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One Nation, Even in Tort Law: How States Can Preempt or Circumvent Federal Preemption of Noneconomic Damage Limitations

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COMMENT

**One Nation, Even in Tort Law:
How States Can Preempt or Circumvent
Federal Preemption of Noneconomic Damage Limitations**

*Emily S. Madden**

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I. INTRODUCTION

In 2016, medical malpractice claimed more than 250,000 lives, making it the nation's third-leading cause of death behind heart disease and cancer.¹ Despite such startling statistics, many professions and organizations in the United States advocate for medical malpractice reform, arguing that frivolous lawsuits have created a medical malpractice crisis.² Ascaris Mayo's and Dr. Shelby Wilbourn's juxtaposed stories illustrate the forty-year debate between reformers and preservers, physicians and doctors, and republicans and democrats.³

Ascaris Mayo went to Columbia St. Mary's Hospital in Wisconsin when she began experiencing abdominal pain and a high fever.⁴ The attending physician's assistant considered the possibility of infection in his diagnosis, but Ascaris was not informed about the possible diagnosis or the available antibiotic treatment.⁵ Rather, Ascaris was told to follow-up with her gynecologist because of her history of uterine fibroids.⁶ After being discharged from St. Mary's, Ascaris went to a different hospital because her symptoms worsened.⁷ There, Ascaris was diagnosed with septic infection.⁸ Ascaris became comatose and developed gangrene in all four extremities, which later required amputation of her arms and legs.⁹ A jury found that the doctors at St. Mary's failed to properly inform Ascaris of the availability of antibiotics and awarded her \$15 million for her pain, suffering, and disfigurement.¹⁰ At the time of litigation, Wisconsin had a statute limiting noneconomic damages to \$750,000.¹¹ The defendants moved to reduce the

¹ Chad Terhune, *Top Republicans say there's a medical malpractice crisis. Experts say there isn't*, THE WASHINGTON POST, Dec. 30, 2016, https://www.washingtonpost.com/news/to-your-health/wp/2016/12/30/top-republicans-say-theres-a-medical-malpractice-crisis-experts-say-theres-nt/?utm_term=.9c8bc76a0b0f.

² See *infra* notes 50–60 and accompanying text.

³ See *infra* notes 4–21 and accompanying text.

⁴ *Mayo v. Wis. Injured Patients & Families Comp. Fund*, 2017 WI App 52, ¶ 2, 377 Wis. 2d 566, 571, 901 N.W.2d 782, 785.

⁵ *Id.*

⁶ *Id.* Uterine fibroids are “smooth muscle growths” that form on the uterus. Rebecca L. Van Court, Note, *Uterine Fibroids and Women's Right to Choose*, 26 J. LEGAL MED. 507, 508 (2005). Typical symptoms include “heavy, prolonged periods, pelvic pain, pain in the back or legs, pain during sexual intercourse, bladder pressure, pressure on the bowel, and an abnormally large abdomen.” *Id.* at 508–09.

⁷ *Mayo*, 2017 WI App 52 at ¶ 2.

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.* at ¶ 5.

¹¹ *Id.* at ¶ 1. The applicable statute defined noneconomic damages as an award “intended to compensate for pain and suffering; humiliation; embarrassment; worry; [or] mental distress.” WIS. STAT. § 893.55 (2007) (held unconstitutional by *Mayo*, 2017 WI App 52 at ¶ 2).

jury award accordingly.¹² When applied to Ascaris's case, the cap would reduce Ascaris's award by over ninety-five percent.¹³ This is the harsh reality for medical malpractice plaintiffs in thirty-three states nationwide.¹⁴

Conversely, Dr. Shelby Wilbourn is an obstetrics and gynecology specialist (Ob/Gyn) who practiced in Nevada for twelve years.¹⁵ In his private practice, Dr. Wilbourn performed approximately 205 deliveries per year.¹⁶ Although Dr. Wilbourn had never been sued in his practicing capacity, he was informed that his medical malpractice insurance premiums were going to increase from \$33,000 to \$108,000 in one year if he kept performing that many annual deliveries.¹⁷ Dr. Wilbourn had three options: retire, relocate, or reduce the number of patients he treated.¹⁸ One additional, albeit laughable, option was for Dr. Wilbourn to borrow \$100,000 per year to cover his insurance premiums and hope the premiums would someday decrease.¹⁹ Dr. Wilbourn ultimately chose to relocate.²⁰ When he left Nevada, Dr. Wilbourn said:

[His] patients, many of whom were with [him] for 12 years, were forced to find another Ob/Gyn, among a dwindling population of Ob/Gyns in Las Vegas. This is the real issue. Patients around the country are losing access to good doctors and quality health care. The end game of the current system is a society without enough doctors to take care of its citizens.²¹

¹² *Mayo*, 2017 WI App 52 at ¶ 6.

¹³ *Id.* at ¶ 43. The jury awarded Ascaris and her husband \$16.5 million: \$15 million awarded to Ascaris and \$1.5 million to Ascaris's husband for loss of society and companionship. *Id.* at ¶ 5. Fortunately for Ascaris and her family, the Court held the \$750,000 cap on noneconomic damages facially unconstitutional and upheld Ascaris's \$16.5 million noneconomic damage award. *Id.* at ¶ 29. Unfortunately, many plaintiffs do not get the same result. *See Zdrojewski v. Murphy*, 657 N.W.2d 721, 739 (Mich. Ct. App. 2002) (holding statute capping noneconomic damages in medical malpractice cases withstood constitutional scrutiny); *Chan v. Curran*, 188 Cal. Rptr. 3d 59, 81–82 (Cal. Ct. App. 1st. Dist. 2015) (finding plaintiff's attack on MICRA's noneconomic damage caps to be unpersuasive).

¹⁴ *See infra* note 67.

¹⁵ *Examining the Status of Patient Access to Quality Health Care, Focusing on the Role of Medical Litigation and Malpractice Reform: Joint Hearing Before the S. Comm. on the Judiciary and the S. Comm. on Health, Educ., Labor, and Pensions*, 108th Cong. 17 (2003) (statement of Dr. Shelby Wilbourn, Am. Coll. of Obstetrics and Gynecology) [hereinafter *Hearings*].

¹⁶ *Id.*

¹⁷ *Id.* The \$108,000 figure was conditional on Dr. Wilbourn delivering no more than 125 deliveries in one year. *Id.* The thresholds are unexplained, though conjecture lends itself to the idea that insurance companies believed more than 125 deliveries in one year was too risky to insure at the \$108,000 amount. *See id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.* at 18.

²¹ *Id.*

This is the harsh reality for physicians and patients in a growing number of states.²² The juxtaposed realities illustrated in Ascaris's and Dr. Wilbourn's stories helped spur the debate surrounding the medical malpractice "crisis" and set lawmakers on a quest for a solution that has yet to be found.²³ The solution, regardless of the outcome, will have serious consequences for Americans. Historically, the resolution seemed unlikely to result from congressional action.²⁴ However, the Patient Protection and Affordable Care Act (Affordable Care Act) pushed health care and its associated costs to the center of the national stage, causing some legal scholars to argue for full federalization of medical malpractice law.²⁵

Part II of this Comment provides background on the medical malpractice debate, including the ostensible medical malpractice "crisis," the arguments concerning the debate, and state responses to the alleged crisis.²⁶ Part III summarizes the formidable attempts by Congress to preempt states in this area, highlighting the Protecting Access to Care Act of 2017 (PACA) as the current congressional attempt.²⁷ PACA is particularly controversial because of its treatment limiting noneconomic damages, which are "damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship . . . , hedonic damages, injury to reputation," and any other nonpecuniary damages.²⁸ Despite its controversial provisions, PACA's passage is imminent given the current political environment.²⁹ Accordingly, Part IV analyzes PACA in the context of preemption.³⁰ "Preemption is a doctrine of American constitutional law under which state and local governments are deprived of their power to act" in a certain area of law.³¹ Under the Supremacy Clause of the United States Constitution, a state law that conflicts with federal law is without effect.³² Part IV illustrates

²² See *id.*

²³ See *infra* notes 87–89 and accompanying text.

²⁴ Michael Matray, *Are Federal Caps on Noneconomic Damages Possible Under a Republican Government?*, CUNNINGHAM GROUP, <https://www.cunninghamgroupins.com/federal-caps-noneconomic-damages-possible-republican-government/> (last visited Oct. 28, 2017) ("Attempts to enact federal noneconomic damage caps have proven fruitless because they face resistance from Democrats as well as the more-conservative members of the Republican Party.").

²⁵ Alan G. Williams, *The Cure for What Ails: A Realistic Remedy for the Medical Malpractice "Crisis"*, 23 STAN. L. & POL'Y REV. 477, 491 (2012).

²⁶ See *infra* notes 43–70 and accompanying text.

²⁷ See *infra* notes 71–95 and accompanying text.

²⁸ H.R. 1215, 115th Cong. § 7(13) (2017).

²⁹ See *infra* notes 96–107 and accompanying text.

³⁰ See *infra* notes 108–26 and accompanying text.

³¹ JAMES T. O'REILLY, FEDERAL PREEMPTION OF STATE AND LOCAL LAW: LEGISLATION, REGULATION AND LITIGATION 1 (2006).

