

ARTICLE

POLICY EXPERIMENTATION WITH ADMINISTRATIVE COMPENSATION FOR MEDICAL INJURY: ISSUES UNDER STATE CONSTITUTIONAL LAW

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Dissatisfaction with the costs and performance of the medical malpractice system has led to interest in far-reaching liability reform. Proposals for experimentation with administrative compensation systems for medical injury, known as "health courts," have caught the attention of state and federal policymakers. The health courts model proposes an administrative tribunal that would operate outside the regular judicial system, with specialized judges awarding compensation in malpractice cases based on a finding of avoidability of injury, rather than negligence. Because health courts would abrogate the traditional authority of the judiciary and the jury, they would probably invite constitutional challenges. This Article describes the potential challenges and assesses how health court systems would likely fare. The Article focuses on state constitutional law, but much of the analysis also applies to federal claims. The Article's conclusions are informed by an analysis of 132 cases involving a range of constitutional challenges to malpractice reforms enacted in 1985–86 and 1974–75. The analysis tracks the success rates of these challenges. This scorecard is pertinent because health courts include many of the features found in previous reforms. However, health courts' core feature—vesting exclusive jurisdiction in a tribunal that does not employ juries—lacks precedent in medical malpractice law. To understand the tests and frameworks that would be applied to this feature, this Article analyzes judicial opinions interpreting jury-trial and open-courts provisions of state constitutions. Recognizing that a dominant theme in this jurisprudence is the

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requirement of a “quid pro quo” when claimants’ rights are limited, the Article considers the social bargain presented by health courts proposals, focusing on the potential for improved access to compensation for claimants and greater reliability of decision-making. The Article concludes that a carefully designed health courts pilot could withstand constitutional scrutiny in many states.

I. INTRODUCTION

The civil justice system provides an important governance structure for regulating the causes and consequences of personal injury. Through imposition of liability, the system pursues social justice objectives, particularly risk pooling and compensation of persons harmed by negligence. It also seeks to advance safety objectives by discouraging actual and potential tortfeasors from engaging in unreasonably hazardous behavior.

Concerns about how well the medical malpractice branch of the civil justice system succeeds in its governance functions are almost as old as medical malpractice litigation itself.¹ The critiques are legion: too much compensation awarded to some injured patients and little or none to others, unpredictability, massive inefficiency, and so on.² During “malpractice crises”—periods in which the premiums physicians pay to professional liability insurers for liability coverage escalate rapidly—such concerns deepen. They also prompt political action. Consensus often forms in state legislatures that the traditional governance structures for medical malpractice have failed (again) and need correction. The standard legislative response, tort reform, is a classic example of the modern trend to displace common law sources of tort rules with statutory ones.

Amidst the malpractice crises of the mid-1970s, mid-1980s, and early 2000s, state-based tort reforms flourished in the United States.³ Many were spurred by and directed specifically at medical malpractice litigation. Caps on noneconomic damages, attorney fee limits, screening panels, amendment of rules for joint and several liability, and shortening of statutes of limitations are among the best-known reforms.

Tort reforms rest on two fundamental premises. First, litigation is excessive; and consequently, the policymaker’s task is to help curb the volume and cost of claims. Second, periodic incremental repairs will suffice. Tort reforms are modest in the sense that they leave largely intact the basic governance and institutional structures for medical injury. To the outside observer, the relatively superficial nature of tort reforms may be perplexing in light of the profound level of dissatisfaction to which they respond; and the growing body of evidence that their impact on litigation activity and liability insur-

¹ KENNETH A. DE VILLE, *MEDICAL MALPRACTICE IN NINETEENTH CENTURY AMERICA* 23 (1990).

² David M. Studdert et al., *Medical Malpractice*, 350 *NEW ENG. J. MED.* 283, 287 (2004).

³ See *id.* at 284.

ance premiums is not large.⁴ The explanation lies in the political forces at work. Caught between the two powerful lobbies of the medical profession (strongly in favor of tort reforms, especially those that promise quick relief from rising insurance costs) and the trial bar (generally opposed to tort reforms), legislatures have shown little appetite for more sweeping and creative options, at least until recently.

The academy is not so constrained. Thus, it should not be surprising that calls for farther-reaching reforms to the medical malpractice system have emanated chiefly from this quarter. Proposed reforms include basing liability on contract rather than tort principles,⁵ shifting away from individual responsibility for medical injury toward institutional or enterprise liability,⁶ and placing alternative dispute resolution techniques at the center of the process.⁷ A particularly longstanding and relatively well-developed proposal calls for replacement of malpractice litigation with a “no-fault” administrative approach to medical injury compensation.⁸

No-fault proposals have evolved over time and differ somewhat, but they generally share two core features: (1) the transfer of some or all medical injury claims from courts of general jurisdiction to a compensation system that is less adversarial and more administratively oriented in its governance structure, and (2) the substitution of the negligence standard with one that does not condition compensation on proof of provider fault. Some versions of the no-fault proposals have envisioned a broad-based shift to an administrative no-fault scheme.⁹ Recognizing the political and financial obstacles to such radical change, later versions have proposed experimentation at the in-

⁴ MICHELLE M. MELLO, *MEDICAL MALPRACTICE: IMPACT OF THE CRISIS AND EFFECT OF STATE TORT REFORMS* (ROBERT WOOD JOHNSON FOUNDATION, THE SYNTHESIS PROJECT, POLICY BRIEF NO. 10) (2006), available at http://www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no10_policybrief.pdf.

⁵ See, e.g., CLARK C. HAVIGHURST, *HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM* 12 (1995); Richard A. Epstein, *Medical Malpractice: The Case For Contract*, 76 AM. B. FOUND. RES. J. 87, 93 (1976).

⁶ See, e.g., Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 398 (1994); William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 10 AM. J.L. & MED. 1 (1994).

⁷ See, e.g., Edward A. Dauer & Leonard J. Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes With Health Care Quality Improvement*, 60 LAW & CONTEMP. PROBS. 185 (1997); Thomas Metzloff, *The Unrealized Potential of Malpractice Arbitration*, 31 WAKE FOREST L. REV. 203 (1996).

⁸ See, e.g., Clark C. Havighurst & Laurence R. Tancredi, “*Medical Adversity Insurance*”—*A No-Fault Approach to Medical Malpractice and Quality Assurance*, 51 MILBANK Q. 125 (1973); Jeffrey O’Connell, *Neo-No-Fault Remedies for Medical Injuries: Coordinated Statutory and Contractual Alternatives*, 49 LAW & CONTEMP. PROBS. 125, 128 (1986); Jeffrey O’Connell, *No-Fault Insurance for Injuries Arising from Medical Treatment: A Proposal for Elective Coverage*, 24 EMORY L.J. 21 (1975); David M. Studdert & Troyen A. Brennan, *No-Fault Compensation: The Prospect for Error Prevention*, 286 JAMA 217 (2001); Paul C. Weiler, *The Case For No-Fault Medical Liability*, 52 MD. L. REV. 908, 920 (1993).

⁹ See, e.g., Studdert & Brennan, *supra* note 8, at 219.

stitutional or specialty level through voluntary insurer-based demonstration projects.¹⁰

The “health court” is the latest label for the administrative/no-fault concept.¹¹ Health courts have been attracting significant attention among state and federal policymakers,¹² with interest fueled by the most recent malpractice crisis and recommendations to test the model from several august bodies, including the National Academy of Science’s Institute of Medicine.¹³ Many technical details of the health court model must be refined before such an experiment could be launched. However, two threshold barriers exist that have the potential to stop a health court demonstration dead in its tracks.

One threshold barrier is political. Despite widespread dissatisfaction with medical malpractice litigation, many stakeholder groups have vested interests in the status quo and could be expected to resist any initiative of this kind, even in experimental form. Vocal opposition from two groups—the plaintiffs’ bar and liability insurance companies—is especially likely. It seems very unlikely that the American Association for Justice or other orga-

¹⁰ See, e.g., Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1629 (2002); INSTITUTE OF MEDICINE, FOSTERING RAPID ADVANCES IN HEALTH CARE: LEARNING FROM SYSTEM DEMONSTRATIONS 84 (Janet M. Corrigan et al. eds., 2002), available at http://www.nap.edu/catalog.php?record_id=10565#toc; COMMON GOOD, WINDOWS OF OPPORTUNITY: STATE-BASED IDEAS FOR IMPROVING MEDICAL INJURY COMPENSATION AND ENHANCING PATIENT SAFETY 13 (2006), available at http://cgood.org/assets/attachments/Windows_of_opportunity_web.pdf.

¹¹ The term “health court” was applied to the model by the nonprofit advocacy organization Common Good. See Paul J. Barringer, *A New Prescription for America’s Medical Liability System*, 9 J. HEALTH CARE L. & POL’Y 235 (2006); COMMON GOOD, FREQUENTLY ASKED QUESTIONS ABOUT HEALTH COURTS (2007), <http://cgood.org/f-healthcourtsfaq.html>.

¹² Legislation was introduced in the 109th Congress that would have facilitated the creation of pilot projects to test the feasibility of the health court model: H.R. 1546, 109th Cong. § 1 (2005), introduced in April 2005 by Representative Mac Thornberry (R-Tex.), and S. 1337, 109th Cong. § 1 (2005), introduced in June 2005 by Senators Michael Enzi (R-Wyo.) and Max Baucus (D-Mont.). As of March 2007, introduction of similar proposals is anticipated in the 110th Congress. At the state level, bills have been introduced in Maryland, see S. 580, 423d Gen. Assemb. (Md. 2007); H.B. 338, 423d Gen. Assemb. (Md. 2007); and H.B. 779, 423d Gen. Assemb. (Md. 2007), Massachusetts, see S. 990, 185th Gen. Court (Mass. 2007); S. 686, 185th Gen. Court (Mass. 2007), and Pennsylvania, see S. 678, 191st Gen. Assemb. (Pa. 2007), that would create health courts or other kinds of administrative compensation systems for medical injuries. Bills to establish health courts also have been introduced in recent years in Illinois and New Jersey. See S. 671, 212th Leg. (N.J. 2006); S. 151, 94th Gen. Assemb. (Ill. 2005). Finally, in a number of states, including Massachusetts, Pennsylvania, Virginia, and Wyoming, legislative commissions or task forces have been directed to consider the feasibility of establishing health courts or other specialized processes for resolving medical injury disputes. E-mail communication between Michelle M. Mello and Paul Barringer, Gen. Counsel, Common Good (Mar. 27, 2007) (on file with Michelle M. Mello). For scholarly commentary on the health courts proposal, see Barringer, *supra* note 11 (arguing in favor of the proposal); Carl W. Tobias, *Health Courts: Panacea or Palliative?*, 40 RICHMOND L. REV. 49, 52 (2005) (describing health courts as a “provocative, but controversial, solution”); and Amy Widman, *Why Health Courts Are Unconstitutional*, 27 PACE L. REV. 55, 81–86 (2006) (asserting that health courts would violate state and federal constitutional provisions including the rights to jury trial, due process, and equal protection).

¹³ INSTITUTE OF MEDICINE, *supra* note 10.

nizations of plaintiffs' attorneys will applaud a health court experiment;¹⁴ they may find a reduced role for their services in the model particularly galling. Malpractice insurers and their reinsurers crave predictability, and whatever health courts' promise, these insurers will not welcome the uncertainty and perceived potential downside of financial risk associated with an experiment of this kind. Whether the political challenges created by these stakeholder concerns can be overcome remains to be seen. State governments could assuage insurers' concerns by assisting with underwriting and reinsurance. At this point, however, it is difficult to envision how a demonstration project could proceed in many if not most jurisdictions other than over the objections of the trial bar.

