Sometimes it’s relatively easy to calculate the damages from a medical error. For example, if an injured patient can no longer work, one can simply calculate his or her future lost wages, in addition to the projected cost of his or her medical care. But other damages are harder to quantify, such as severe pain or emotional distress caused by a medical injury. These are called noneconomic damages.

The fact that there are likely to be subjective judgments about the extent of these damages leads to particular problems in medical malpractice lawsuits. Plaintiffs’ attorneys have strong incentives to maximize noneconomic damages for their clients, in part because they are typically paid a percentage of the amount awarded. Juries also may be inclined to weight these damages very heavily.

One policy solution adopted by a number of states is to cap noneconomic damages. At various times, legislation also has been proposed at the federal level to cap noneconomic damages at $250,000 or $500,000. These approaches are referred to in shorthand as “tort reform.” (In law, a tort is a wrongful act that causes injury, allowing the injured person to sue the wrongdoer for damages—as in medical malpractice cases.)

**PROS AND CONS OF CAPS**

Proponents of caps argue that they have several beneficial effects. First, caps should decrease the average size of claims paid out in malpractice cases. Second, caps should discourage lawyers from filing suit unless there are large economic losses to recover. These effects should lower medical malpractice insurance premiums for providers. In turn, that should make providers less inclined to practice “defensive” medicine, and should save on overall national health costs. To what degree any or all of these assertions are true, however, is a matter of some debate.

**ESTIMATED IMPACT:** Studies demonstrate that noneconomic damage caps decrease the average size of awards in malpractice cases. Studies vary in terms of effects on insurance premiums. Whether a particular state’s cap actually decreases payments to plaintiffs depends on its dollar amount and whether it applies to all defendants together or to each individually. In California, where noneconomic damages were capped at $250,000 in the 1970s, and in Texas, where a similar cap was adopted in 2003, both payouts and the number of lawsuits have dropped.

Researchers have demonstrated a somewhat greater supply of physicians, such as obstetricians, in states that have adopted caps. The Congressional Budget Office (the nonpartisan agency that calculates the effect of legislation under consideration) estimates that the caps and other specific tort reforms imposed at the national level could have reduced national health care spending by 0.5 percent, or about $11 billion, in 2009.

A newly published study suggests that caps on damages have unexpectedly little impact on defensive medicine. The reason is that
physicians’ fears of malpractice litigation are more driven by emotion than by the specific tort laws in their states. In addition, it’s also hard to isolate the effect of defensive medicine from other forces that drive up the volume of health care services, such as fee-for-service payment incentives, patient demands, physicians’ habits, and other factors.

Noneconomic damage caps can also have disparate effects on different patient populations or other plaintiffs in malpractice cases. For example, elderly plaintiffs, homemakers, and poorer individuals who are injured and involved in malpractice cases may not be able to claim much in economic damages, such as lost wages. Capping their noneconomic damages could thus leave them with very little payout from a malpractice suit and therefore very little incentive for a lawyer to assist them.

By contrast, other types of plaintiffs may be able to claim economic damages that are so large that capping their noneconomic damages would have relatively little effect—and thus would do little to deter them from filing claims. An example would be newborns who are permanently disabled as a result of malpractice—and may require “life care plans” for future medical expenses that can amount to tens of millions of dollars.

**STATE TRENDS**

In 1975 California enacted its Medical Injury Compensation Reform Act, which set a pattern for many other states. By the mid-1980s a total of 23 states had enacted caps on noneconomic damages; 18 of those states still retain the caps in law today.

Other states took steps to enact caps or modify existing ones in the early 2000s, when malpractice insurance premiums again began to rise. Many of these caps have been challenged in court when they were enacted by the state legislatures, as opposed to through a change in state constitution.

**NATIONAL ACTION?** At the federal level, Congress has made several attempts to pass a national tort reform law that would limit noneconomic damages in cases of medical malpractice across all the states. The HEALTH Act of 2005 (HR 5) was one notable example. It would have limited noneconomic damages and reduced the time following injury for a lawsuit to be brought. Such measures have routinely been passed by the House of Representatives when it has been under Republican control, but have never been passed by the Senate, regardless of which party has controlled that body.

Caps on noneconomic damages are not the only way to address problems in the medical malpractice system, although they are one of the few with evidence to back them up. The federal government has provided $25 million in grants to states and health care systems to test alternative approaches, such as disclosures by providers of medical errors, apologies to injured patients and their families, and prompt offers of settlement. Starting next year, $50 million more will become available to evaluate alternatives to current medical tort litigation. All these efforts are designed to make resolving medical errors a less adversarial process.

Evidence may emerge in coming years to show that these strategies do curb lawsuits, malpractice insurance premiums, and defensive medicine. However, some experts believe that these strategies will have to be put in place in tandem with traditional tort reforms to have much impact on the perceived threat, cost, and number of malpractice lawsuits.

**POLICY RECOMMENDATIONS**

- There should be a **broad effort at the national and state levels** to reduce medical errors and improve patient safety.
- More alternatives to conventional malpractice litigation should be tested—for example, the **creation of special health courts featuring full-time judges** with specific health care expertise, where malpractice cases would be adjudicated.
- Federal agencies should **invest in further research** that examines the impact of state-level tort reform, to shed light on the possible impact of tort reform at the national level.