³² *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981). When a state law conflicts with federal law, it is often referred to as conflict preemption. WILLIAM W. BUZZBEE, PREEMPTION CHOICE:

how the seventeen states that have not limited noneconomic damages in medical malpractice suits are in conflict with PACA's objectives and will be preempted on that basis.³³

Given the imminent passage of PACA and subsequent preemption of state laws, Part V proposes three options for states facing preemption.³⁴ This Comment argues preempted states should adopt the sovereign concession approach because it aligns more closely with the objectives of tort law.³⁵ This option first requires states to concede to preemption by accepting the implicit PACA requirement that there be a cap on noneconomic damages in medical malpractice cases.³⁶ In some states, this may require a constitutional amendment.³⁷ Once legislation of this nature is constitutionally permissible, the sovereign concession approach requires an imposition of a cap that exceeds \$1,136,263, the modern day valuation of the Medical Injury Compensation Reform Act (MICRA) limitation amount, and accounts for inflation.³⁸ Additionally, sovereign concession statutes should exempt cases resulting in death or disfigurement and categorically exempt nursing homes.³⁹ Such statutes should also work in tandem with an active Plaintiff Compensation Fund (PCF) to ensure additional compensation will be available if necessary.⁴⁰ Wyoming is used as an example throughout Section V because Wyoming will have one of the more challenging journeys following preemption given its constitutional provision prohibiting limitations on damages⁴¹ and its inactive PCF.⁴²

II. BACKGROUND

A. *Medical Malpractice Reform*

Medical malpractice is a subset of tort law but, unlike traditional negligence torts, medical malpractice claims require a showing of a health care

THE THEORY, LAW, AND REALITY OF FEDERALISM'S CORE QUESTION 125 (2009); *see also* ERWIN CHEMERINSKY, CONSTITUTIONAL LAW PRINCIPLES AND POLICIES 435 (Erwin Chemerinsky et al. eds., 5th ed. 2015). There are, however, other ways to find preemption. *See id.* at 411–34.

³³ *See infra* notes 109–26 and accompanying text.

³⁴ *See infra* notes 127–208 and accompanying text.

³⁵ *See infra* notes 168–208 and accompanying text.

³⁶ *See infra* notes 121–26 and accompanying text.

³⁷ *See infra* note 70 and accompanying text.

³⁸ *See infra* notes 128–48 and accompanying text.

³⁹ *See infra* notes 180–91 and accompanying text.

⁴⁰ *See infra* notes 192–208 and accompanying text.

⁴¹ WYO. CONST. art. 10, § 4(a).

⁴² Frank. A. Sloan et al., *Public Medical Malpractice Insurance: An Analysis of State-Operated Patient Compensation Funds*, 54 DEPAUL L. REV. 247, 249 (2005) (“Wyoming’s legislature passed a statute creating a PCF, but it was never formally created in practice.”). *See also* WYO. STAT. ANN. § 26-33-105 (2008) (the statute creating Wyoming’s Medical Liability Compensation Account).

provider-patient relationship.⁴³ The objectives of medical malpractice are “to increase the quality of healthcare through deterrence of future incidences of malpractice and to provide sufficient redress for injuries resulting from actual negligence.”⁴⁴ The frequency of medical malpractice claims began to rise in the 1960s because of a changing legal landscape that provided plaintiffs with more opportunities to successfully bring medical malpractice actions.⁴⁵ Such opportunities allegedly increased both the number of excess jury awards and the price of medical malpractice insurance premiums, ultimately causing some practitioners to leave the market and others to practice without insurance.⁴⁶ Loss of insurance coverage and higher premiums was a springboard for public and political outcry by physicians, birthing the mid-1970s “insurance crisis.”⁴⁷

The medical malpractice insurance “crisis” is still heavily debated.⁴⁸ Although tort law has traditionally been a state law area, medical malpractice reform has increasingly become the focal point of national debates concerning both the cause and the solution of the medical malpractice “crisis.”⁴⁹

⁴³ 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 285 (2004).

⁴⁴ Kyle Miller, Note, *Putting the Caps on Caps: Reconciling the Goal of Medical Malpractice Reform with the Twin Objectives of Tort Law*, 59 VAND. L. REV. 1457, 1470 (2006).

⁴⁵ See *MICRA: A Brief History*, CAL. MED. ASSOC., <http://www.cmanet.org/issues-and-advocacy/cmas-top-issues/micra/micra-a-brief-history/> (last visited Nov. 9, 2017). The commonality of the medical malpractice claim can be attributed to advances in medical technology, which resulted in higher-risk treatments, a changing legal landscape sparked by the removal of previously imposed regulations that shielded charitable institutions from suit, and a general decline in satisfaction with the healthcare industry. Joseph S. Kass, *Medical Malpractice Reform*, 18 [J]AMA OF ETHICS 299, March 2016, <http://journalofethics.ama-assn.org/2016/03/pfor6-1603.html>.

⁴⁶ *MICRA: A Brief History*, *supra* note 45.

⁴⁷ *Id.* In the mid-1970s, anesthesiologists and surgeons in California saw their insurance premiums triple, causing practitioners to refuse “to handle any patients except those in imminent danger of death.” *Id.*; see also Glen O. Robinson, *The Medical Malpractice Crisis of the 1970s: A Retrospective*, 49 L. & CONTEMP. PROBS. 5 (1986). The “insurance crisis” refers to the situation where the amount of medical malpractice awards are believed to be steadily and dramatically increasing, making it difficult to insure physicians. David N. Hoffman, *The Medical Malpractice Insurance Crisis, Again*, 35 HASTINGS CTR. REP. 15, 15 (2005). This situation is exacerbated because “fewer dollars [are] available to pay for doctor’s malpractice settlements and judgments” and it is impossible for physicians to place the additional cost on their patients. *Id.* at 17.

⁴⁸ See *Hearings*, *supra* note 15.

⁴⁹ See Fred Charatan, *Bush pushes for limit to medical malpractice awards*, NAT’L INST. OF HEALTH (Jan. 22, 2005), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC545016/>. In 2005, President George W. Bush asked Congress to impose a \$250,000 limitation for noneconomic damages because “doctors should be focused on fighting illnesses, not on fighting lawsuits.” *Id.*; see also Y. Peter Kang, *Bar Association Urges Congress to Reject Tort Reform Bill*, LAW360 (June 13, 2017, 7:19 PM), <https://www.law360.com/articles/934039/bar-association-urges-congress-to-reject-tort-reform-bill>; see *infra* notes 87–89 and accompanying text.

Proponents of medical malpractice reform are generally physicians,⁵⁰ defense lawyers,⁵¹ and Republicans.⁵² Proponents blame the civil litigation system for the “crisis,” believing “medical errors [are not] a problem when compared to the problem of frivolous medical malpractice lawsuits.”⁵³ Excessive litigation and mega-jury awards make insurance premiums unaffordable, according to proponents.⁵⁴ They argue that, when premiums are unaffordable, practitioners either quit practicing or move to states with lower premiums.⁵⁵ The result, according to proponents, is an urgent patient-access crisis where patients have trouble finding treatment.⁵⁶ Proponents also blame juries for the increased premiums.⁵⁷ They argue juries are too biased against doctors and too incompetent to decide complex technical issues, and award heightened damages simply because they assume doctors can afford to pay the bill.⁵⁸ Because proponents believe the problem stems from excessive litigation and incompetent, overly-sympathetic juries, one offered solution is to cap noneconomic damage awards.⁵⁹ Proponents believe such a cap provides greater predictability in jury verdicts and creates more stability in the insurance market.⁶⁰

⁵⁰ Andrew Jay McClurg, *Fight Club: Doctors vs. Lawyers – A Peace Plan Grounded in Self-Interest*, 83 TEMP. L. REV. 309, 352 n.283 (2011). One member of the American Medical Association proposed a resolution to the House of Delegates that would allow doctors to stop providing medical services to medical malpractice plaintiff’s lawyers and their families. James W. Jones et al., *Ethics of Refusal to Treat Patients as a Social Statement*, 40 J. OF VASCULAR SURGERY 1057, 1057 (2004).

⁵¹ See Roselle L. Wissler et al., *Decision Making About General Damages: A Comparison of Jurors, Judges, and Lawyers*, 98 MICH. L. REV. 751 (1999). According to one defense lawyer, “there’s no limit on what jurors can award for pain and suffering, so too often they act like Santa Claus, handing out millions of dollars in cases involving comparatively minor injuries.” *Id.* at 804 n.155 (quoting James Griffith, *What it Will Take to Solve the Malpractice Crisis*, MED. ECON., Sept. 1982, at 195).

⁵² See Stuart L. Weinstein, *Medical Liability Reform Crisis 2008*, NAT’L INST. OF HEALTH (Nov. 7, 2008), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2628503/> (stating “[i]n 2005, President George W. Bush made tort reform, particularly medical liability, his highest priority.”).

⁵³ See *Williams*, *supra* note 25, at 487. “One-third of surveyed physicians named medical malpractice lawsuits and medical malpractice insurance as the two biggest problems in healthcare, but only 5% listed medical errors resulting in patient injuries as the biggest problem in healthcare.” *Id.*

⁵⁴ *Hearings*, *supra* note 15, at 2.

⁵⁵ *Id.* at 39 (statement of Senator Enzi). Senator Enzi noted that a doctor in Wheatland, Wyoming had to quit practicing because his insurance premiums exceeded \$150,000. *Id.*

⁵⁶ *Id.* at 1.

⁵⁷ NEIL VIDMAR, *MEDICAL MALPRACTICE AND THE AMERICAN JURY* 7 (1995).

⁵⁸ *Id.*

⁵⁹ See H.R. 1215, 115th Cong. (2017). Capping noneconomic damages is only one solution. *Id.* For example, PACA has provisions reducing statute of limitations periods, limiting attorney contingency fees, and governing expert witness testimony and qualifications. *Id.*

⁶⁰ Joanna M. Shepherd, *Tort Reforms’ Winners and Losers: The Competing Effects of Care and Activity Levels*, 55 UCLA L. REV. 905, 916 (2008).