The second barrier is legal. If legislation were enacted, constitutional challenges to it likely would come from the first wave of injury claims channeled into the health courts.¹⁵ It has been an accepted principle of constitutional law for over 200 years that the judicial branch is the ultimate arbiter of whether a legislature's enactments comport with constitutional requisites.¹⁶ If a court holds that they do not, the legislation will be invalidated.

The relevant constitutional criteria emanate from two sources. The U.S. Constitution limits the power of every state vis-à-vis its citizens. States also have their own constitutions, which often impose additional limitations on state legislative power. In some respects, state constitutional provisions mirror those of the U.S. Constitution, and state courts borrow heavily from the analytical frameworks developed in federal cases when interpreting their own constitutions. Equal protection and due process protections, for example, tend to be similarly formulated and interpreted at state and federal levels.¹⁷ A litigant who wished to challenge state-level health courts legislation could do so in state court, under the state or federal constitution or both.

In a separate article, our colleague E. Donald Elliott has explored the federal constitutional questions surrounding health courts, particularly chal-

¹⁴ See MAXWELL J. MEHLMAN & DALE A. NANCE, *MEDICAL INJUSTICE: THE CASE AGAINST HEALTH COURTS* (2007) (raising a number of objections to health courts in a report commissioned by the American Association for Justice).

¹⁵ See Victor E. Schwartz et al., *Tort Reform Past, Present and Future: Solving Old Problems and Dealing With "New Style" Litigation*, 27 WM. MITCHELL L. REV. 237 (2000) (discussing efforts at "judicial nullification" as the trial bar's strategy in response to the defense side's legislative successes). See also David M. Studdert & Troyen A. Brennan, *Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the United States*, 27 AM. J.L. & MED. 225, 235, 241-44, 252 (2001) (discussing constitutional issues relating to an earlier proposal for administrative compensation for medical injuries).

¹⁶ The United States Supreme Court case that established this principle is *Marbury v. Madison*, 5 U.S. (1 Cranch) 137 (1803).

¹⁷ Compare, e.g., HAW. CONST. art. 1, § 5 ("No person shall be deprived of life, liberty or property without due process of law, nor be denied the equal protection of the laws.") with U.S. CONST. amend. XIV, § 1 ("No State shall . . . deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.").

lenges that could arise under federal health courts legislation.¹⁸ In this Article, we address potential constitutional objections to state-based legislation, focusing primarily on claims arising under state constitutional provisions.¹⁹ First, we outline the structure of health courts. Second, we review the legal principles that would be salient in challenges to health courts. We then examine the historical record of malpractice reforms that have been evaluated under these principles. Finally, we draw inferences from this doctrinal and empirical analysis about the constitutional prospects of health courts.

II. STRUCTURE OF HEALTH COURTS

We have described the structural features of health courts in detail elsewhere.²⁰ We summarize them here, focusing on those features most relevant to the constitutional issues addressed in the analysis that follows.

The health court is an alternative forum for adjudication of medical injury claims. It sits outside the traditional court system. The model itself does not dictate any particular jurisdictional parameters—the covered injuries may be defined regionally, according to health care institutions, or by specialty or injury type within designated institutions. The court could be located within the judicial branch or within an administrative agency. However, the integrity of the model does depend on exclusive jurisdiction within whatever parameters are chosen. If patients elected to receive treatment from a provider covered by the scheme, any subsequent claim for injury arising from that care would fall within the purview of the health court. Post-injury venue choice would be impermissible.

The system would be designed to encourage providers to take a series of initial steps after an injury occurs, beginning with disclosure to the patient of the occurrence of medical injury, causal investigation by the hospital and its insurer, notice of the right to file a claim with the health court, and, if appropriate, an offer of compensation. The health court would be notified of all offers. If either the patient or the provider were dissatisfied with the initial determination and offer, or if patients believed that a compensable injury occurred but was not disclosed to them, they could file a claim with the health court by completing a simple application form. Both patients and involved clinicians could retain counsel at any point in the process, though the

¹⁸ E. Donald Elliott et al., *Administrative “Health Courts” for Medical Injury Claims: The Federal Constitutional Issues*, 34 J. HEALTH POL. POL’Y & L. (forthcoming July 2009).

¹⁹ Because state legislation establishing health courts could also be challenged under provisions of the U.S. Constitution, Elliott’s analysis of separation-of-powers issues and Seventh Amendment rights to jury trial, *see id.* (manuscript at 36–43, on file with authors), is highly relevant to evaluating the legal permissibility of such legislation.

²⁰ Michelle M. Mello et al., “*Health Courts*” and Accountability for Patient Safety, 84 MILBANK Q. 459 (2006). *See also* COMMON GOOD, *supra* note 10 (describing in detail the proposal that was developed by Common Good in partnership with Harvard School of Public Health faculty members).

goal would be to design procedures that were sufficiently user friendly and protective of the parties' interests that they need not necessarily do so.²¹

Either party could request a hearing. An administrative law judge would preside over proceedings and act as the decision maker. Health court judges would have special training and experience in medical matters, but would not typically be trained as physicians. They would be nominated by a board assembled by the governor, and would be appointed by the governor or whomever the state constitution vested with the judicial appointment power. In making their decisions, the judges would be assisted by a panel of court-appointed medical experts with clinical expertise relevant to the claim at hand. Unlike in conventional medical malpractice litigation, the expert's role in a health court would not be to advocate for or against the claim. Rather, the expert would be charged with explaining the clinical complexities, scientific and epidemiologic evidence base, and prevailing practice standards to the judge as a neutral advisor. Experts would make a recommendation on the claimant's eligibility for compensation insofar as eligibility turned on scientific or clinical issues, which it often would.

Compensation would depend on a judgment that it was more likely than not that the injury was avoidable—that is, that it would not have occurred if best practices had been followed or an optimal system of care had been in place. No proof of negligence, a more stringent standard for claimants, would be required. Panels of medical and legal experts would regularly be convened by the health court to determine whether certain kinds of injuries could be deemed presumptively compensable (a so-called “accelerated-compensation event”)²² in light of persuasive scientific evidence of their avoidability. Such injuries could be processed for compensation rapidly, generally without a live hearing (although, again, a hearing would be held if requested).

Claimants with avoidable injuries would receive damages for economic loss in the usual way; for noneconomic losses, however, their level of damages would be guided by a schedule designed to promote fair and consistent

²¹ For example, in the administrative compensation system in Sweden, the claimant “completes a simple form that is available in all clinics and hospitals, typically with the help of hospital personnel.” Patricia M. Danzon, *The Swedish Patient Compensation System: Lessons for the United States*, 15 J. LEGAL MED. 199, 215 (1994).

²² The concept and development process for accelerated-compensation events (also known as “avoidable classes of events”) are described in several papers by Randy Bovbjerg and Lawrence Tancredi. See Randall R. Bovbjerg & Lawrence R. Tancredi, *Rethinking Responsibility for Patient Injury: Accelerated-Compensation Events, a Malpractice and Quality Reform Ripe for a Test*, 54 LAW & CONTEMP. PROBS. 147 (1991); Randall R. Bovbjerg & Lawrence R. Tancredi, *Advancing the Epidemiology of Injury and Methods of Quality Control: ACEs as an Outcomes-Based System for Quality Improvement*, 18 QUALITY REV. BULL. 201 (1992); Randall R. Bovbjerg & Lawrence R. Tancredi, *Liability Reform Should Make Patients Safer: Focusing on “Avoidable Classes of Events” Can Improve Patient Safety and Compensation for Medical Injury*, 33 J.L. MED. & ETHICS 478 (2005); Lawrence R. Tancredi, *Identifying Avoidable Adverse Events in Medicine*, 12 MED. CARE 935 (1974); Lawrence R. Tancredi, *No-Fault and Medical Malpractice: The Causation Issues of Defining Compensable Events*, 14 INQUIRY 341 (1977).

awards.²³ For efficiency reasons, a minimal eligibility threshold would apply, such as four weeks of lost work time or a few thousand dollars in medical expenses. Claims for more minor injuries would fall outside the health court's jurisdiction and be actionable in tort, though in practice, attorneys are generally unwilling to take on claims of such low expected value.

Claimants who were dissatisfied with the health court's decision could appeal to a higher-level administrative tribunal and, after that, to a judicial court. Appellate bodies would apply a deferential standard of review.

III. STATE CONSTITUTIONAL ISSUES

We begin our analysis of the constitutional implications of health courts with the prudent lawyer's best friend—a caveat. The decisions of state courts on these constitutional challenges will not be uniform. When we examined previous challenges to medical malpractice reforms, we observed considerable variability among the state courts, even when courts were addressing similar laws under virtually indistinguishable constitutional texts.²⁴ Conclusions drawn in this Article cannot be a substitute for a targeted analysis of the judicial decisions in a particular state. Our goal is to describe generally how state courts are likely to approach claims that health courts violate state constitutions, and to provide a roadmap for analysts seeking to investigate the likelihood that a health court would survive state constitutional challenge in a particular jurisdiction.

A. *State Constitutions and the Features of Health Courts*

The types of state constitutional challenges health courts would face are readily identifiable from an analysis of states' historical experiences with other tort reforms and consideration of how the particular features of health courts would be perceived as affecting rights at common law. Challenges could be brought under five constitutional provisions²⁵: (1) equal protection

²³ For a summary of approaches to designing such a schedule, see DAVID M. STUDDERT & MICHELLE M. MELLO, *OPTIONS FOR RATIONAL SCHEDULING AND VALUATION OF NONECONOMIC DAMAGES*, REPORT TO THE WASHINGTON STATE NONECONOMIC DAMAGES TASK FORCE (2005).

²⁴ The diversity was much larger across states than within them. The inter-state variability seemed to be more pronounced in areas where state constitutions speak and the U.S. Constitution is silent. Where the state and federal constitutional provisions are similar—as in equal protection and due process jurisprudence—state courts have tended to follow the lead of the federal courts, and their decisions are therefore more uniform. Where the provision at issue has no federal analog, state courts have taken cognizance of each other's decisions but are not compelled to follow them.

²⁵ In some states, other constitutional provisions may provide additional avenues of legal challenge. Some states have, for example, "single subject" provisions preventing a legislature from creating "Christmas Tree" legislation—statutes that combine multiple, often unrelated provisions in a single bill—as a political strategy. *See, e.g.*, *Evans v. State*, 56 P.3d 1046, 1069–70 (Alaska 2002); *Associated Builders & Contractors v. Ventura*, 610 N.W.2d 293, 301–02 (Minn. 2000). Litigants have occasionally attacked medical malpractice reforms on

of the laws; (2) due process; (3) separation of powers; (4) right to jury trial; and (5) open courts and right to remedy (hereinafter “access to courts”).²⁶ Although state constitutions vary considerably, almost every state has some version of these five provisions,²⁷ the first three of which have counterparts in the U.S. Constitution. To keep our discussion concise, we do not dwell on the origins and historical interpretation of these provisions, but focus on analyzing how each has been applied in challenges to medical malpractice tort reforms and considering how they are implicated by health courts proposals.

