claims. Research consistently shows that many severely injured patients—especially

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[51] Ibid.
[52] Of course, these design improvements matter only in states where caps remain constitutionally permissible; jurisdictions like Illinois or Florida would require constitutional amendments before adopting any version of a tiered system.
[53] Thaler and Sunstein, *Nudge: Improving Decisions About Health, Wealth, and Happiness*, 5.

those with limited resources or low health literacy—never file claims at all.[54] This creates a mismatch between actual harm and the system's liability outputs. States or large health systems could implement patient-navigator programs that are automatically triggered after serious adverse events. These navigators would not act as advocates for litigation but would provide neutral explanations of rights and options. The advantage of this intervention is its potential to reduce inequities in access. The difficulty lies in ensuring neutrality and avoiding perceptions that hospitals are attempting to steer patients away from exercising their rights.

Finally, policymakers should adopt a sequencing strategy for reform. A phased approach, starting with decision-support redesign, followed by structured disclosure systems, and then by more complex reforms to damages and patient navigation, would allow stakeholders to adapt gradually and generate data to inform subsequent steps. Such sequencing mirrors the behavioral principle that people respond better when choices are introduced in manageable increments rather than sweeping overhauls.[55]

IVb. Prediction

Large-scale legislative reform is unlikely in the near future. Malpractice policy has low political salience, generates limited electoral payoff, and would require courts or legislatures to revisit entrenched constitutional doctrines. States that currently have caps will mostly retain them, while states without caps will not adopt them unless there is a dramatic constitutional change. Instead, the most plausible evolution will occur within hospitals, insurers, and risk-management systems. Incremental, behaviorally informed redesign—quietly adopted because it improves operations and reduces internal costs—will shape the future far more than

[54] Melinda R. Pappadis et al., "The Relationship of Health Literacy to Health Outcomes Among Individuals With Traumatic Brain Injury: A Traumatic Brain Injury Model Systems Study," *Journal of Head Trauma Rehabilitation* (2024).
[55] Thaler and Sunstein, *Nudge: Improving Decisions About Health, Wealth, and Happiness*, 4.

statutory change. The result will be a system that evolves gradually at the institutional level while formal tort rules remain broadly stable and deeply fragmented across states.