In response, opponents suggest tougher regulation of the insurance industry, not a restraint on the civil justice system.⁶¹ Opponents also put forth constitutional arguments based on Seventh, Tenth, and Fourteenth Amendment grounds.⁶² Arguments against reform also highlight the potential of increased marginalization of women, the elderly, and the poor, claiming meritorious plaintiffs in these demographics will be unable to justify the cost and risk of pursuing legal redress if there are low noneconomic damage limitations.⁶³

B. State Responses to the Medical Malpractice “Crisis”

The first wave of reforms in the mid-1970s contained general limitations on noneconomic damages with rigid thresholds.⁶⁴ Recent legislative enactments include more complex initiatives such as higher caps for egregious injuries and

⁶¹ See Alexander Tabarrok & Amanda Agan, *Medical Malpractice Awards, Insurance, and Negligence: Which Are Related?*, MANHATTAN INST. (May 1, 2006), <https://www.manhattan-institute.org/html/medical-malpractice-awards-insurance-and-negligence-which-are-related-5890.html> (“A commonly stated alternative is that insurance companies are gouging doctors and hospitals for treatment and pharmaceutical companies are charging outrageous prices for prescriptions.”); *Hearings*, *supra* note 15, at 5; Tom Baker, *An Excerpt from The Medical Malpractice Myth*, THE UNIVERSITY OF CHICAGO PRESS, <http://www.press.uchicago.edu/Misc/Chicago/036480.html> (last visited Nov. 3, 2017) (declaring the real problem is too much medical malpractice, not too much litigation).

⁶² See Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damage Caps*, 80 NYU L. REV. 391, 413 (2005). The Seventh Amendment argument claims legislation on the matter will violate a plaintiff’s right to a jury trial by taking away the determination of the award from the jury. Mark A Behrens & Carly Silverman, *The Constitutional Foundation for Federal Medical Liability Reform*, 15 J. HEALTH CARE L. & POL’Y 173, 184–85 (2012); see also *Boyd v. Bulala*, 877 F.2d 1191 (4th Cir. 1989). The Tenth Amendment argument claims medical malpractice reform and tort litigation are rights reserved to the states and should remain that way. Julian Pequet, *GOP Clashes Over Medical Malpractice*, THE HILL (Feb. 2, 2011, 2:03 PM), <http://thehill.com/blogs/healthwatch/state-issues/143009-tea-party-influence-sparks-gop-clash-over-tort-reform?tmpl=component&print=1&page=>. The Fourteenth Amendment argument claims caps on noneconomic damages discriminates between plaintiffs in medical malpractice suits and plaintiffs in other areas of tort law. Todd M. Kossow, Note, *Fein v. Permanente Medical Group: Future Trends in Damage Limitation Adjudication*, 80 NW. U. L. REV. 1643, 1664 (1986).

⁶³ Michael L. Rustad, *Neglecting the Neglected: The Impact of Noneconomic Damage Caps on Meritorious Nursing Home Lawsuits*, 14 ELDER L.J. 331, 360 (2006) [hereinafter *Neglecting the Neglected*] (“Because elderly plaintiffs have no loss of past, present, or future earnings, and little by way of special damages, the typical nursing home case is not cost-effective without the possibility of noneconomic damages.”). This is also true for the poor and some women who may not have sufficient past, present, or future earnings to justify taking on the costs of medical malpractice cases. *Id.*; see also *Hearings*, *supra* note 15, at 62 (statement of Linda McDougal) (Linda McDougal went for a routine mammogram and was told she had breast cancer. With her doctors and family, Linda decided to undergo a double mastectomy to maximize her time alive. Forty-eight hours after surgery, Linda was informed she did not have breast cancer. The pathologist had switched Linda’s biopsy slides with another patient’s. Linda’s lost wages were approximately \$8,000 and her hospital expenses were \$48,000. The lost wages and medical expenses were categorized as economic damages. However, to Linda, her loss was “almost entirely noneconomic.”).

⁶⁴ Sharkey, *supra* note 62, at 413.

sliding scale amounts for limitations.⁶⁵ The newer legislative models are largely attributable to courts striking down blanket damage caps in a number of states.⁶⁶

There are currently thirty-three states that limit noneconomic damages in medical malpractice cases.⁶⁷ In those states, the limitation ranges from \$250,000 to \$770,000, with less than a handful of states accounting for inflation or providing exceptions for catastrophic incidents.⁶⁸ Seventeen states do not cap noneconomic damages in medical malpractice cases.⁶⁹ Of those states, eight states have constitutional provisions prohibiting such caps.⁷⁰

III. NATIONALIZED TORT LAW? PAST AND PRESENT CONGRESSIONAL ATTEMPTS

Presently, states choose whether to adopt limitations or expand tort laws based on their own jurisdictional needs.⁷¹ The concept of nationalized tort law introduces a one-size-fits-all federal approach where states will be unable to tailor solutions to state problems unless the solutions align with the federal agenda.⁷² Despite the recognized importance of noneconomic damages at common law, Congress has introduced numerous pieces of legislation to limit noneconomic damages over the last forty years.⁷³ In 1975, California enacted MICRA,⁷⁴ which has heavily influenced these repetitive attempts at federal legislation.⁷⁵ This

⁶⁵ *Id.*

⁶⁶ *Id.* (“These exceptions and sliding scales were included, at least in part, because blanket damage caps were previously struck down as unconstitutional in Florida, Ohio, and Texas.”).

⁶⁷ MED. MALPRACTICE CTR., <http://malpracticecenter.com/legal/damage-caps> (last visited Oct. 30, 2017). Alaska, California, Colorado, Florida, Georgia, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, and Wisconsin. *Id.*

⁶⁸ *Id.*

⁶⁹ *Id.* Alabama, Arizona, Arkansas, Connecticut, Delaware, Illinois, Iowa, Kentucky, Minnesota, Missouri, New Hampshire, New York, Pennsylvania, Rhode Island, Vermont, Washington, and Wyoming. *Id.*

⁷⁰ *Id.* Arizona, Arkansas, Kentucky, New York, Ohio, Oklahoma, Pennsylvania, and Wyoming. ARIZ. CONST. art. XVIII, § 6; ARK. CONST. art. II, § 13; KY. CONST. § 54; N.Y. CONST. art. I, § 16; OHIO CONST. art. I, § 19a; OKLA. CONST. art. XXIII, § 7; PENN. CONST. art. III, § 18; WYO. CONST. art. X, § 4(a).

⁷¹ Michael L. Rustad, *Nationalizing Tort Law: The Republican Attack on Women, Blue Collar Workers, and Consumers*, 48 RUTGERS L. REV. 673, 683 n.32 (1996) [hereinafter *The Republican Attack*].

⁷² *Id.*

⁷³ See *infra* notes 87–89 and accompanying text.

⁷⁴ See CAL. CIV. CODE § 3333.2 (West 1975). The statute limits noneconomic damages to \$250,000. *Id.*

⁷⁵ Matray, *supra* note 24 (“Since its enactment, [MICRA] has been the gold standard of medical liability tort reform legislation.”).

section provides a brief description of MICRA and the congressional attempts to nationalize tort law in this area.

A. Medical Injury Compensation Reform Act (MICRA): What is it and Why Does Congress View it as a Basis for Proposed Legislation?

In the mid-1970s, California experienced a self-proclaimed medical malpractice insurance crisis when a high amount of malpractice litigation allegedly increased insurance premiums to record levels.⁷⁶ In response, some insurance companies determined medicine was no longer an insurable risk, which caused a number of insurance providers to exit the market.⁷⁷ In some geographic and practice areas, insurance premiums more than tripled, causing practitioners, including anesthesiologists and surgeons, to deny treatment to some patients.⁷⁸ Such circumstances motivated the California Medical Association to lead a grassroots campaign to raise awareness of the crisis amongst the public.⁷⁹ Eventually, the California legislature enacted MICRA in an attempt to reduce the burden of high insurance premiums.⁸⁰

MICRA limits noneconomic damage awards to \$250,000.⁸¹ Proponents praise the effects of MICRA, which has led to its national recognition and modeling in subsequent legislative proposals.⁸² Some empirical studies of MICRA have shown that:

[B]etween 1976 and 2002, malpractice premiums in California rose 235 percent, while premiums in the rest of the country rose more than 750 percent. Before MICRA was adopted, California's percentage of loss payments was significantly higher than its proportion of physicians as compared to the rest of the country. Since then, medical malpractice costs have fallen substantially as a percentage of the U.S. total, while physician residence in the state has held steady at approximately fifteen percent of the U.S. total.⁸³

⁷⁶ *MICRA: A Brief History*, *supra* note 45.

⁷⁷ ANDREW F. POPPER, *TORT REFORM—COMMENTARY AND OTHER MATERIALS* loc. 2856 (2010) (ebook).

⁷⁸ *MICRA: A Brief History*, *supra* note 45.

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ CAL. CIV. CODE § 3333.2 (West 1975). Though not the focus of this Comment, MICRA also limits attorney contingency fees, declares a short statute of limitations period, requires advance notice of a claim, and provides for periodic payments for future damages, similar to PACA. *Id.*

⁸² Sharkey, *supra* note 62, at 394. MICRA has served as a model for the adoption of damage caps in medical malpractice suits for state legislatures, Congress, and the White House. *Id.*

⁸³ POPPER, *supra* note 77, at loc. 2864.