1. Equal Protection

Generally tracking the federal provision, state equal protection clauses forbid a state from denying any person legal rights equal to those afforded others.²⁸ Equal protection challenges to malpractice reforms have alleged that the legislation creates impermissible distinctions between medical malpractice plaintiffs and plaintiffs in other types of personal injury litigation, between malpractice defendants and other tortfeasors, and (in cases challenging caps on damages) between malpractice plaintiffs with large and small losses.²⁹ State courts generally have applied the federal framework for tiered scrutiny and evaluated malpractice legislation under rational basis review, finding no suspect class or fundamental right to be implicated.³⁰ The actual degree of scrutiny under the ostensibly rational basis review has varied from state to state, however, with some courts taking a fairly hard look at the evidence supporting the legislature’s finding that the reform would serve its intended policy purpose of arresting the rise of physicians’ professional liability insurance premiums.³¹

Equal protection has been a common basis for challenging caps on noneconomic damages, and under the same logic could be a vehicle for challenging the use of a schedule of noneconomic damages in a health court system. As in claims against flat-dollar caps, it could be alleged that a dam-

such grounds, claiming that a comprehensive reform bill with numerous provisions violated the requirement that no bill address more than one subject. *See, e.g.,* *Street v. City of Anniston*, 381 So. 2d 26 (Ala. 1980). These and similar provisions are idiosyncratic and should be known to policy makers in the individual states. We do not address them here.

²⁶ We address separately the issues surrounding patient consent to inclusion in a demonstration project or even a permanent system based on actual or “deemed” opting-in. *See infra* Part V.

²⁷ Open-courts and right-to-remedy provisions appear in forty of the fifty state constitutions, generally in states admitted to the Union later than the original colonies. *See* Thomas R. Phillips, *The Constitutional Right to a Remedy*, 78 N.Y.U. L. REV. 1309, 1310 (2003).

²⁸ In one state in our sample in which the constitution does not contain an equal protection clause, the state’s due process clause is read as containing the equivalent of the federal equal protection provision. *See, e.g.,* *Garhart v. Columbia/HealthOne*, 95 P.3d 571, 583 (Colo. 2004).

²⁹ Carly N. Kelly & Michelle M. Mello, *Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation*, 33 J.L. MED. & ETHICS 515, 522 (2005).

³⁰ *Id.*

³¹ *Id.* at 522–23.

ages schedule constrains medical malpractice plaintiffs in their recoveries more than other tort victims and protects malpractice defendants against large judgments more than other tortfeasors. Because a damages schedule, unlike a flat cap, would apply to injuries of all levels of severity (excluding those that did not qualify for inclusion in the health court scheme), it would not be feasible to argue that the schedule discriminated among malpractice plaintiffs with low- and high-value claims, fully compensating some while denying full compensation to others.

If, however, introduction of health courts occurred gradually by beginning with experimentation in a single medical center or particular class of events, an approach for which we have previously advocated,³² a more promising version of the equal protection argument may be available to malpractice plaintiffs. Injured patients could argue that caps, eligibility thresholds, or other restrictive measures associated with the health court's exclusive jurisdiction mean that their injuries are subjected to rules that do not bind patients who sustain injuries in institutions or clinical contexts not covered by the new scheme.

In addition, equal protection objections could be made against a health court's use of collateral-source offsets, which also restrict claimants' recoveries. Similarly, equal protection could be the basis for a challenge to the health court's periodic payment provision. It should be noted, however, that both collateral-source offset and periodic payment are already widely in use among the states, having survived such challenges.³³

2. *Due Process*

Federal law divides the due process requirement into two components: procedural and substantive. Procedural due process refers to the fairness of procedures by which an individual's constitutional interests in life, liberty, and property are limited. In procedural due process challenges to tort reform legislation, courts' analyses have tended to focus on whether claimants have a cognizable property interest in a jury's damages award that would trigger constitutional rights to fair pre-deprivation procedures. The answer generally has been "no."³⁴ In jurisdictions that do recognize such a right, the analysis focuses on whether the abrogation of the right is compensated with an appropriate "quid pro quo"—a matter we discuss in depth below.

Substantive due process limits interference with rights attaching to certain domains of individual liberty. The connection to malpractice reforms is tenuous, but in some cases, substantive due process claims have been resolved using much the same framework as has been used to analyze equal

³² See Mello et al., *supra* note 20, at 461.

³³ See generally RONEN AVRAHAM, DATABASE OF STATE TORT LAW REFORMS (2d ed. 2006), available at <http://ssrn.com/abstract=942827>.

³⁴ Kelly & Mello, *supra* note 29, at 523–24.

protection claims.³⁵ Although substantive due process generally has not proved to be a barrier to malpractice reform,³⁶ it can be more potent in the states when considered in connection with access-to-courts clauses, also discussed below.

Several features of health courts raise potential due process concerns. Procedural due process claims may spring from the elimination of juries, the reliance on experts appointed by the court or state rather than retained by litigants, and the possibility that some claims may be resolved on an expedited basis without a live hearing.³⁷ The imposition of an exclusive remedy and binding judgment on persons who may be compromised in their ability to give meaningful consent to be bound by the scheme raises further procedural fairness questions. Additionally, the restrictions on damages (scheduled noneconomic damages, collateral-source offset, and periodic payment) could give rise to claims of deprivation of both procedural and substantive interests in receiving full compensation for losses, as determined by a jury.³⁸

Finally, the appeal process is vulnerable to a procedural challenge. Appeals in the health courts model would not allow *de novo* access to the courts of original jurisdiction. They would be directed either to appellate courts or to trial courts after going through an administrative process. In both cases, the controlling legislation would specify that the standard of review on appeal would be deferential, akin to the “arbitrary and capricious” standard common in review under federal administrative law. Given that the record from a health court proceeding may be less well developed than the record from a full judicial trial, claimants may object that there is insufficient opportunity to obtain a meaningful review on appeal.

3. Separation of Powers

The legislative, executive, and judicial branches of government are meant to be independent and coequal. In particular, the legislature may not encroach on the powers of the judiciary by, for example, legislating away traditional judicial functions.³⁹ Additionally, state courts have often read the state’s constitutional provisions that establish the judicial branch as forbid-

³⁵ This framework hinges on a determination of whether a suspect class or fundamental right is involved. *Id.* at 524.

³⁶ *See, e.g.,* Marco de Sa e Silva, *Constitutional Challenges to Washington’s Limit on Noneconomic Damages in Cases of Personal Injury and Death*, 63 WASH. L. REV. 653, 670 (1988) (noting that state courts have consistently rejected substantive due process challenges to medical malpractice damages caps).

³⁷ The last claim would be difficult to make in light of the provision that a hearing would be held at the request of either party, however.

³⁸ *See* MEHLMAN & NANCE, *supra* note 14, at 109.

³⁹ *See, e.g.,* *Best v. Taylor Mach. Works*, 689 N.E.2d 1057, 1079 (Ill. 1997) (overturning a statute that would have interfered with courts’ ability to order remittitur of a judgment, which was “a traditional and inherent power of the judicial branch of the government”).

ding delegation of judicial power.⁴⁰ One example of a statute offending such provisions is a law providing that non-judges may adjudicate claims on an equal basis with qualified judges.⁴¹

Medical malpractice reforms have sometimes been challenged on separation of powers grounds. The analysis in such cases tends to focus on whether the challenged legislation represents a manifestation or extension of the legislature's right to modify actions at common law, rather than an encroachment on judicial power to administer justice.⁴²

Although separation of powers challenges to damages caps and other reforms generally have been unsuccessful,⁴³ these arguments might have greater traction against health courts because health courts not only modify judicial procedures, but also, depending on the specific design selected, may be construed as moving the adjudication of medical injury claims from the judicial branch to the executive branch.⁴⁴ Should a state choose to locate its health court within an administrative agency, rather than the judiciary, it may be especially vulnerable to the challenge. Reliance on state-appointed experts also could trigger complaints that the legislature has usurped two traditional judicial functions—the qualification of experts and the admission of evidence. A similar argument could be made about damages schedules, which remove some aspects of the determination of damage awards from the courts. Such arguments have been made (unsuccessfully) about flat-dollar caps on damages.⁴⁵

4. *Right to Jury Trial*

Violation of the right to trial by jury is the most obvious constitutional challenge that could be brought to health courts, and the argument is straightforward—health courts are a binding and exclusive remedy that involves no juries. “Liability” and damages are determined by an administrative law judge, and the noneconomic damages schedule that the judge follows is created by the legislature or its designees.

⁴⁰ See, e.g., *Carson Fisher Potts & Hyman v. Hyman*, 559 N.W.2d 54 (Mich. App. 1996) (prohibiting the grant of fact-finding authority to a non-judge expert as an unconstitutional delegation of the judicial power).

⁴¹ *Wright v. Central DuPage Hosp. Ass'n*, 347 N.E.2d 746 (Ill. 1976) (invalidating a statute authorizing a non-judge to participate equally with judges on a malpractice pre-trial screening panel).

⁴² See Kelly & Mello, *supra* note 29, at 525.

⁴³ *Id.* But see *Bernier v. Burris*, 497 N.E.2d 763 (Ill. 1986) (invalidating a pretrial screening panel on separation-of-powers grounds).

⁴⁴ Although no cases in our sample invalidated a statute on precisely that basis, the claim has been made and taken seriously. For example, in *Kranda v. Houser-Norborg Med. Corp.*, 419 N.E.2d 1024, 1036 (Ind. 1981), the court upheld a pre-trial screening panel statute against such an attack, noting that, under the statute as written, although “such power clearly resides with the courts . . . [n]either the Indiana Department of Insurance nor the medical review panel makes an adjudication on the merits of a claim. Neither conducts a hearing or a trial and neither renders a decision or a judgment on the claims before it.”

⁴⁵ Kelly & Mello, *supra* note 29, at 525.

Although there is a jury trial provision in the Seventh Amendment to the U.S. Constitution, the Supreme Court has held that it does not apply to the states.⁴⁶ Virtually every state⁴⁷ has its own constitutional analog, however, that typically provides that the right to trial by jury shall remain inviolate.⁴⁸ Some states define the right narrowly as prohibiting only legislation that blocks claimants from having their claims heard by a jury.⁴⁹ A broader reading in other states would potentially invalidate any legislation that significantly limits the jury's function.⁵⁰ The inquiry in right-to-jury-trial challenges focuses on whether the legislature abridged a right that existed at the time the state constitution was adopted.⁵¹ In litigation over malpractice damages caps, courts have either focused on whether a common law right to recover damages for malpractice existed at that time or on the scope of the jury trial right at that time.⁵²

5. Access to Courts

Thirty-nine state constitutions include some variation of the rule that "courts of justice shall be open to every person, and speedy remedy afforded for every injury of person, property, or character."⁵³ Similar to the open-courts provision, and typically operating in tandem with it, some state constitutions add that "[e]very person is entitled to a certain remedy in the laws for all injuries or wrongs which he may receive to his person, property or character."⁵⁴ Because these two clauses tend to be considered together and in similar ways in judicial decisions on the constitutionality of tort reforms,⁵⁵

⁴⁶ See *Minneapolis & St. Louis R.R. Co. v. Bombolis*, 241 U.S. 211, 218 (1916).

⁴⁷ Colorado and Louisiana are exceptions.

⁴⁸ See, e.g., ALA. CONST. art. I, § 11 ("the right of trial by jury shall remain inviolate"); ARIZ. CONST. art. 6, § 17 ("The right to jury trial as provided by this Constitution shall remain inviolate, but trial by jury may be waived by the parties in any civil cause.").

⁴⁹ See, e.g., *Adams v. Children's Mercy Hosp.*, 832 S.W.2d 898, 907 (Mo. 1992) (upholding a cap on noneconomic damages against a right-to-jury challenge because "the jury assessed liability and then determined damages, both economic and noneconomic. With that the jury completed its constitutional task.").

⁵⁰ See, e.g., *Moore v. Mobile Infirmary Ass'n*, 592 So. 2d 156, 162-65 (Ala. 1992) (striking down a cap on noneconomic damages because it impinged upon determinations reserved for juries under Alabama's constitution).

⁵¹ See, e.g., *State v. Mosley*, 436 S.E.2d 632 (Ga. 1993).

⁵² Kelly & Mello, *supra* note 29, at 525. For a compelling historical argument that the Seventh Amendment does not preclude judges or legislatures from setting parameters for or limits on noneconomic damages (an argument that would apply to state constitutional analogs to the Seventh Amendment as well), see Ronald J. Allen & Alexia Brunet, *The Judicial Treatment of Non-Economic Compensatory Damages in the Nineteenth Century*, 4 J. EMPIRICAL LEGAL STUD. 365 (2007) and Ronald J. Allen et al., *An External Perspective on the Nature of Non-Economic Compensatory Damages and Their Regulation*, 56 DEPAUL L. REV. 1249 (2007).

⁵³ David Schuman, *The Right to a Remedy*, 65 TEMP. L. REV. 1197, 1201 (1992).

⁵⁴ MINN. CONST. art. I, § 8. While the language varies somewhat among the states, this formulation is not untypical.

⁵⁵ Our sample of medical malpractice reform cases contained none in which a legislative act was held to violate a remedies clause but not an open-courts clause. For an excellent dis-

we treat them as essentially constituting a single basis for constitutional challenge.

Access-to-courts provisions frequently have been the basis for challenging malpractice reforms that modify the judicial process for medical injury claims.⁵⁶ The dominant approach among state courts in such cases has been to define the scope of the right narrowly, as a procedural guarantee of the availability of a judicial process, and hold that legislation that merely modifies the rules of trials is permissible.⁵⁷ In states that construe the right more broadly to preclude some legislative attempts to restrict causes of action and remedies, courts conduct an interest balancing to determine the reasonableness of the infringing legislation.⁵⁸ A key decision factor in these states is whether an adequate quid pro quo was provided to those whose rights have been limited.⁵⁹

An access-to-courts challenge is colorable against nearly every major feature of a health court system. The elimination of juries and the possibility that some claims could be adjudicated without a hearing clearly implicate open-courts provisions. The exclusivity of the alternative remedy may likewise test access-to-courts rights, most obviously where the administrative process precludes access to courts either *ab initio* or by way of *de novo* review.⁶⁰ It could also be argued that the replacement of the negligence standard with the avoidability standard eliminates a remedy, in violation of state constitutions. Such challenges would have to contend with the fact that the new standard expands, rather than contracts, the range of medical injuries that are eligible for compensation. The health courts' approach to damages awards could attract access-to-courts objections alleging that the schedule of noneconomic damages and the imposition of collateral-source offsets and periodic payment restrict the remedies available at common law. Finally, the imposition of an administrative appeal layer before claimants could reach judicial review also could serve as a basis for an open-courts challenge.

The foregoing avenues for constitutional challenges to health courts are summarized in Table 1. Other types of claims may also be possible, but these constitute the clearest avenues of challenge. Before discussing how likely it is that any of the challenges might succeed in invalidating a health courts statute, we address one critical issue, relevant to most of the constitutional

cussion of the historical background of remedies clauses, see *Smothers v. Gresham Transfer, Inc.*, 23 P.3d 333 (Or. 2001).

⁵⁶ See Kelly & Mello, *supra* note 29, at 518–20.

⁵⁷ See *id.* at 519–20.

⁵⁸ See *id.* at 519.

⁵⁹ See, e.g., *Kluger v. White*, 281 So. 2d 1, 4 (Fla. 1973) (“[W]here a right of access to the courts for redress for a particular injury has been provided . . . the Legislature is without power to abolish such a right without providing a reasonable alternative . . . unless the Legislature can show an overpowering public necessity.”).

⁶⁰ Exclusivity would become particularly difficult under right-to-remedy clauses if the new eligibility criteria excluded any case that the traditional tort system might have allowed. Our health courts proposal does not have this feature, however.

objections and almost certain to be visited in judicial evaluations of health courts: the quid pro quo requirement.

TABLE 1. FEATURES OF HEALTH COURTS RAISING POTENTIAL CONSTITUTIONAL CONCERNS

Feature	Potential constitutional challenges
Restricted eligibility	Equal protection
Location within an administrative agency	Separation of powers
Elimination of juries	Right to jury trial; access to courts; due process
Elimination of negligence standard	Access to courts
Exclusive remedy / binding judgment	Access to courts; due process
Reliance on state-appointed experts	Due process; separation of powers
Some judgments reached without live hearing	Access to courts; due process
Scheduled noneconomic damages	Right to jury trial; access to courts; equal protection; due process; separation of powers
Collateral-source offset	Access to courts; equal protection; due process
Periodic payment	Access to courts; equal protection; due process
Appeals process	Access to courts; due process

B. The Quid Pro Quo Requirement

None of the constitutional provisions just described are absolute prohibitions against legislatures changing what traditionally has been a judicial process. If they were, the law could well be frozen in time without hope of ever adapting to shifting social and economic preferences and conditions. The provisions operate instead as filters and frictions, to assure that as environmental changes dictate legal changes, fundamental expectations of governmental decency and juridical fairness are neither sacrificed nor forced to evolve too quickly in the name of modernity or at the whim of transient sentiment.⁶¹ Procedural due process is tested against a slowly evolving standard of fundamental fairness; equal protection, by whether the new law discriminates in ways that advance evolving notions of proper state interests and their importance. A substantial majority of the states have developed similarly plastic tests for their constitutions' provisions on the right to jury

⁶¹ We mean this as our own observation about the process of constitutional adjudication viewed over the long term, not as an articulated juridical principle.

trial and access to courts. We explore these frameworks, which hinge on the notion that an abridgment of traditionally held rights is counterbalanced by some compensating benefit—an appropriate *quid pro quo*.

1. *Three Questions for Evaluating the Right to Jury Trial*

We begin with the right to trial by jury, the right most clearly implicated by health courts. State constitutions typically promise that “the right of trial by jury as heretofore enjoyed shall remain inviolate.”⁶² Not every state includes the words “as heretofore enjoyed,” but most states’ courts adopt the idea in their jurisprudence.⁶³ For a myriad of reasons—sometimes as a way of parceling out authority between the legislature and the judiciary, sometimes as a way of affording ground for legal change as well as stability—these courts hold that jury trials are guaranteed only for claims that were recognized as causes of action heard by a jury as of some identifiable date, typically the date when the constitution was adopted.⁶⁴ An initial question, therefore, is whether medical malpractice was a jury-triable cause of action at that time. The dominant answer among state courts is “yes,” because medical malpractice is regarded as a species of ordinary negligence-based personal injury, which predated most state constitutions.⁶⁵

Assuming that the cause of action is within the scope of constitutional protection, the second question is whether a legislature may abrogate or limit the right. States have given two different answers: “yes” and “maybe.” In “yes” states, the rationale for allowing legislative change is that it is permissible for legislatures to abolish a right entirely (as most states have with respect to alienation of affection, for example); hence, it is logically within the legislature’s authority to leave a right in place but limit or condition access to it.⁶⁶ The other frequently accepted argument in “yes” states is that the open-courts clause—operating in these cases in tandem with the right to a jury trial—is meant not as a limit on legislative action, but rather as a protection of the citizenry against courts themselves acting to delay, deny, or hinder access to justice.⁶⁷

In the “maybe” states, the key test (of due process in some, of impermissible abrogation in others) is that of the *quid pro quo*. Thus, even where the cause of action affected by the new legislation is within the embrace of

⁶² *Supra* note 48.

⁶³ *See, e.g.*, *State v. Mosley*, 436 S.E.2d 632 (Ga. 1993).

⁶⁴ *See id.*

⁶⁵ *See, e.g.*, *Kirkland v. Blaine County Med. Ctr.*, 4 P.3d 1115, 1118 (Idaho 2000). This is not the case for every kind of medical malpractice claim, however. Wrongful death actions, for example, were created in many states as legislative enactments some time after adoption of their constitutions, and as such are not as protected against legislative abrogation as other medical injury claims. *See, e.g.*, *Travelers Indem. Co. v. Fuller*, 892 S.W.2d 848, 850–51 (Tex. 1995).

⁶⁶ *See, e.g.*, *Rybeck v. Rybeck*, 358 A.2d 828, 842 (N.J. Super. Ct. Law Div. 1976) (upholding automobile no-fault law).

⁶⁷ *See, e.g.*, *Meech v. Hillhaven West, Inc.*, 776 P.2d 488, 492 (Mont. 1989).

the jury-trial clause, the legislature may obstruct access to courts and jury trials if it either provides an adequate substitute remedy,⁶⁸ identifies an imperative public need that no other practical alternative can satisfy,⁶⁹ or, in a few states, neither.⁷⁰ In fact, the difference between the “yes” states and the “maybe” states is less crisp than it might appear. Even in states that permit their legislature to abrogate the common law, the enactments must still pass the tests of equal protection and due process, among others.⁷¹

While not every state would articulate the relationships among open courts, jury trial, due process, and the quid pro quo requirements in this way, the following is not an atypical formulation: “The legislature can modify the right to a jury trial . . . [but] modification of the common law must meet due process requirements and be reasonably necessary in the public interest Due process requires that the legislature substitute [a] statutory . . . remedy . . . to replace the loss of the right.”⁷²

The third question that has resulted in variation among the states regards how much quid is needed for a given quo. In our study of the case law, no constant measuring rods for the social bargain appear. Moreover, the states differ even on what counts as part of the benefits of the substituted remedy.

At one extreme, some courts have been willing to consider the legislative substitution adequate if society as a whole is better off with the new system than it was under the old.⁷³ At the other extreme, some courts ask whether a particular plaintiff now has a remedy as good as that which was

⁶⁸ See, e.g., *Judd v. Drezga*, 103 P.3d 135, 139 (Utah 2004) (upholding cap on noneconomic damages in medical malpractice cases).

⁶⁹ See, e.g., *Kluger v. White*, 281 So. 2d 1, 4 (Fla. 1973) (invalidating auto no-fault law); *Smith v. Dep’t of Ins.*, 507 So. 2d 1080, 1089 (Fla. 1987) (invalidating medical malpractice damage cap).

⁷⁰ See, e.g., *Bushnell v. Sapp*, 571 P.2d 1100, 1103–04 (Colo. 1977) (upholding an automobile no-fault law). In states that hold either that the cause of action is not within the constitutional protection in the first place or that the open-courts clause is a guardian against a politically captured judiciary, the remaining limitation is that of due process: the legislation must be a rational and non-arbitrary response to a legitimate state objective. For an example of such an interpretation of the open-courts provision, see *Adams v. Children’s Mercy Hosp.*, 832 S.W.2d 898, 905–06 (Mo. 1992) (open-courts challenge to medical malpractice cap).

⁷¹ See, e.g., *Sims v. U.S. Fid. & Guar. Co.*, 730 N.E.2d 232, 237 (Ind. Ct. App. 2000) (“The General Assembly can abrogate common law rights as remedies, as long as doing so does not interfere with constitutional rights.”).