Conversely, some studies conclude MICRA has had an overall negligible effect on health care costs and suggest that, if MICRA had solved the “crisis,” Californians would not be advocating for recent federal healthcare reform.⁸⁴

Nevertheless, because some empirical evidence suggests MICRA reduced malpractice insurance premiums, many proponents push provisions of MICRA on legislative proposals.⁸⁵ This is evident in both the past and present congressional attempts to nationalize tort law, especially with regards to the \$250,000 limitation on noneconomic damages.⁸⁶

B. Past Congressional Attempts

During the first wave of medical malpractice reform in the 1970s, some congressmen acknowledged the need to “explore the phenomenon of medical malpractice lawsuits.”⁸⁷ This exploratory phase led to the emergence of proposals limiting noneconomic damages to \$250,000.⁸⁸ Despite a lack of empirical data speaking directly to the overall effectiveness of state caps on noneconomic damages, proposals for such caps have steadily increased over time and contain more complex measures than their 1970s counterparts, including provisions governing contingency fees and statute of limitation periods.⁸⁹

⁸⁴ Heather E. Stern, *Healthcare Reform Should Not Follow MICRA's Example*, 33 L.A. LAW. 60 (2010).

⁸⁵ Matray, *supra* note 24 (“Since its enactment, [MICRA] has been the gold standard of medical liability tort reform legislation.”).

⁸⁶ S. 1936, 102nd Cong. (1991) (a bill limiting noneconomic damages in medical malpractice suits to \$250,000); *e.g.*, S. 1770, 103rd Cong. (1993); H.R. 956, 104th Cong., 1st Sess. § 203(a) (1995); H.R. 1215, 115th Cong. (2017).

⁸⁷ H.R. 5052, 93rd Cong. (1973) (a Republican bill to establish a commission on medical malpractice awards); H.R. 6293, 94th Cong. (1975) (a Republican bill to establish a reinsurance program for medical malpractice awards); S. 1720, 96th Cong. (1979) (a bill to investigate the condition of malpractice insurance in America at the time); *see also* William J. Phelan, IV, Comment, *A Chronic Concern No More: How Federal Medical Malpractice Caps Will Survive Under the Equal Protection Clause of the United States Constitution*, 23 J. CONTEMP. HEALTH L. & POL'Y 168 (2006).

⁸⁸ H.R. 2659, 99th Cong. (1985); H.R. Res. 386, 99th Cong. (1986) (a resolution to reform state tort law as to put caps on noneconomic losses in medical malpractice cases).

⁸⁹ *See supra* notes 64–66 and accompanying text. For example, in the early 1990s, Democrats controlled both houses, but Republican Senator John Chafee of Rhode Island introduced the Health Equity and Access Improvement Act of 1991 and the Health Equity and Access Reform Today Act of 1993. S. 1936, 102nd Cong. (1991); S. 1770, 103rd Cong. (1993). Both of Senator Chafee's proposals primarily sought to limit noneconomic damages to \$250,000. S. 1936 § 332(b); S. 1770 § 4023(a).

C. *Protecting Access to Care Act of 2017 (PACA): What is it and Why is it Going to Pass?*

1. *What is PACA?*

Most recently, the House passed PACA, largely along party lines, by a vote of 218–210.⁹⁰ PACA limits noneconomic damages⁹¹ to \$250,000 in any applicable suit and applies to virtually all aspects of medical malpractice, including surgical errors, abuse and neglect in nursing homes, sexual assault by doctors, and side effects from prescription drugs.⁹² With regard to noneconomic damages, PACA will not preempt any state law:

[T]hat specifies a particular monetary amount of economic or noneconomic damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this section and regardless of whether the state imposed limitation is effective before, on, or after the date of enactment of [PACA].⁹³

⁹⁰ OFF. OF THE CLERK, U.S. H.R., FINAL VOTE RESULTS FOR ROLL CALL 337 (June 28, 2017), <http://clerk.house.gov/evs/2017/roll337.xml>. Nineteen Republicans and 191 Democrats opposed the bill, with six members abstaining. *Id.* Wyoming Representative Liz Cheney voted in favor of the legislation, despite a state constitutional provision prohibiting damage caps in personal injury suits. *Id.*

⁹¹ H.R. 1215 § 4(e). As defined in the statute, the term noneconomic damages means damages for “physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature incurred as a result of the provision or use of (or failure to provide or use) health care services or medical products, unless otherwise defined under applicable state law.” *Id.*

⁹² H.R. 1215 § 7(7). The legislation applies to all “health care lawsuit[s]” which is defined as “any health care liability claim concerning the provision of goods or services for which coverage was provided in whole or in part via a Federal program, subsidy or tax benefit, or any health care liability action concerning the provision of goods or services for which coverage was provided in whole or in part via a Federal program, subsidy or tax benefit, brought in a State or Federal court or pursuant to an alternative dispute resolution system. . . .” *Id.* “Health care lawsuit” does not include “a claim or action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.” *Id.* The bill includes other familiar provisions from previous proposals, including limits on contingency fee arrangements and a three-year statute of limitations period. *Id.*

⁹³ *Id.* at § 3(e).

Put another way, PACA *will* preempt any state law that does not satisfy this criterion.⁹⁴ This is an unprecedented incursion of federal law into a traditional area of state sovereignty.⁹⁵

2. *Why is PACA Going to Pass?*

There have been numerous proposals to rein in healthcare spending since Republicans took control of both Congress and the White House.⁹⁶ One such proposal is PACA.⁹⁷ Previous measures to limit noneconomic damages have repeatedly failed in both the House and the Senate.⁹⁸ There are some who believe tort reform will never come to fruition and that PACA will stall or fail like its predecessors.⁹⁹ Others believe PACA will need to be part of larger legislation before it will receive sixty votes in the Senate.¹⁰⁰ Some opponents argue the repeal and replace chaos surrounding the Affordable Care Act will push other phases of Republican-proposed healthcare reform, such as PACA, to a lower priority.¹⁰¹

PACA is different than its predecessors, though. According to some commentators, the difference in prior legislation is that “[l]urking in the background was always a frustrating reality for supporters: Even if 60 votes could be found to pass the bill, a veto threat by President Obama made Senate action seem futile, especially with so many competing priorities.”¹⁰² The Senate may

⁹⁴ See *infra* notes 109–26 and accompanying text.

⁹⁵ See Robert M. Ackerman, *Tort Law and Federalism: Whatever Happened to Devolution?*, 14 YALE L. & POL’Y REV. 429, 436 (1996) (discussing defamation as one area of tort law where the Supreme Court has actively intervened). “[A]ssuming that these measures are a legitimate exercise of Congress’s commerce power, there would appear to be little constitutional problem with the fact that Congress would be altering the rules that have applied in the state courts. . . . Whether or not such interventions are good policy is yet another matter. . . .” *Id.* Ultimately, passage of PACA presents a substantial question of federalism. See *id.*

⁹⁶ Meg Bryant, *House narrowly passes malpractice reform legislation*, HEALTHCARE DIVE (June 30, 2017), <http://www.healthcaredive.com/news/house-narrowly-passes-malpractice-reform-legislation/446208/>. In addition to PACA, there have been at least two other bills that advanced in the House that prioritized doctors and corporations over plaintiffs. H.R. 985, 115th Cong. (2017) (a bill requiring every person in a class action to suffer the same type and scope of alleged injury before they can file); H.R. 720, 115th Cong. (2017) (a bill requiring mandatory sanctions on those who file frivolous lawsuits); see also S. 237, 115th Cong. (2017) (companion proposal in the senate).

⁹⁷ See Billy Corriher, *The Other Terrible Health Care Bill Pending in Congress*, CTR. FOR AM. PROGRESS (July 20, 2017), <https://www.americanprogress.org/issues/courts/reports/2017/07/20/436343/terrible-health-care-bill-pending-congress/>.

⁹⁸ See *supra* notes 87–89 and accompanying text.

⁹⁹ See Andis Robeznieks, *Senators may stall medical liability-reform legislation*, AMA WIRE, July 12, 2017, <https://wire.ama-assn.org/practice-management/senators-may-stall-medical-liability-reform-legislation>.

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² Bruce Kaufman, *Push to Enact Civil Justice Bills Follows Industry Playbook*, BLOOMBERG BNA (Feb. 28, 2017), <https://www.bna.com/push-enact-civil-n57982084551/>.

now be more inclined to pass PACA since President Trump will likely be advised to sign it into law.¹⁰³ Furthermore, PACA differs from previous attempts because it provides more flexibility for states to keep past legislation or pass new legislation so long as it limits noneconomic damages to some extent.¹⁰⁴ Considering that one of the reasons for prior opposition was distaste for preemption, the flexibility contained in PACA's provisions may give the assurance some congressmen need to favor the bill.¹⁰⁵ Additionally, some scholars have advocated for full federalization of medical malpractice law considering the government is funding a significant portion of health care subsidies.¹⁰⁶ The federal government is projected to spend \$51 billion over a ten-year period on health care.¹⁰⁷ Arguably, it is easier to swallow the preemption pill when the federal government is spending significant amounts of money on healthcare.

IV. IMPENDING PREEMPTION OF SEVENTEEN STATES¹⁰⁸

The doctrine of preemption is rooted in the Supremacy Clause of the United States Constitution.¹⁰⁹ Under the Supremacy Clause, a state law that conflicts with federal law is without effect.¹¹⁰ Nevertheless, judicial consideration of preemption issues begins with “the assumption that the historic police powers of the States [are] not to be superseded by . . . Federal Act unless that [is] the clear and manifest purpose of Congress.”¹¹¹ Thus, Congress's purpose is the “ultimate

¹⁰³ THE WHITE HOUSE, H.R. 1215—PROTECTING ACCESS TO CARE ACT OF 2017 (June 14, 2017), <https://www.whitehouse.gov/the-press-office/2017/06/14/hr-1215-%E2%80%93protecting-access-care-act-2017>.