⁷² *Samsel v. Wheeler Transp. Servs., Inc.*, 789 P.2d 541, 555 (Kan. 1990) (citing Howard A. Learner, Note, *Restrictive Medical Malpractice Compensation Schemes: A Constitutional “Quid Pro Quo” Analysis to Safeguard Individual Liberties*, 18 HARV. J. ON LEGIS. 143 (1981)).

⁷³ See, e.g., *Bonin v. Vannaman*, 929 P.2d 754, 768–69 (Kan. 1996) (upholding medical malpractice statute of repose on ground that “continued availability of healthcare in Kansas” was a sufficient quid pro quo); *Olson v. Bismarck Parks & Recreation Dist.*, 642 N.W.2d 864, 870 (N.D. 2002) (upholding statute providing tort immunity to landowners who allow the public to use the land for recreation, holding that the benefit is an encouragement of private landowners to allow their land to be used in that way); *Craftsman Builder’s Supply v. Butler Mfg.*, 974 P.2d 1194, 1199–1200 (Utah 1999) (upholding builders’ statute of repose on grounds that extended liability would ultimately increase the cost of living in the state).

taken away.⁷⁴ In between are those that would validate a new system if the class of people likely to be affected, taken as whole, has a remedy as good as before.⁷⁵

Proponents of health courts have advanced a series of arguments that have relevance to each level of the benefit inquiry: administrative compensation is vastly more efficient than jury-based tort litigation; recoveries come sooner and with less difficulty; more people will be compensated under an avoidability standard than would be the case under negligence; predictability in compensation will help stabilize liability insurance markets, leading to gains (or at least no further erosion) in access to medical services; and, because it enhances the prospects for reducing medical errors, the new system will improve the quality of care for all.⁷⁶ Though compelling, none of these advantages are trumps. Most are hoped for, but untested. Moreover, in quid pro quo analyses that focus on remedies and advantages afforded to particular claimants, it will always be possible to point to or imagine patients who had a compelling case before a traditional jury and stand to gain little from a shift to health courts.

Based on the case law we have examined, it is not possible to predict which path, among the several choices, a given state court would take on the basis of differences in their constitutional texts. Because health courts would differ in important ways from previously enacted medical malpractice reforms, the case law involving previous reforms is likewise insufficient to offer a metric for health courts. We therefore looked at two other areas in which the quid pro quo question had been posed concerning reforms that eliminated jury adjudication: workers compensation and automobile no-fault.

2. *The Workers' Compensation Bargain*

The workers' compensation system encountered the same kinds of challenges that we have described for health courts—access to courts, right to jury trial, due process, equal protection, and separation of powers—and in the vast majority of cases overcame them.⁷⁷ Two separate rounds of litigation

⁷⁴ See, e.g., *Wright v. Cent. DuPage Hosp. Ass'n*, 347 N.E.2d 736, 742 (Ill. 1976) (specifically denying that a social benefit—greater healthcare access from reduced medical liability insurance premiums—is a sufficient quid pro quo); *Lucas v. United States*, 757 S.W.2d 687, 690 (Tex. 1988) (rejecting the argument “that the statue may be supported by alleged benefits to society generally”).

⁷⁵ See, e.g., *Gentile v. Altermatt*, 363 A.2d 1, 15 (Conn. 1976) (upholding automobile no-fault law); *Estabrook v. American Hoist & Derrick, Inc.*, 498 A.2d 741, 750 (N.H. 1985) (invalidating statutory amendment to workers compensation system that would benefit all employer-defendants and limit recovery possibilities by employee-plaintiffs); *In re Knowles*, 544 N.W.2d 183, 191 (S.D. 1996) (holding medical malpractice damage cap unconstitutional); *Lawson v. Hoke*, 77 P.3d 1160 (Or. Ct. App. 2003) (upholding automobile no-fault law).

⁷⁶ See Mello et al., *supra* note 20, at 471–87.

⁷⁷ Some states, such as Wyoming, California, Ohio, and Pennsylvania, found it necessary to pass constitutional amendments to overcome the constitutional problems. See, e.g., Jackson

occurred, one when the laws were originally enacted in the early 20th century and the other in the period between 1970 and 1990 when a round of fairly major reforms was made to programs nationwide. The first round challenged statutes that moved workplace injury claims from the negligence-based tort system to an administrative process with a right to bring a limited appeal in the traditional courts, tightly constrained damage schedules, and (often) exclusivity of remedy. The early challenges were typically brought not by workers but by employers, who perhaps saw the no-fault guarantee as an unfavorable alternative because it created an ongoing source of insurance costs. By and large, courts held that the exchange was an adequate quid pro quo.⁷⁸ In return for sure and speedy compensation, workers forwent common law claims. Employers, on the other hand, gained broad immunities from full-blown litigation at a time when historical barriers to workers' recovery, such as fellow servant and assumption of risk doctrines, were beginning to be eroded by the courts.⁷⁹ Society avoided a looming tidal wave of expensive litigation over workplace injuries.

The second round of challenges was brought in the 1970s and 1980s by injured workers. In this era, states had adopted a round of reforms to their workers' compensation systems, often reducing eligibility for compensation.⁸⁰ The question litigated was whether a bargain originally validated on quid pro quo grounds could be invalidated when the deal was modified in a single (pro-employer) direction. Most courts refused to do a marginal analysis, asking instead whether the system as amended would have survived the initial challenge and validating it where, as was almost always the case, it would have.⁸¹

v. Dravo Corp., 603 F.2d 156 (10th Cir. 1979); Benjamin v. Ricks, 132 Cal. Rptr. 758 (Cal. Ct. App. 1976).

⁷⁸ See, e.g., Sims v. U.S. Fid. & Guar. Co., 782 N.E.2d 345, 352 (Ind. 2003). The United States Supreme Court in *New York Cent. R.R. Co. v. White*, 243 U.S. 188, 201–02 (1917)—the case first suggesting, though not requiring, the quid pro quo criterion—described the bargain as follows:

If the employee is no longer able to recover as much as before . . . he is entitled to moderate compensation in all cases of injury, and has a certain and speedy remedy without the difficulty and expense of establishing negligence or proving the amount of the damages. . . . On the other hand, if the employer is left without defense respecting the question of fault, he at the same time is assured that the recovery is limited, and that it goes directly to the relief of the designated beneficiary. . . . The act evidently is intended as a just settlement of a difficult problem, affecting one of the most important of social relations, and it is to be judged in its entirety.

⁷⁹ Price v. Fishback & Shawn Everett Kantor, *The Adoption of Workers' Compensation in the United States, 1900-1930*, 41 J.L. & ECON. 305, 313–14 (1998).

⁸⁰ For example, Wyoming amended its original act to redefine compensable mental injuries to include only those that result from a compensable physical injury. 1994 Wyo. Sess. Laws Ch. 86 (codified as amended at WYO STAT. ANN. § 27-14-102(a)(xi)(J) (2005)). The economic exigencies leading to these and other states' amendments are discussed by the court in *In re Merta Franz*, 932 P.2d 750 (Wyo. 1997).

⁸¹ See, e.g., Thone v. Liberty Mut. Ins. Co., 549 A.2d 778, 780–81 (N.H. 1988) (upholding amendments); Young v. Prevue Prods., Inc., 534 A.2d 714, 717 (N.H. 1987) (same). But see Grantham v. Denke, 359 So. 2d 785 (Ala. 1978) (holding invalid an amendment to Alabama's

The workers' compensation cases are helpful for thinking about the constitutionality of a health court because both schemes completely replace the tort system with an exclusive, binding administrative remedy with limited appeal rights. The loss of rights for claimants is similar. The quid pro quo is not equal, however. Both schemes broaden eligibility for compensation, but the replacement standard for workers' compensation, strict liability, is more generous toward claimants than the avoidable injury standard of health courts. Moreover, no abrogation of defenses is contemplated in health courts proposals, whereas workers compensation legislation eliminated the fellow-servant doctrine, which had been a substantial impediment to recovery in many cases. Arguably, therefore, workers' compensation programs provided more quid than would health courts.

Workers' compensation jurisprudence makes clear that the bargain struck in that legislation was adequate, but unfortunately gives few clues as to how high the clearance was or where the bar lies. A potentially more promising analogy is to the automobile no-fault schemes enacted by a number of states in the 1970s.⁸²

3. *Automobile No-Fault Schemes*

It has never been economically feasible for plaintiffs to bring small claims in tort for damages and minor personal injuries arising from motor vehicle accidents. But these are by far the most common type of accident insurance claim, and their sheer volume clogged insurers' claims systems.⁸³ Taking cues from suggestions in the academic literature, state legislatures passed statutes shifting the system from third-party to first-party insurance, in which drivers would insure themselves for minor accidents and have their economic losses reimbursed by their own insurer on a contractual basis, with no fault or liability determination required.⁸⁴

Like workers' compensation laws, these statutes were, on the whole, treated favorably by the courts. A common judicial sentiment expressed in

optional workers' compensation system that eliminated tort actions against a co-employee on the ground that the original bargain was to promote workplace safety, which the amendment at issue would not do). It should be noted, however, that Alabama's workers' compensation system is technically optional, and is seen as a trade between employer and employee. *See also* Easton W. Orr, Jr., Note, *The Bargain Is No Longer Equal: State Legislative Efforts to Reduce Workers' Compensation Costs Have Impermissibly Shifted the Balance of the Quid Pro Quo in Favor of Employers*, 37 GA. L. REV. 325 (2002) (analyzing decisions holding that the correct analysis is to assess the statute as amended).

⁸² For example, see Pennsylvania No-Fault Motor Vehicle Insurance Act, PA. STAT. ANN. tit. 40, § 1009.101 et seq. (1974) (repealed 1984) and the Pennsylvania Supreme Court's analysis in *Singer v. Sheppard*, 346 A.2d 897 (Pa. 1975). Like other such statutes, the Pennsylvania statute barred low-level automobile accident damage claims from the tort system in exchange for providing mandatory first-party no-fault recovery.

⁸³ For a review of state statutes and the financial problems they were designed to address, see INSURANCE INSTITUTE, NO-FAULT AUTO INSURANCE, <http://www.iii.org/media/hottopics/insurance/nofault.I/> (last visited Nov. 10, 2007).

⁸⁴ *See supra* note 82 and accompanying text.

these cases was that the legislature had replaced a cumbersome remedy with an efficient one, even if the claimants did have to pay the insurance premium themselves.⁸⁵ Courts were satisfied that the “prompt and sure recovery of economic loss” was an adequate substitute for a “delayed and uncertain” award.⁸⁶ One case also deemed it an adequate quid pro quo that although a cap was placed on noneconomic losses under the no-fault law, the statute removed the courts’ ability to impose remittitur on noneconomic damage awards.⁸⁷

The courts’ emphasis on the certainty and celerity of compensation in automobile no-fault systems, as compared with the contingencies of tort litigation, is highly salient for thinking about how health courts might be evaluated. However, there are obvious distinguishing factors. Like injured workers, injured drivers need only show that their injuries were causally connected to the covered activity; in contrast, injured patients would need to persuade a health court of both causality and avoidability. In this regard, health courts again appear to offer a less substantial quid pro quo than their historical analog. Additionally, most of the automobile no-fault laws effectively displaced litigation over minor or moderate losses but preserved the right to sue for economic (or all) damages in excess of the insured amount.⁸⁸ The health court flips this in its carve-out approach, excluding very small losses but capturing all claims with injuries above the minimum severity threshold.