¹⁰⁴ Robeznieks, *supra* note 99; *see also* H.R. 1215, 115th Cong. § 4(e) (2017).

¹⁰⁵ *See infra* note 123 and accompanying text.

¹⁰⁶ *See* Williams, *supra* note 25, at 491 (“However, as healthcare and its associated costs have become national issues, and with the 2010 enactment of the [Patient Protection and Affordable Care Act], legal scholars have advocated full federalization of medical malpractice law.”).

¹⁰⁷ *See* CONG. BUDGET OFF., HEALTH CARE, <https://www.cbo.gov/topics/health-care> (last visited Nov. 9, 2017).

¹⁰⁸ This analysis only concerns preemption of noneconomic damage limitations in medical malpractice claims. If a state caps damages only in medical malpractice suits, the state would effectively adopt the cap of \$250,000 for all other health care liability suits, including nursing homes. *Id.*; Tatum O'Brien, H.R. 1215—an Anti-Justice Bill Limiting Recovery for those Injured in Healthcare Cases, THE LEGAL EXAMINER (June 27, 2017), <http://fargo.legalexaminer.com/2017/06/27/h-r-1215-an-anti-justice-bill-limiting-recovery-for-those-injured-in-healthcare-cases/>.

¹⁰⁹ U.S. CONST. art. VI (“This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.”); *Cipollone v. Liggett Group*, 505 U.S. 504, 516 (1992).

¹¹⁰ *Cipollone*, 505 U.S. at 516; *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981). For alternative ways to find preemption, *see* CHEMERINSKY, *supra* note 32, at 411–34.

¹¹¹ *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947).

touchstone” of a preemption analysis.¹¹² Congress’s purpose to preempt state law may be demonstrated by either express or implied intent.¹¹³ Express intent occurs when Congress’s intent is explicitly stated in a statute.¹¹⁴ Implied preemption may occur when Congress’s intent to preempt state law is implicitly contained in a statute’s structure and purpose.¹¹⁵ Preemptive intent may be inferred if the state and federal law conflict with one another.¹¹⁶ This is often referred to as conflict preemption.¹¹⁷

The starting point for a conflict preemption analysis is to determine the federal objective.¹¹⁸ Then, the analysis turns on whether the determined federal objective is inconsistent with a state law, creating discord between the two.¹¹⁹ The stated intent of PACA is “[t]o improve patient access to health care services and provide improved medical care by reducing the excessive burden the liability system places on the health care delivery system.”¹²⁰ In terms of noneconomic damage limitations, a state law will not be preempted if the state law limits noneconomic damage awards in a health care lawsuit, regardless of whether the limitation is greater or lesser than the \$250,000 PACA amount.¹²¹ PACA also allows qualified state legislation to be effective regardless of whether the legislation is enacted before, on, or after the date of the enactment of PACA.¹²² These provisions imply that Congress intends for states to impose a cap on noneconomic damage awards.¹²³ Accordingly, any state that does not have a cap on noneconomic damages directly conflicts with Congress’s objective of imposing

¹¹² *Retail Clerks Intern. Ass’n, Local 1625, AFL-CIO v. Schermerhorn*, 375 U.S. 96, 103 (1963).

¹¹³ *Gade v. Nat’l Solid Waste Mgmt. Ass’n*, 505 U.S. 88, 98 (1992).

¹¹⁴ *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977).

¹¹⁵ *Id.*

¹¹⁶ *Altria Group, Inc. v. Good*, 555 U.S. 70, 76 (2008).

¹¹⁷ BUZBEE, *supra* note 32, at 125; *see also* CHEMERINSKY, *supra* note 32, at 435.

¹¹⁸ *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941). To arrive at the preemption analysis, it must first be determined that Congress has constitutional authority to legislate on the matter. *See* U.S. CONST. art. I, § 8 (“The Congress shall have power to . . . regulate commerce with foreign nations, and among the several states, and with the Indian tribes.”); *see also* U.S. CONST. amend. X (“The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people.”). However, health care is commonly considered to implicate interstate commerce, granting Congress the authority to act. Ackerman, *supra* note 95, at *439; *see also* *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 545–51 (2012).

¹¹⁹ Amanda G. Lewis, *Federal Preemption of State and Local Laws: State and Local Efforts to Impose Sanctions on Employers of Unauthorized Aliens* 6–7 (2008), <http://web.law.columbia.edu/sites/default/files/microsites/career-services/Federal%20Preemption%20of%20State%20and%20Local%20Laws.pdf>.

¹²⁰ *See also* H.R. 1215, 115th Cong. (2017).

¹²¹ *Id.* at § 3(e).

¹²² *Id.*

¹²³ *H.R. 1215: Lawmakers looking out for citizens will vote NO*, JDSUPRA (June 14, 2017), <https://www.jdsupra.com/legalnews/h-r-1215-lawmakers-looking-out-for-75522/>. *See also* CONGR. BUDGET OFFICE, *OPTIONS FOR REDUCING THE DEFICIT: 2017 TO 2026* (2016) (“When the bill has

a cap in every state.¹²⁴ This conflict requires states that do not have noneconomic damage caps on or before the enactment of PACA to be preempted with the \$250,000 cap.¹²⁵ The only way for states to stop federal preemption is to preempt or circumvent the preemption by imposing their own caps.¹²⁶

V. STATE RECOMMENDATIONS: APPROACHES TO PREEMPT OR CIRCUMVENT FEDERAL PREEMPTION

Because PACA will preempt state laws in seventeen states, this Comment describes three approaches preempted states can consider in dealing with federal preemption. To ensure plaintiffs in preempted jurisdictions are protected when preemption occurs, states should implement statutes following the guidelines set forth in the sovereign concession approach. To do so, states need to either preempt preemption by passing sovereign concession statutes before the enactment of PACA, or circumvent preemption by passing sovereign concession statutes after the enactment of PACA. The State of Wyoming is used as an example throughout Section V because it will face significant challenges following preemption given its constitutional provision prohibiting legislative limitations on damages and its inactive PCF.¹²⁷

A. *The Dormant Approach*

The most obvious response is to do nothing. A state that chooses this option will effectively adopt PACA's \$250,000 cap on noneconomic damages.¹²⁸ The advantage of this option is an efficient use of legislative resources, meaning state legislatures would not focus time on this specific area.¹²⁹ However, states should

provisions regarding 'State Flexibility' these provision (sic) are in-fact preemption clauses, mandating a strict federal regime that contradicts the decisions of state legislatures and state courts. Even CBO has recognized this bill's preemption of state law." *See also id.* ("Some people might oppose this option because it would be a federal preemption of state laws.").

¹²⁴ *See supra* notes 118–23 and accompanying text.

¹²⁵ *See supra* notes 118–23 and accompanying text.

¹²⁶ *See infra* notes 127–208 and accompanying text.

¹²⁷ WYO. CONST. art. 10, § 4(a) ("No law shall be enacted limiting the amount of damages to be recovered for causing injury or death of any person."). *See also* WYO. STAT. ANN. § 26-33-105 (2008) (creating the Medical Liability Compensation Account). The American Medical Association claims Wyoming's medical liability compensation account has never been implemented. Dean Gereau, *Basics of Patient Compensation Funds by State*, ARTHUR J. GALLAGHER & CO. (Apr. 29, 2015), <http://www.gallaghermalpractice.com/blog/post/basics-of-patient-compensation-funds>; Sloan, *supra* note 42, at 247.

¹²⁸ H.R. 1215, 115th Cong. § 3(e) (2017).

¹²⁹ *See* Stephen A. Spiller, *Opportunity Cost Consideration*, 38 J. OF CONSUMER RES. 595, 595 (2011) (There are "unlimited wants but limited resources, so satisfying one want means not satisfying another (the opportunity cost). An opportunity cost is the evaluation placed on the most highly valued of the rejected alternatives or opportunities or the loss of another alternative when one alternative is chosen.") (quotations and citations omitted). When the legislature spends time on one matter, it necessarily follows that they do not spend that time on other matters. *See id.*

not respond with the dormant approach because PACA's noneconomic damages cap disregards the objectives of the medical malpractice liability system.¹³⁰

The American medical malpractice liability system seeks “to increase the quality of healthcare through deterrence of future incidences of malpractice and to provide sufficient redress for injuries resulting from actual negligence.”¹³¹ Noneconomic damages help to achieve those objectives by compensating plaintiffs and deterring tortious activity.¹³² Therefore, states need to ensure that noneconomic damage limitations achieve the objectives of compensation and deterrence, neither of which can be satisfied with a \$250,000 ceiling.¹³³ From a compensation standpoint, the \$250,000 threshold is unconscionably insufficient to compensate most victims of medical malpractice.¹³⁴ The \$250,000 amount stems from the 1975 enactment of MICRA and, for unexplained reasons, has not been altered despite the forty-two-year separation between MICRA and current legislative proposals.¹³⁵ Today, the 1975 value of \$250,000 is only worth \$55,004.¹³⁶ If inflation is not accounted for, a damage cap becomes “a de facto reduction in the award intended for the plaintiff by the trier-of-fact.”¹³⁷ Refusing to account for inflation effectively decreases buying power of each dollar the longer inflation remains ignored. For example, the buying power of the 1975 MICRA value was reduced by nearly sixty-six percent by 1998.¹³⁸ If the \$250,000

¹³⁰ See *infra* notes 131–48 and accompanying text.

¹³¹ Miller, *supra* note 44, at 1470.

¹³² Shepherd, *supra* note 60, at 912.

¹³³ See *infra* notes 134–48 and accompanying text.

¹³⁴ See *infra* notes 135–48 and accompanying text.

¹³⁵ U.S. HOUSE COMM. ON THE JUDICIARY—DEMOCRATS, STATEMENT OF THE HONORABLE JOHN CONYERS, JR. IN OPPOSITION TO H.R. 1215, THE SO-CALLED “PROTECTING ACCESS TO CARE ACT OF 2017” (2017) (“The bill’s \$250,000 aggregate limit for noneconomic damages—an amount established more than 40 years ago pursuant to a California statute . . .”); Leonard J. Nelson III et al., *Damages Caps in Medical Malpractice Cases*, THE MILBANK Q. (2007). Further, it is unclear where the \$250,000 amount came from in the first place, but the legislature “may have felt that the fixed \$250,000 limit would promote settlements by eliminating the unknown possibility of phenomenal awards for pain and suffering that can make litigation worth the gamble.” *Fein v. Permanente Medical Group*, 695 P.2d 665, 683 (Cal. 1985).

¹³⁶ *The Consumer Price Index and Inflation - Calculate and Graph Inflation Rates*, MATHEMATICAL ASSOC. OF AM., <https://www.maa.org/press/periodicals/locic/joma/the-consumer-price-index-and-inflation-calculate-and-graph-inflation-rates> (last visited Oct. 1, 2017) [hereinafter *Consumer Price Index and Inflation*]. This number was reached by using the inflation rate between 1975 and 2017. *Id.* The inflation rate formula is as follows: (CPI in 1975/CPI in 2017) x 2017 USD Value = 1975 USD Value. *Id.* When the historical consumer price index values are inserted into the formula, the result is this: (53.8/244.524) x \$250,000 = \$55,004.83. See *id.*

¹³⁷ Bennet Abosch, *The Capping of Non-Economic Damages: Does California’s Micra Statute Sacrifice Equal Protection for Ineffective Tort Reform?*, 29 U. WEST. L.A. L. REV. 357, 377 (1998).

¹³⁸ *Id.* (stating in 1998: “By virtue of inflation, the buying power of that money under the cap has been reduced by almost two-thirds, thereby making the award unreasonable and inadequate.”).

MICRA value is maintained in 2017, the buying power is reduced by almost eighty percent.¹³⁹ The longer inflation remains ignored, the more egregious and insufficient the plaintiff's award becomes.¹⁴⁰ To properly compensate plaintiffs, even in the face of damage caps, legislation must be cognizant of inflation.¹⁴¹ Accordingly, any new legislation on the matter should, at a minimum, equate the 1975 MICRA value to the 2017 valuation, which would be approximately \$1,136,263.¹⁴² Any limitation should also increase each year to account for inflation.

From a deterrence standpoint, a low damage cap decreases the incentive for practitioners to take the level of care necessary to avoid accidents.¹⁴³ Indeed, a study conducted by Northwestern University examined the effects of damage caps.¹⁴⁴ The study found the adoption of caps results in an average increase of ten to fifteen percent in adverse patient safety events.¹⁴⁵ If physicians need not pay the full cost of their negligence, then they will be undeterred from engaging in dangerous activity.¹⁴⁶ The \$250,000 threshold is simply too low to require a physician to consider weighing the costs and benefits of certain activity and does not require a payment of the full cost of negligence in some cases.¹⁴⁷ As any damage cap will structurally limit liability, thereby reducing full payments in circumstances where damages are immense, those caps need to be large enough to make physicians weigh the costs and benefits of their potentially dangerous activities. The \$250,000 cap is too low to achieve this goal.¹⁴⁸

B. *The Simple Concession Approach*

The simple concession approach differs from the dormant approach because it recommends states impose their own damage cap rather than settling for the \$250,000 PACA amount.¹⁴⁹ For reasons stated in the previous section, states that

¹³⁹ *Consumer Price Index and Inflation*, *supra* note 136. This figure was calculated by dividing the consumer price index data from 1975 by 2017 (53.8/244.524), and multiplying it by 100, to get the percentage of buying power decrease between the two years. *See id.*

¹⁴⁰ Abosch, *supra* note 137, at 377–78.

¹⁴¹ *See id.*

¹⁴² *Consumer Price Index and Inflation*, *supra* note 136. This number resulted from the inflation rate calculation. *See id.* Specifically: (Consumer Price Index in 2017/Consumer Price Index in 1975) x 1975 USD value = 2017 USD value. *See id.* When the consumer price index values are inserted into the formula, it becomes: (244.524/53.8) x \$250,000 = \$1,136,363.94. *See id.*

¹⁴³ Shepherd, *supra* note 60, at 922.

¹⁴⁴ *See* Miller, *supra* note 44, at 1470–74.

¹⁴⁵ Zenon Zabinski & Bernard Black, *The Deterrent Effect of Tort Law: Evidence from Medical Malpractice Reform 3* (NW Univ. Inst. for Pol'y Res. Working Paper No. 13-xx, 2004), <https://business.illinois.edu/nmiller/mhec/Zabinski.pdf>.

¹⁴⁶ *Id.*

¹⁴⁷ *See id.*

¹⁴⁸ *See supra* notes 131–47 and accompanying text.

¹⁴⁹ *See supra* notes 150–67 and accompanying text.

choose this option should start, at a minimum, with the 2017 valuation of the 1975 MICRA amount and account for inflation.¹⁵⁰ States that have constitutional provisions prohibiting such legislation must implement constitutional amendments, which will likely be more difficult than simply passing legislation on the matter.¹⁵¹

1. *Amend the Constitution, if Necessary*

Wyoming is one state that will require a constitutional amendment.¹⁵² The Wyoming Constitution currently provides that “[n]o law shall be enacted limiting the amount of damages to be recovered for causing the injury or death of any person.”¹⁵³ To amend the Wyoming Constitution, a bill must pass both houses and be presented to the governor for signature.¹⁵⁴ Then, the proposed amendment must receive a majority of the total votes cast in the general election.¹⁵⁵

In 2015, the Wyoming State Legislature sought to amend this constitutional provision by limiting noneconomic damages in health care provider lawsuits to \$500,000.¹⁵⁶ The 2015 proposal failed.¹⁵⁷ There is relatively little legislative history stating why the 2015 proposal failed,¹⁵⁸ but a similar bill failed in 2003 because of legislative uncertainty.¹⁵⁹ Addressing the failed 2003 proposal, United States Senator Michael B. Enzi stated,

My own State, Wyoming, had a lively legislative debate on medical liability reform this year, but we have a constitutional amendment that prohibits limits on the amounts that can be recovered through lawsuits. The Wyoming Senate considered

¹⁵⁰ See *supra* notes 131–47 and accompanying text.

¹⁵¹ See ROBERT B. KEITER, *THE WYOMING STATE CONSTITUTION* 20 (G. Alan Tarr, 2nd ed. 2017) (“If the ratification requirement were simply a majority of the votes cast on the amendment, then thirty-one more amendments would have been added to the [Wyoming] constitution.”). In Wyoming, a proposed constitutional amendment must be ratified by the majority of votes in the electorate, not by those voting on the amendment. *State ex rel. Blair v. Brooks*, 99 P. 874, 874 (Wyo. 1909).

¹⁵² See WYO. CONST. art. 10, § 4.

¹⁵³ *Id.*

¹⁵⁴ KEITER, *supra* note 151, at 20; *Geringer v. Bebout*, 10 P.3d 514, 521 (Wyo. 2000).

¹⁵⁵ WYO. CONST. art. 20, § 1. The phrase “electors” is interpreted to mean those persons “who are entitled to vote” in the general election. *Sch. Dist. Nos. 2, 3, 6, 9, and 10, in the Cty. of Campbell v. Cook*, 424 P.2d 751, 757 (Wyo. 1967).

¹⁵⁶ HJ0011, 63rd Leg., 2015 Gen. Sess. (Wyo. 2015).

¹⁵⁷ WYO. LEGIS. SERV. OFF., STATUS OF BILLS, HJ0011, 63rd Leg., 2015 Gen. Sess. (2015).

¹⁵⁸ See Debora A. Person, *Legislative Histories and the Practice of Statutory Interpretation in Wyoming*, 10 WYO. L. REV. 559, 568 (2010) (“Wyoming’s lack of published legislative material has been a hindrance to researching legislative histories and searching out legislative intent.”).

¹⁵⁹ See 108th Cong. Rec. 20575 (2003).

a bill to amend our State's constitution . . . the bill died in a tie vote on the Wyoming Senate floor. According to one of the sponsors of the bill, Senator Charlie Scott, one of the biggest obstacles to passage was the uncertainty surrounding this new idea. . . . No one knew . . . how much injured patients would recover compared to what they recover now. Senator Scott wrote me to say that federal support for finding answers to these questions might help the bill's sponsors sufficiently respond to the legitimate concerns of their fellow Wyoming legislators.¹⁶⁰

PACA should not serve as a model for the Wyoming State Legislature, but rather as incentive to pass a constitutional amendment in both houses.¹⁶¹ Imposing a cap higher than PACA's \$250,000 amount is necessary to ensure injured plaintiffs will be able to recover as much as they can under the current model. A cap that begins with the 2017 valuation of the 1975 MICRA amount and accounts for inflation is necessary to guarantee such an outcome.¹⁶² The Wyoming State Legislature should have no difficulty passing legislation of this kind in both houses given their previous attempts to do so. The concern about adequate plaintiff recovery that attached to the prior legislation should propel legislation of this kind to be passed.