4. Other Precedent

Cases in other areas shed some additional light on how courts may approach the quid pro quo balancing exercise, though they do not support any broad generalization. In Kansas, for example, a statute abrogating hospitals’ vicarious liability for their physicians’ negligence was upheld because the statute also provided for mandatory risk management and a liability insurance pool linked to the hospital’s immunity.⁸⁹ The resulting assurance of payment, combined with promised improvements in health care quality and availability, was held to be a sufficient quid pro quo.⁹⁰ It should be noted,

⁸⁵ See, e.g., *Samsel v. Wheeler Transp. Servs.*, 789 P.2d 541 (Kan. 1990).

⁸⁶ *Singer v. Sheppard*, 346 A.2d 897, 904 (Pa. 1975); see also *Bonin v. Vannaman*, 929 P.2d 754, 769 (Kan. 1996) (quoting *Aves ex rel. Aves v. Shah*, 258 Kan. 506, 522–23 (1995)) (noting that the quid pro quo for automobile no-fault was “prompt efficient payment” and for workers’ compensation was a reduced burden of proof for recovery); *Lasky v. State Farm Ins. Co.*, 296 So. 2d 9, 14 (Fla. 1974); *Pinnick v. Cleary*, 271 N.E.2d 592, 598 (Mass. 1971).

⁸⁷ *Samsel*, 789 P.2d at 557–58.

⁸⁸ This feature was explicitly noted by some courts. See, e.g., *Lawson v. Hoke*, 77 P.3d 1160, 1164–66 (Or. Ct. App. 2003).

⁸⁹ *Lemuz ex rel. Lemuz v. Fieser*, 933 P.2d 134 (Kan. 1997).

⁹⁰ *Id.* at 959.

however, that Kansas is among the few states holding that a broad public benefit is sufficient to satisfy the quid pro quo requirement.⁹¹

In Louisiana, a \$500,000 medical malpractice cap was upheld because the same statute that created the cap also created a state insurance fund which could not contest liability in cases where one of the claimed defendants had paid or settled for at least \$100,000.⁹² In exchange for being deprived of the ability to recover large awards, claimants became better able to collect judgments because physicians were more likely to be covered by a solvent insurer and the plaintiff could recover economic losses without further liability being contested.⁹³ The court deemed this tradeoff fair.⁹⁴ Again, however, there are generalizability concerns: Louisiana is one of the very few states that do not have a constitutional right to jury trial.⁹⁵

We note, finally, litigation concerning a Florida statute that imposed caps on noneconomic damages in malpractice cases and provided, in essence, encouragement to both parties to agree to arbitrate.⁹⁶ If the defendant offered to arbitrate and the plaintiff declined, there would be a \$350,000 cap on noneconomic damages; if the plaintiff agreed, a \$250,000 cap would apply. The Florida Supreme Court found that there were commensurate benefits in exchange for the cap, and that these benefits were both public and private in nature.⁹⁷ It found that private plaintiffs enjoyed the advantages that arbitration brings: prompt recovery, relaxed evidentiary and procedural standards, and (due to a pre-suit investigation requirement) a rapid determination by the defendant of its probable liability. Additionally, the court noted that Floridians as a whole benefited from the effects that the cap was expected to have on the liability insurance market.⁹⁸ The court found reasonable the legislature's conclusions that the malpractice insurance crisis in Florida in the mid-1980s had led to higher health care prices as providers passed on their increased insurance premium costs, had left some physicians unable to find insurance coverage, and had made policy action necessary as a matter of public necessity.⁹⁹ Further, the court held that the legislature had reasonably concluded that damages caps would help address these problems better than

⁹¹ See Lemuz, *supra* note 89, at 148–49 (finding an adequate quid pro quo in the reduction of medical errors and the favorable effect it would have on healthcare costs).

⁹² *Butler v. Flint Goodrich Hosp.*, 607 So. 2d 517, 519 (La. 1992).

⁹³ *Id.* at 521.

⁹⁴ *Id.*

⁹⁵ See David A. Anderson, *First Amendment Limitations in Tort Law*, 69 *BROOK L. REV.* 744, 793 (2004) (noting that “almost all” states guarantee a right to jury trial in civil cases).

⁹⁶ *University of Miami v. Echarte*, 618 So. 2d 189 (Fla. 1993). The entire legislative scheme and the court's reasoning were more complex than is conveyed in this brief summary.

⁹⁷ *Id.* at 195–98.

⁹⁸ *Id.*

⁹⁹ *Id.* at 196–98.

other reforms.¹⁰⁰ Subsequent rulings implied that the perceived social benefits may have been particularly persuasive in the court's calculus.¹⁰¹

Considered as a whole, existing case law addressing the question of what constitutes an adequate quid pro quo is remarkable more for its diversity than for the degree to which it depicts how courts are likely to weigh the tradeoffs associated with health courts. A key variable in the weighing exercise will be whether the courts of the sponsoring state tend to focus on benefit to the present claimant, benefit to the class of people affected (including all potential claimants), or benefit to society. We consider specific arguments that may be made at each of these levels later in the Article.

IV. PREDICTIONS ABOUT VALIDATION AND NULLIFICATION

Niels Bohr once quipped, "Prediction is very difficult, especially about the future." Bohr's field of quantum physics offers an apt analogy for our own investigation into state constitutional challenges to health courts. Quantum mechanics replaces observable causality with statistical probability. Because health courts come with combinations of features not previously addressed in most states, predictions based on traditional legal analysis are less certain than is usually the case. The exercise is nonetheless important. Gaining some sense of how the cluster of features associated with the health courts model might fare in state constitutional challenges may offer guidance about the kinds of design choices that could impair or improve the fit of health courts with the values expressed in the state constitutions. We aimed to accomplish this by systematically reviewing how other malpractice reforms have fared in state constitutional challenges.

We suspected at the outset that there would be significant variability among the states,¹⁰² and this was quickly confirmed. As already noted, ex-

¹⁰⁰ *Id.*, described in Kelly & Mello, *supra* note 29, at 520.

¹⁰¹ In 2000, the Florida Supreme Court invalidated a portion of Florida's no-fault automobile law because it required medical providers to arbitrate claims assigned to them by patients against personal injury protection insurers. *Nationwide Mut. Fire Ins. Co. v. Pinnacle Med., Inc.*, 753 So. 2d 55 (Fla. 2000). Arbitration, the court held, denies providers their right to trial and limits the right of appeal without providing adequate offsetting benefit. This suggests that it may have been the societal benefit in the damages caps case that tipped the scales in favor of finding an adequate quid pro quo.

¹⁰² One source of variability is heterogeneity in constitutional texts. *See, e.g.*, Phillips, *supra* note 27 (noting that forty states have right-to-remedy clauses in their constitutions, appearing in thirty-two different formulations and referred to by eight different names). Additionally, studies reported in the political science literature have identified exogenous variables affecting judicial behavior in constitutional cases. One study, for example, found that judges whose appointments are made through a nominating and merit system are less likely to invalidate legislative acts than are those in states with appointments processes that are more overtly political. James Wenzel et al., *Legislating From the State Bench: A Comparative Analysis of Judicial Activism*, 25 AM. POL. Q. 363 (1997) (concluding that "politicization enhances the propensity of courts to behave in activist fashion" and that "the most activist courts [those most likely to overturn legislation] are in states where justices reach office through district-based [rather than statewide] electoral systems"). *See also* Craig Emmert, *An Integrated Case-Related Model of Judicial Decision-Making: Explaining State Supreme Court Decisions*

cept for state constitutional provisions with federal analogs (principally, equal protection and due process), state courts tend to rely on their own juridical histories rather than seeking consonance with decisions on the same issues in other states, as they might when interpreting a Uniform Act. As a result, finding that a certain proportion of the states would validate a particular feature under an open-courts clause does not allow us to say anything about the probability of validation in any particular state. It is thus an opportune moment to repeat the caveat that nothing one can say by way of overview is a substitute for close analysis one state at a time. The results of a survey can, however, signal the kinds of questions a single-state analysis should explore and, with less certainty but equal importance, the kinds of design features that require close attention.

A. *Previous Reviews of the Constitutionality of Malpractice Reforms*

We began by searching the literature for previous articles that analyzed outcomes of constitutional litigation over malpractice reforms. Prior to the mid-1980s, published analyses were limited to either reviews of the decisions of a single state's courts or student papers that examined multiple states but in a somewhat superficial fashion. Constitutional challenges to reforms adopted in response to the malpractice crisis of the mid-1970s had just begun to work their way through the courts in the mid-1980s. Malpractice reforms were struck down in Idaho, Illinois, North Dakota, and Ohio in the late 1970s¹⁰³ and were upheld in Maryland, Wisconsin, and New York.¹⁰⁴ A broader range of constitutional challenges was anticipated,¹⁰⁵ but had not yet come to pass.

By the mid-1980s, a modest body of case law had accumulated concerning caps on damages, pretrial screening panels, and other tort reforms.¹⁰⁶ Several papers from this period reviewed the types of claims being brought and tallied up the outcomes.¹⁰⁷ A few of these summarized individual case

in *Judicial Review Cases*, 54 J. POL. 543 (1992) (multivariate analysis of all decisions challenging the constitutional validity of state statutes between 1981 and 1985). Thus, political factors may also account in part for variability in judicial decision-making.

¹⁰³ See Richard S. Kuhl, Comment, *A Proposal to Cap Tort Liability: Avoiding the Pitfalls of Heightened Rationality*, 20 U. MICH. J.L. REFORM 1215, 1225 & n.54 (1986-1987).

¹⁰⁴ See Richard C. Turkington, *Constitutional Limitations on Tort Reform: Have the State Courts Placed Insurmountable Obstacles in the Path of Legislative Responses to the Perceived Liability Insurance Crisis?*, 32 VILL. L. REV. 1299, 1317 n.52 (1987).

¹⁰⁵ See Martin H. Redish, *Legislative Response to the Malpractice Insurance Crisis: Constitutional Implications*, 55 TEX. L. REV. 759 (1977).

¹⁰⁶ See Turkington, *supra* note 104, at 1317 nn.52-53.

¹⁰⁷ See *id.*; Gary D. Jensen, *Legislative Larceny: The Legislature Acts Unconstitutionally When It Arbitrarily Abolishes or Limits Common Law Redress for Injury*, 31 S.D. L. REV. 82 (1985-1986); Larry S. Milner, *The Constitutionality of Medical Malpractice Legislative Reform: A National Survey*, 18 LOY. U. CHI. L.J. 1053 (1986-1987); David Randolph Smith, *Battling a Receding Tort Frontier: Constitutional Attacks on Medical Malpractice Laws*, 38 OKLA. L. REV. 195 (1985); Ronald E. Wagner & Jesse M. Reiter, *Damage Caps in Medical Malpractice: Standards of Constitutional Review*, 1987 DETROIT C.L. REV. 1005 (1987). How-

outcomes in narrative fashion and highlighted factors that were influential in driving case outcomes and distinguishing cases.¹⁰⁸ Chief among these factors was the level of scrutiny applied by the court: commentators distinguished jurisdictions that analyzed tort reforms using a true rational basis standard (and upheld them) from jurisdictions that used a heightened standard (and generally struck them down).¹⁰⁹ Other outcome predictors in cases considering caps on damages were the type of damages limited by the cap (noneconomic damages caps generally withstood challenge better than total damages caps) and the existence of an adequate quid pro quo.¹¹⁰ The quid pro quo criterion, in particular, was noted in these articles to be a key factor explaining the decisions of some state courts to invalidate damages caps in malpractice cases while upholding damages limitations in other incursions into tort law, such as workers' compensation, that offered "no-fault" remedies.¹¹¹ In right-to-jury-trial claims, the determinative factors were said to be the particular language of the state constitutional provision, the degree of importance placed on the right, the court's view about whether the right encompassed jury determination of damages, and the level of judicial scrutiny applied.¹¹²

The 1970s–1980s studies drew varying conclusions about the constitutionality of malpractice reforms overall. Early analyses were optimistic, noting that the criteria for passing rational basis review seemed clearly to be met.¹¹³ But by the mid-1980s, some commentators had grown more pessimistic, noting the considerable proportion of state constitutional challenges that had succeeded,¹¹⁴ the most immediate explanation for which was the application of standards of review that were more rigorous than had been anticipated.¹¹⁵

Legal scholarship on malpractice reforms ebbed and flowed with periods of volatility in the malpractice insurance market, and virtually disappeared during the halcyon days of the 1990s. When a new insurance crisis was declared around 2000, scholars responded with a number of fresh analyses of the status of constitutional challenges to tort reforms.¹¹⁶ However,

ever, most of the literature from this era again consisted of somewhat superficial student papers. *See, e.g.*, Kuhl, *supra* note 103; Wesley Leonard & Marcia Blase Stevens, Comment, *Legislative Limitations on Medical Malpractice Damages: The Chances of Survival*, 37 *MERCER L. REV.* 1583 (1985–1986); Mary Ann Willis, Comment, *Limitation on Recovery of Damages in Medical Malpractice Cases: A Violation of Equal Protection*, 54 *U. CIN. L. REV.* 1329 (1986).

¹⁰⁸ *See, e.g.*, Kuhl, *supra* note 103.

¹⁰⁹ *See id.* at 1229–30; Wagner & Reiter, *supra* note 107, at 1009–11.

¹¹⁰ *See* Kuhl, *supra* note 103, at 1232.

¹¹¹ *See* Turkington, *supra* note 104, at 1332; Wagner & Reiter, *supra* note 107, at 1018.

¹¹² *See* Wagner & Reiter, *supra* note 107, at 1015–16.

¹¹³ *See* Redish, *supra* note 105, at 763.

¹¹⁴ *See* Smith, *supra* note 107, at 229; Turkington, *supra* note 104, at 1317 & n.52.

¹¹⁵ *See* Turkington, *supra* note 104, at 1328–29. Federal constitutional claims were another matter; few had succeeded. *See id.* at 1304 n.13, 1311.

¹¹⁶ *See, e.g.*, Kelly & Mello, *supra* note 29; Robert S. Peck, *Violating the Inviolable: Caps on Damages and the Right to Trial by Jury*, 31 *U. DAYTON L. REV.* 307 (2006); Robert S. Peck

only two papers have attempted comprehensively to catalog state constitutional decisions on tort reforms. In 2001, Victor Schwartz and Leah Lorber examined the time period from 1983 through 2001, counting 82 decisions from 26 states striking down tort reforms and 140 decisions from 45 states upholding tort reforms.¹¹⁷ Their review spanned the field of personal injury law; it was not limited to medical malpractice reforms. More recently, Carly Kelly and Michelle Mello surveyed decisions on the constitutionality of caps on damages for personal injury, including medical malpractice, through April 2005.¹¹⁸ This analysis found that caps have been subjected to constitutional challenge in at least twenty-five states.¹¹⁹ (In late 2005 and 2006, another three states considered challenges to caps.¹²⁰) Noneconomic damages caps have generally been upheld in the face of a range of constitutional challenges, while caps on total damages have experienced a more uneven record. These findings are presented in greater detail in Table 2.

& Ned Miltenberg, *Challenging the Constitutionality of Tort "Reform,"* in 3 ATLA'S LITIGATING TORT CASES § 29:11 (2006); Phillips, *supra* note 27; Schwartz et al., *supra* note 15; Victor E. Schwartz & Leah Lorber, *Judicial Nullification of Civil Justice Reform Violates the Fundamental Federal Constitutional Principle of Separation of Powers: How to Restore the Right Balance*, 32 RUTGERS L.J. 907 (2001); Studdert & Brennan, *supra* note 15; Robert F. Williams, Foreword, *Tort Reform and State Constitutional Law*, 32 RUTGERS L.J. 897 (2001). See also John C.P. Goldberg, *The Constitutional Status of Tort Law: Due Process and the Right to a Law for the Redress of Wrongs*, 115 YALE L.J. 524 (2005) (evaluating the right to a means of legal redress for private wrongs and proposing an analytical framework for due process challenges to tort reform legislation); Schuman, *supra* note 53 (reviewing cases on the right to a common law tort remedy and highlighting the primacy of the quid pro quo requirement); John Fabian Witt, *The Long History of State Constitutions and American Tort Law*, 36 RUTGERS L.J. 1159 (2004–2005) (reviewing the history of constitutional challenges to tort reforms).

¹¹⁷ Schwartz & Lorber, *supra* note 116, at 952–76; see also Goldberg, *supra* note 116, at 527 (tallying Schwartz & Lorber's findings).

¹¹⁸ Kelly & Mello, *supra* note 29.

¹¹⁹ *Id.* at 518.

¹²⁰ The decisions handed down since the Kelly & Mello review concluded are *Arrington v. ER Physicians Group*, 940 So. 2d 777 (La. Ct. App. 2006) (holding that the real value of Louisiana's \$500,000 cap on total damages had eroded so much with inflation that it was no longer an adequate remedy); *Ferdon ex rel. Petrucelli v. Wis. Patients Comp. Fund*, 701 N.W.2d 440 (Wis. 2005) (holding that Wisconsin's noneconomic damages caps violated equal protection); *Hughes v. PeaceHealth*, 131 P.3d 798 (Or. Ct. App. 2006) (upholding Oregon's \$500,000 noneconomic damages cap for wrongful death cases against right-to-remedy and jury-trial challenges); and *Clarke ex rel. Clarke v. Or. Health Sci. Univ.*, 138 P.3d 900 (Or. Ct. App. 2006) (finding that the \$200,000 damages cap of the Oregon Tort Claims Act was an adequate remedy, given the state's sovereign immunity, and did not violate the right to jury trial).

TABLE 2. OUTCOMES OF STATE CONSTITUTIONAL CHALLENGES TO DAMAGES CAPS¹²¹

	Caps on noneconomic damages		Caps on total damages	
	States finding no violation	States finding a violation	States finding no violation	States finding a violation
Access to courts	6	1	3	4
Right to jury trial	11	3	5	3
Equal protection	8	3	6	5
Due process	9	1	7	2
Separation of powers	5	—	2	—

B. Methodology of the Present Review

In addition to updating the Kelly & Mello review of damages caps legislation, we conducted a fifty-state review of litigation concerning the other major approaches states have taken to malpractice reform. These approaches consist of pretrial screening panels, mandatory pretrial arbitration or mediation, limitations on attorney fees, statutes of limitations, statutes of repose, changes to collateral-source rules, changes to joint-and-several liability rules, expert precertification, and penalties for unsuccessful or frivolous claims. We aimed to extract insights into judicial behavior that might have predictive value for future cases in which health courts are challenged.

Using LexisNexis and Westlaw, we gathered the most recent decisions since 1985 from the states' highest courts evaluating challenges to one or more of these reforms. For a few states, where we found opinions reported after 1976 but none after 1985, we added cases from the earlier period. Similarly, although we focused on cases addressing medical malpractice reform legislation, we added cases from those few states where the reform initiatives affected personal injury torts in general.¹²² This yielded a sample of 144 judicial opinions from 30 states.¹²³

We summarized the cases using a standardized form that directed the reviewer to abstract the following information about the reform(s) in question: the date of the decision; the issuing court; the date the reform was enacted; the case outcome (treated as a dichotomous variable, validated or invalidated); the nature of the constitutional challenges; the standard of review or other constitutional test(s) applied; a summary of the court's ratio-

¹²¹ Adapted from Kelly & Mello, *supra* note 29, at 519. We have added the aforementioned decisions issued after the Kelly & Mello review concluded.

¹²² We acknowledge that there may be distinct political forces and doctrinal issues in play in these cases that are not equally present in medical malpractice cases.

¹²³ The states are AK, AR, AL, AZ, CA, CO, CT, DE, FL, IA, IL, IN, MD, MI, MT, MN, NC, NH, NJ, NY, OH, OR, PA, TN, TX, UT, VA, WA, WI, and WV.

nale for its decision, including distinctions (if any) drawn among reforms; the court's use of external data; and the court's reliance on judicial opinions from other states. Eliminating those cases in which these data could not be discerned (or in which the same reform was tested at two different levels of courts) netted 132 usable cases from 29 states.

C. Findings and Implications

1. Quantitative Findings

Almost a third of the judicial opinions in our sample (42 out of 132) invalidated one or more of the legislature's reforms on state constitutional grounds. The proportion varied considerably across reforms (see Table 3). Statutes that interposed obstacles before trial (pretrial screening panels, non-binding arbitration or mediation, expert certification) tended to fare better than statutes that had wholly precluded some claims (statutes of limitations and repose) or reduced the recoverable damages (periodic payment, collateral-source offset).

TABLE 3. CASES VALIDATING AND INVALIDATING MALPRACTICE REFORMS, BY TYPE OF REFORM (N=132)¹²⁴

Reform	Considered	Validated	Invalidated	% Invalidated
All reforms	228	167	61	27%
Periodic payment	15	8	7	47%
Statute of limitations (and statute of limitations concerning minors)	52	30	22	42%
Statute of repose	25	17	8	32%
Collateral-source offset	22	15	7	32%
Expert pretrial affidavit / pre-notification	21	16	5	24%
Attorney fee limits	10	8	2	20%
Expert credentials / other evidence limitations	10	8	2	20%
Joint-and-several liability rule reform	17	14	3	18%
Pretrial mediation or arbitration	30	27	3	10%
Pretrial screening panel	26	24	2	8%

¹²⁴ Table 3 counts numbers of reforms challenged in the sample of cases, omitting a handful of idiosyncratic reforms that were challenged in only one case. Additionally, the

Table 4 analyzes the case outcomes by the type of challenge brought. These findings should be interpreted with recognition given to the possible role of selection bias in driving them. The mix of constitutional challenges brought in any particular case is the product of strategic decisions on the part of the plaintiffs' attorneys. Some attorneys may take a "kitchen sink" approach, naming every colorable basis for invalidating the statute even if some are near-certain losers. Others may be more selective, discarding some potential claims based on a judgment that they are unlikely to succeed given the state's jurisprudential history. Finding that access-to-courts challenges, for example, succeed over a third of the time suggests that a significant potency inheres in the open-courts principle when compared with, for example, the fifteen percent success rate for due process challenges. However, we cannot know whether the higher success rate for access-to-courts claims is due to greater care on the part of attorneys in bringing such claims only in states and situations where precedent suggests they are relatively likely to succeed.