Wyoming may have difficulty with the second requirement: convincing a majority of voters that such legislation is beneficial.¹⁶³ In 2004, Wyoming voters rejected a proposed constitutional amendment that would have allowed legislation capping noneconomic damages.¹⁶⁴ The proposal was defeated by a vote of 50.35% to 49.65%.¹⁶⁵ A new constitutional amendment may be perceived publicly as an overstepping of political values, which is why it is important to be open and honest with constituents in explaining why the constitutional amendment is

¹⁶⁰ *Id.*

¹⁶¹ *See supra* notes 131–47 and accompanying text.

¹⁶² *Id.* Adopting the dormant approach would decrease the amount plaintiffs could recover in Wyoming compared to what they have the potential to recover now since Wyoming law currently does not limit recovery of damages. *See supra* notes 131–47 and accompanying text; WYO. CONST. art. 10, § 4(a) (“No law shall be enacted limiting the amount of damages to be recovered for causing injury or death of any person.”).

¹⁶³ To reiterate, damage caps are not generally beneficial. *See supra* notes 130–48 and accompanying text. However, if federal preemption is inevitable, states should concede on their own terms to protect plaintiffs. *See supra* notes 127–62 and accompanying text; *infra* notes 167–208 and accompanying text.

¹⁶⁴ WYOMING SECRETARY OF STATE, 2004 GENERAL ELECTION RESULTS, STATEWIDE CANDIDATES, JUDICIAL RETENTIONS, CONSTITUTIONAL AMENDMENTS AND TOTAL BALLOTS CAST 8, Constitutional Amendment D.

¹⁶⁵ *Id.*; *see also* Becky Bohrer, *Voters reject caps on malpractice damage awards*, THE BILLINGS GAZETTE, Nov. 2, 2004, http://billingsgazette.com/news/state-and-regional/wyoming/voters-reject-caps-on-malpractice-damage-awards/article_6851d2cf-b2db-574d-9941-f05b12689d9b.html.

necessary: to adequately compensate plaintiffs by preempting or circumventing PACA's intrusion into this traditional state law area.¹⁶⁶

For plaintiffs to receive the most protection, though, Wyoming and similarly situated states should select the sovereign concession approach, which goes beyond the basic tenets of the simple concession approach.¹⁶⁷

C. *The Sovereign Concession Approach*

The sovereign concession approach adopts the basic tenets of the simple concession because it would also require a constitutional amendment in some states.¹⁶⁸ However, the sovereign concession approach moves beyond the simple concession approach because it urges statutes to include enormously large noneconomic damage limitations, categorically exempt nursing homes and cases resulting in death or disfigurement, and to implement or activate a PCF.¹⁶⁹ This approach aligns more closely with the objectives of tort law than the other approaches while also maintaining state sovereignty in light of federal preemption in this traditional state law area.

1. *Impose an Unusually High Limitation on Noneconomic Damages*

The sovereign concession approach requires the cap to be unusually high in terms of traditional thresholds.¹⁷⁰ Though the amount will be somewhat arbitrary, as is the nature of noneconomic damage limitations,¹⁷¹ the threshold should reflect both the importance and purpose of noneconomic damages and the institutional values reflected in the preempted states' constitutions.¹⁷²

¹⁶⁶ See *supra* notes 94–95 and accompanying text. Any state that does not have some cap on noneconomic damages directly conflicts with Congress's objective in PACA of imposing a cap in every state. See *supra* notes 109–26 and accompanying text. This conflict requires states that do not have noneconomic damage caps on or before the enactment of PACA to be preempted with the \$250,000 cap. See *supra* notes 109–26 and accompanying text. The only way for states to stop the preemption is to preempt or circumvent the preemption by imposing their own caps. See *supra* notes 109–26 and accompanying text.

¹⁶⁷ See *supra* note 70 and accompanying text.

¹⁶⁸ See *supra* note 70 and accompanying text.

¹⁶⁹ See *infra* notes 170–208 and accompanying text.

¹⁷⁰ See *supra* note 68 and accompanying text.

¹⁷¹ *Lucas v. United States*, 757 S.W.2d 687, 692 (Tex. 1988) (citing *Smith v. Dep't. of Ins.*, 507 So.2d 1080, 1088–89 (Fl. 1987) (acknowledging that, if the legislature could cap recovery at one amount, there is no reason why it could not cap the recovery at some other figure, including \$1)).

¹⁷² See *infra* notes 173–79 and accompanying text. The institutional value reflected in constitutions, prohibiting such limitations, is that states do not want to limit the amount a plaintiff can recover. See John Fabian Witt, *The Long History of State Constitutions and American Tort Law*, 36 RUTGERS L. J. 1159, 1168 (2005) (“[D]emocratic dissatisfaction with statutory caps on damages in death cases produced a wave of constitutional provisions and amendments.”). State constitutions often contain provisions that are expressive of the state's values. See Justin R. Long,

The importance of noneconomic damages becomes evident when asking oneself whether an injured patient's recovery should be based solely on the patient's income and wealth.¹⁷³ This importance is emulated in Wyoming's constitutional provision prohibiting damage caps.¹⁷⁴ The provision also reflects the basic common-law tenet that plaintiffs receive all noneconomic damages awarded by the fact-finder.¹⁷⁵ Though any limitation on noneconomic damage makes the tenet of compensation less effective, it is still possible to conceive of a limitation that will allow a plaintiff to receive all, if not most, of a jury award given the infrequency of large medical malpractice verdicts in the state.¹⁷⁶ Simply put, Wyoming can impose a limitation that is high enough to meet foreseeable needs of even the most injured plaintiffs while still meeting the requirements of PACA. The congressional requirement that every state impose a noneconomic damage limitation, coupled with the arbitrary nature of such caps, effectively authorizes imposition of a seemingly facetious cap upwards of \$10 million.

To illustrate, a \$10 million damage cap would satisfy the requirements of PACA because it would be an imposition of damage caps.¹⁷⁷ The \$10 million cap would also meet the foreseeable needs of the most injured Wyoming plaintiffs because Wyoming's largest medical malpractice verdict is currently \$9 million.¹⁷⁸ When the verdict was announced, many Wyomingites classified it as an anomaly,¹⁷⁹ which demonstrates that the foreseeable needs of Wyoming

State Constitutions as Interactive Expressions of Fundamental Values, 74 ALB. L. REV. 1739, 1744 (2010) (“[T]he expressive power of the norms embedded in the constitutional text itself draws a state polity together, creating a community of shared commitments to the values in the text.”). Accordingly, any change in the law in this regard should continue to reflect such institutional values, since the purpose of amending the constitutions is not to override the institutional value itself, but rather to ensure its perpetuity in light of federal preemption. See *supra* note 163 and accompanying text.

¹⁷³ *The Republican Attack*, *supra* note 71, at 707 (“The importance of these nonpecuniary losses can be seen by asking yourself whether you would be indifferent or even nearly indifferent between an uninjured state and a severely injured state, such as paraplegia, blindness, or severe brain damage, so long as your income and wealth remained constant.”).

¹⁷⁴ WYO. CONST. art. 10, § 4(a).

¹⁷⁵ *The Republican Attack*, *supra* note 71, at 707.

¹⁷⁶ Scott Harper, *Largest Medical Malpractice Verdict in Wyoming History*, TRIAL LAW. C. (June 9, 2017), <https://www.triallawyerscollege.org/blog/?p=5831> (After a Wyoming jury awarded a \$9 million verdict, the highest verdict in the history of Wyoming, Robert Teideken, a Wyoming attorney said, “Two blocks away from the federal courthouse where the verdict you are asking me about occurred, there was a defense verdict in a medical malpractice case the next week. We never hear about those.”).

¹⁷⁷ H.R. 1215, 115th Cong. § 4(e) (2017).

¹⁷⁸ *Prager v. Campbell Cty. Mem. Hosp.*, 731 F.3d 1046, 1053 (10th Cir. 2013). The jury awarded Mr. Prager, the plaintiff, \$7 million in compensatory damages and Mrs. Prager, the plaintiff's wife, \$2 million for loss of consortium. *Id.*

¹⁷⁹ See Harper, *supra* note 176. Wyoming Governor Matthew H. Mead responded to the verdict by saying it got his attention, but he did not believe one verdict warranted an over-reaction. *Id.*

plaintiffs will be satisfied with such an amount. By meeting foreseeable needs of Wyoming plaintiffs, the \$10 million amount also comports with the underlying principles of noneconomic damages because it will adequately compensate most Wyoming plaintiffs.

2. *Exempt Nursing Homes and Cases Resulting in Death or Disfigurement*

Sovereign concessions statutes should also exempt nursing homes from the limitation on noneconomic damages. The first (and perhaps most obvious) reason for exempting this class of plaintiffs is because the type of litigation these plaintiffs raise is customarily different from the typical medical malpractice claim.¹⁸⁰ The typical malpractice case involves an improper or failed diagnosis, while nursing home cases generally involve emotional and sexual abuse, bedsores, and neglect.¹⁸¹ Most importantly, though, nursing home patients are generally vulnerable, “elderly Medicaid recipients, often with dementia or Alzheimer’s disease,” and are widely cut-off from the outside world.¹⁸² Given the vulnerability of nursing home plaintiffs in combination with the reality that noneconomic damage awards make up a relatively large portion of any successful nursing home claim, the importance of establishing an exception for this class of plaintiffs is readily apparent.¹⁸³ A cap on noneconomic damages that includes nursing homes would erect a dangerous barrier to the courtroom for such plaintiffs because it would make it nearly impossible for victims of nursing home negligence to find attorneys willing to represent them.¹⁸⁴ Stated bluntly, “[t]he real victims of caps on noneconomic damages are our most vulnerable citizens, our mothers and grandmothers who are victimized by profit driven corporate nursing home chains.”¹⁸⁵

States preempting or circumventing PACA should also exempt cases resulting in death or disfigurement for two reasons. First, a statute that neglects to exempt cases resulting in death or disfigurement effectively claims that all injuries, regardless of severity, are not worth more than \$250,000.¹⁸⁶ Such legislation

¹⁸⁰ Rustad, *Neglecting the Neglected*, *supra* note 63, at 344.

¹⁸¹ *Id.*

¹⁸² Michael L. Rustad, *Heart of Stone: What is Revealed About the Attitude of Compassionate Conservatives Toward Nursing Home Practices, Tort Reform, and Noneconomic Damages*, 35 N.M.L. REV. 337, 338 (2005).

¹⁸³ Rustad, *Neglecting the Neglected*, *supra* note 63, at 344 (“[E]conomic damages tend to constitute a relatively small portion of nursing home awards, and noneconomic damages tend to constitute a relatively large portion.”).

¹⁸⁴ *Id.* at 390.

¹⁸⁵ *Id.* at 390–91.

¹⁸⁶ Ralph Peeples & Catherine T. Harris, *Learning to Crawl: The Use of Voluntary Caps on Damages in Medical Malpractice Litigation*, 54 CATH. U. L. REV. 703, 721 (2005) (discussing how damage limitations are problematic because not all injuries or plaintiffs are alike).

allows differential treatment for less serious injuries but not more serious injuries, where differential treatment is perhaps more justified due to the severity of the injury.¹⁸⁷ States who fail to implement exemptions of this kind will penalize the most injured victims of medical malpractice.¹⁸⁸ Second, the chances of a cap reducing a claimant's recovery increase with the severity of the injury.¹⁸⁹ In fact, empirical evidence indicates claimants with the most catastrophic injuries are at the highest risk of inadequate compensation.¹⁹⁰ Preempted states should exempt cases resulting in death or disfigurement or risk marginalizing victims of the most egregious malpractice.¹⁹¹

3. *Implement or Activate a PCF*

A PCF “offer[s] insurance for medical malpractice liability that exceeds the specified threshold amounts covered by” an insurance policy.¹⁹² A PCF works with the malpractice insurance market to place a surcharge on malpractice insurance premiums that will recycle into the fund.¹⁹³ If a plaintiff is awarded damages that exceed the statutory limit, the plaintiff is paid the excess amount from the PCF so long as the doctor or hospital who was found liable is a participating member in the fund.¹⁹⁴ A PCF is the best way to simultaneously protect insurance providers against future liabilities and to allow plaintiffs to collect sufficient compensation on a successful claim.¹⁹⁵ In some states, participation in the fund is voluntary, while other states mandate participation.¹⁹⁶ Wyoming must mandate participation in the fund because Wyoming has only one insurance provider.¹⁹⁷ If Wyoming allows voluntary participation, the sole provider may choose not to participate and the activation of the fund would be fruitless.

¹⁸⁷ *Id.*

¹⁸⁸ *Id.*

¹⁸⁹ *Id.*

¹⁹⁰ David M. Studdert et al., *Are Damages Caps Regressive? A Study of Malpractice Jury Verdicts in California*, 23 HEALTH AFF. 54, 55 (2004); see also Frank A. Sloan & Chee Ruey Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?*, 24 L. & SOC'Y REV. 997 (1990).

¹⁹¹ Rustad, *Neglecting the Neglected*, *supra* note 63, at 350 (“An astonishing 65% of plaintiffs in catastrophic brain damage cases had their awards reduced due to California’s MICRA cap.”).

¹⁹² Sloan, *supra* note 42 at 247.

¹⁹³ Gereau, *supra* note 127.

¹⁹⁴ *Id.*

¹⁹⁵ Ed Schrero, Note, *Patient Compensation Funds: Legislative Responses to the Medical Malpractice Crisis*, 5 AM. J. L. & MED. 175, 179 (1979).

¹⁹⁶ Gereau, *supra* note 127.

¹⁹⁷ *Wyoming insurance provider seeks almost 50-percent rate hike*, CASPER STAR TRIBUNE, Aug. 3, 2017, http://trib.com/news/state-and-regional/wyoming-insurance-provider-seeks-almost-percent-rate-hike/article_31d5c02f-3dbd-5d0a-8f70-fdc92a7764eb.html. As of November 9, 2017, Blue Cross Blue Shield was the only provider of health insurance in Wyoming. *Id.*

Wyoming created a PCF in 1977 under the Medical Liability Compensation Account.¹⁹⁸ The account is currently inactive.¹⁹⁹ In theory, the PCF is regulated by the account's commissioner who uses invested monies to purchase insurance for the PCF and its obligations.²⁰⁰ Participation in the fund is presently voluntary and allows qualified physicians to pay an annual surcharge determined by the commissioner.²⁰¹ To qualify as a participant in the fund, a physician must carry liability insurance coverage of at least \$50,000 per occurrence and pay an annual surcharge.²⁰² Wyoming must activate the PCF and amend the statute to require participation given the one-provider environment.

However, PCFs have two critical disadvantages. First, PCFs "arguably insulate the most negligent providers" because they only become applicable when damage awards exceed the statutory threshold.²⁰³ Second, given the limited nature of the fund, a plaintiff may have to wait longer to receive damage awards.²⁰⁴ For instance, most states that currently have active funds permit a fixed dollar amount to be paid to a single plaintiff in a given year.²⁰⁵ Therefore, any award that is drawn from the PCF would be paid in installments over a period of years to guarantee funds are available in the event of a second verdict in excess of the limitation.²⁰⁶ While this is not ideal, it is favored over the situation where a meritorious plaintiff is unable to find representation because of a damage cap.²⁰⁷ Nevertheless, the two disadvantages of a PCF become nearly inapposite if an unusually high threshold is imposed. A \$10 million threshold would not insulate the most negligent providers as much as a \$250,000 limitation would, making the first disadvantage less cautionary. Additionally, it is improbable that two verdicts exceeding \$10 million would be awarded in Wyoming within a given year considering Wyoming does not have a history with verdicts exceeding the proposed threshold amount.²⁰⁸ Because it is unlikely two verdicts in excess of the amount would need to be paid out of the PCF within the same year, the second disadvantage becomes less cautionary as well.

¹⁹⁸ WYO. STAT. ANN. § 26-33-105 (2008).

¹⁹⁹ *Id.* The American Medical Association claims Wyoming's medical liability compensation account has never been implemented. Gereau, *supra* note 127; Sloan, *supra* note 42.

²⁰⁰ WYO. STAT. ANN. § 26-33-105(a).

²⁰¹ *Id.* § 26-33-105(c).

²⁰² WYO. STAT. ANN. § 26-33-102 (1983).

²⁰³ Schrero, *supra* note 195, at 187.

²⁰⁴ *Id.* at 181.

²⁰⁵ *Id.*

²⁰⁶ *Id.*

²⁰⁷ See *supra* note 63 and accompanying text.

²⁰⁸ Harper, *supra* note 176.

4. *The Sovereign Concession Approach Summary*

To conclude, the sovereign concession approach requires states to go beyond the guidelines set forth in the simple concession approach. Specifically, states should impose an unconventionally high cap on noneconomic damages and account for inflation, exempt cases resulting in death or disfigurement, categorically exempt nursing homes, and mandate participation in an active PCF to ensure additional compensation will be available if necessary.

VI. CONCLUSION

Even though medical malpractice was the third-leading cause of death in 2016,²⁰⁹ some proponents advocate for medical malpractice reform to constrain the civil litigation system.²¹⁰ The debate between reformers and preservers, physicians and doctors, and republicans and democrats has yet to produce federal legislation limiting noneconomic damages despite numerous proposals.²¹¹ The Holy Grail for Republicans has been, and will continue to be, a cap on noneconomic damages in medical malpractice suits,²¹² and the 115th Congress is arguably the closest Congress has ever come to federalizing medical malpractice claims. This Comment argues the passage of PACA is inevitable.²¹³ If, for some reason, PACA were to stall or fail in this session, Congress will undoubtedly propose and pass similar legislation during the current span of Republican-control. It is unimaginable that a business-friendly President and a Republican-controlled Congress will let 2018 slip away without successfully passing one health care bill, and the time for medical malpractice reform seems to be now.

States should prepare accordingly to ensure their citizens are not left without an adequate remedy when catastrophic medical malpractice incidents occur. States that have yet to enact noneconomic damage limitations, and especially states similarly situated to Wyoming,²¹⁴ should follow the guidelines set forth in the sovereign concession approach.²¹⁵ Without such measures, “the medical malpractice system [will become] a failure, for most of the people, most of the time,” at least as it pertains to fulfilling the objectives of compensation and deterrence.²¹⁶ This failure would be an actual and undebatable crisis. To avoid

²⁰⁹ See Terhune, *supra* note 1.

²¹⁰ See *supra* notes 50–60 and accompanying text.

²¹¹ Matray, *supra* note 24 (“Attempts to enact federal noneconomic damage caps have proven fruitless . . .”); see also *supra* notes 86–88 and accompanying text.

²¹² *Id.*

²¹³ *Id.*

²¹⁴ See *supra* note 69–70.

²¹⁵ See *supra* notes 168–208 and accompanying text.

²¹⁶ Peeples & Harris, *supra* note 186, at 714.

such an outcome, states should pass enormously large noneconomic damage limitations, categorically exempt instances that result in death or disfigurement and nursing homes, and require the implementation or activation of a PCF.²¹⁷ By doing so, states will protect plaintiffs while adhering to the objectives of tort law and medical malpractice.

²¹⁷ *Id.*