TABLE 4. OUTCOMES OF CONSTITUTIONAL CHALLENGES TO MALPRACTICE REFORMS, BY BASIS OF CHALLENGE (N=228)¹²⁵

Challenge	Considered	Validated	Invalidated	% Invalidated
All challenges	228	167	61	27%
Open courts / right to remedy	41	25	16	39%
Equal protection / special legislation	75	50	25	33%
Separation / delegation of powers	20	16	4	20%
Right to jury trial	28	22	6	21%
Due process – substantive and procedural	48	41	7	15%
Other	16	13	3	19%

Table 5 presents a combination of the two foregoing tabulations. Although many of the cell sizes are very small, we have flagged reform/challenge combinations with a success rate of more than twenty-five percent.

denominator (indicated in the "Considered") column may be biased upwards or downwards by the fact that some courts, having found a statute invalid under one constitutional provision, found it unnecessary to consider other challenges; other courts decided everything before them. In addition, many of the statutes being challenged were parts of more comprehensive reform packages. Upon finding one part of a package unconstitutional, in some cases courts severed the offending part and upheld the rest; in other cases the one part may have been held not severable, thus invalidating other aspects of the enactment.

¹²⁵ The denominator here is the number of distinct constitutional claims decided within the 132 cases examined.

Among the most robust findings are the relatively high success rates (around fifty percent) of access-to-courts and equal protection challenges to statutes of limitations and repose, as well as equal protection challenges to collateral-source offsets.

TABLE 5. CASES INVOLVING SUCCESSFUL CHALLENGES, BY TYPE OF REFORM AND TYPE OF CHALLENGE¹²⁶

	Open courts/ right to remedy	Right to jury trial	Equal protection	Due process - substantive/ procedural	Separation/ delegation of powers	Other
Periodic payment	1/1 [‡]	3/6 [‡]	1/4	1/3 [‡]	—	1/1
Statute of limitations (incl. minors)	9/16 [‡]	0/1	10/20 [‡]	2/11	—	1/4
Statute of repose	2/9	—	4/10 [‡]	1/4	—	1/2
Collateral-source offset	1/2 [‡]	1/1 [‡]	4/11 [‡]	1/5	0/1	0/2
Expert pretrial affidavit / pre- notification	2/4 [‡]	0/1	2/5 [‡]	0/5	1/5	0/1
Attorney fee limits	—	—	1/4	0/3	1/3 [‡]	—
Expert credentials / other evidence limitations	0/2	—	1/4	0/2	1/2 [‡]	—
Joint-and-several liability rule reform	—	0/2	1/5	2/6 [‡]	0/1	0/3
Pretrial mediation or arbitration	1/4	1/9	1/9	0/4	0/3	0/1
Pretrial screening panel	0/3	1/8	0/3	0/5	1/5	0/2

[‡] Greater than 25% success rate

2. Qualitative Findings

In a second, qualitative analysis of the cases in our sample, we tried to glean salient differences between cases in which legislation was invalidated and cases in which it was upheld. This was admittedly an impressionistic

¹²⁶ The denominator in the table represents the total number of cases in which each type of challenge was brought.

exercise that could not capture potentially important but unobserved variables. For example, in a highly charged environment of malpractice insurance “crisis,” judges may be influenced by political considerations in ways that are not reflected in their opinions. A legal realist critique of our exercise would note the role of the moral, social, and philosophical predilections of individual judges in influencing decisions—factors that we did not measure. Although the practice of writing opinions provides some brake on the force of caprice, the deliberate elasticity of constitutional principles offers judges considerable freedom, particularly in areas of first impression (as many of the features of health courts will be) and on constitutional topics where the leveling influence of federal analogs is absent.

Our impression was that judges often exercised this freedom to achieve particular aims. Two examples illustrate the point. The first is the willingness of judges to follow the mandate to construe a statute so as to preserve its constitutionality. In California, for instance, a statute of limitations that did not expressly include a tolling period for delayed discovery by injured minors was construed to include the same tolling period as that of a limitations statute applicable to adults.¹²⁷ The court’s explicit interpretive preference saved the statute from invalidation on equal protection grounds.¹²⁸ In Florida, a mandatory pretrial mediation program would have been invalid on equal protection grounds if the court had read it as requiring the admissibility of panel decisions in which plaintiffs participated but as disallowing evidence of physicians’ non-participation.¹²⁹ But instead, the court construed the statute to include a provision that allowed that evidence, thereby saving the statute.¹³⁰ The canon of interpretation in favor of preserving constitutionality may be a standard part of the judicial repertoire across states, but the decision of whether a statute is ambiguous enough as written to admit a life-preserving construction is not.

A second technique, applicable principally to equal protection and substantive due process challenges, relates to the selection of the degree of judicial scrutiny. As in the federal regime, there are three levels available: strict scrutiny, intermediate scrutiny, and rational basis review. According to long-established federal jurisprudence, strict scrutiny is reserved by most courts for application in cases where distinctions are drawn on the basis of a suspect class or where the statute affects a fundamental right.¹³¹ Although the ability to file malpractice claims seems to be a much less important interest than other interests that courts have classified as fundamental rights,¹³² occa-

¹²⁷ *Young v. Haines*, 718 P.2d 909 (Cal. 1986).

¹²⁸ *Id.*

¹²⁹ *Carter v. Sparkman*, 335 So. 2d 802 (Fla. 1976).

¹³⁰ *Id.*

¹³¹ See 16B C.J.S. *Constitutional Law* §§ 1117, 1118 (2007).

¹³² *Id.* at §1118 (listing the right to vote, the right to travel, the right to marry, privacy, procreation, certain aspects of criminal processes, First Amendment rights, and freedom of association as the widely recognized fundamental rights).

sionally judges have characterized it as fundamental.¹³³ Such cases are exceptional, but they establish the latitude that courts have sometimes exercised to take a harder look at malpractice reforms than established rules of jurisprudential analysis require.

In the overwhelming proportion of cases, malpractice reforms have been subject to what courts characterize as rational basis review. But even among the rational basis cases, there is heterogeneity in the depth of scrutiny. Some decisions have actually hewed closer to intermediate scrutiny.¹³⁴ On the other hand, some cases involve virtually no scrutiny. The Indiana Supreme Court, for example, in upholding a statute of limitations, began with the principle that “considerable deference should be accorded to the manner in which the Legislature has balanced the competing interests involved,” found that the legislature “may well have given consideration” to a reasonable rationale, and held that that possibility was enough to satisfy the rational basis test.¹³⁵

3. Conclusions

A few general conclusions regarding the prospects for health courts proposals can be drawn from our review of the historical record. First, substantive due process challenges to malpractice reforms usually fail. It is rare that courts apply heightened scrutiny, and, if they do, they generally do not find that a plaintiff’s interest in a malpractice damages award rises to the level of a fundamental right. Second, procedural due process challenges have rarely succeeded against malpractice reforms. These challenges are relatively straightforward from a doctrinal perspective (for that reason, we have not dwelt on them much in our analysis): reforms are evaluated against the standard requirements of notice, opportunity to be heard, and opportunity for appeal. Attention to the standard set of procedural safeguards in design of a health court would likely go far toward minimizing the potency of any such challenge.

Third, equal protection challenges have had relatively good success against traditional malpractice reforms, though not according to a predictable pattern. Their success has primarily come against reforms that serve as complete bars to claims: namely, statutes of limitations and repose. They have been much less successful against reforms that merely limit recoverable damages. The key question in equal protection cases is: what makes

¹³³ For example, a North Carolina appellate court applied strict scrutiny to a statute that imposed expert pretrial certification on malpractice claims but not other personal injury claims, because it found that the statute implicated a fundamental right. *Anderson v. Assimos*, 553 S.E.2d 63, 68–69 (N.C. Ct. App. 2002) (striking the statute down because it was not the least restrictive method for addressing the asserted state interest in reducing frivolous lawsuits).

¹³⁴ This finding emerged from the Kelly & Mello review of damages caps cases. See Kelly & Mello, *supra* note 29, at 522–23.

¹³⁵ *Johnson v. St. Vincent Hosp.*, 404 N.E.2d 585, 604 (Ind. 1980).

malpractice plaintiffs different from all other personal injury plaintiffs? While courts are disinclined to view malpractice plaintiffs as a suspect class, they vary in the tenor of their rational basis review. Some courts find the exigencies of a malpractice “crisis” a persuasive rationale for treating malpractice claimants differently, others dispute the existence of a crisis, and still others agree that there is a problem but disagree that the solution is rationally related to it.

Fourth, separation of powers challenges generally have been unsuccessful against malpractice reforms. However, the few cases in which such challenges were sustained articulate principles that suggest that, in some states, these challenges may be more potent against health courts, which constitute a greater legislative intrusion into judicial processes. For example, the Alabama Supreme Court held that a statute directing trial courts to review jury awards of punitive damages without any presumption that the jury’s award was correct violated separation of powers because it effected a “fundamental change in the manner in which common law courts have always exercised their judicial power and discretion.”¹³⁶ In addition, courts have generally disfavored laws that affect the rules of evidence¹³⁷ and laws that introduce nonjudicial authority into the malpractice claims resolution process.¹³⁸ Again, these cases represent the minority viewpoint but should be taken seri-

¹³⁶ *Armstrong v. Roger’s Outdoor Sports, Inc.*, 581 So. 2d 414, 418 (Ala. 1991); *see also* *Clark v. Container Corp. of Am., Inc.*, 589 So. 2d 184 (Ala. 1991) (invalidating a statute requiring the court to reduce some portions of a jury award of future damages to their present value before entering judgment on the basis that the statute violated the right to trial by jury by abrogating the jury’s historical fact-finding function).

¹³⁷ For example, an Arizona statute that prohibited plaintiffs from introducing evidence that would show a financial relationship between a defendant’s expert witness and an implicated malpractice insurer was invalidated because the court could not “allow a legislature to define what [evidence] is relevant” in court. *Barsema v. Susong*, 751 P.2d 969, 974 (Ariz. 1988). Another example is *Ohio Acad. of Trial Lawyers v. Sheward*, 715 N.E.2d 1062 (Ohio 1999), in which the Ohio Supreme Court struck down a comprehensive tort reform statute that would have amended over 100 separate provisions of Ohio law, including such judicial prerogatives as the assessment of evidence and the standards for judgments. An obviously incensed court opined that the wars of tort reform had been waged with respect for the principles of separation of powers, “that is, until now.” *Id.* at 1073. The Ohio Supreme Court also struck down a periodic payment statute, holding that the determination of damages is a function of the jury. The opinion distinguished and upheld a part of the act that prescribed prejudgment interest on the basis that while a jury is to determine damages, prejudgment interest is not a question of “fact” and therefore not part of the jury’s domain. *Galayda v. Lake Hosp. Sys., Inc.*, 644 N.E.2d 298 (Ohio 1994).

¹³⁸ For instance, the Illinois Supreme Court upheld every part of an omnibus medical liability reform act except one—a pretrial screening process in which judges sat with non-judges and shared authority to make nonbinding factual findings. Under separation of powers principles, the court held that the legislature lacked the ability to affect judicial authority to render decisions. *Bernier v. Burris*, 497 N.E.2d 763 (Ill. 1986). *See also* *Wright v. Central DuPage Hosp. Ass’n*, 347 N.E.2d 736, 739–40 (Ill. 1976). Along the same lines, a North Carolina statute requiring a malpractice plaintiff to obtain pretrial expert certification that medical care was substandard was struck down because, *inter alia*, the requirement allowed a non-judge to determine whether a case could go forward. *Anderson*, 553 S.E.2d at 68 (“It is for the courts . . . to adjudicate . . . the merits of an injured party’s claim.”).

ously in considering the constitutional issues that may arise in relation to health courts.

Fifth, challenges based on the right to jury trial have rarely succeeded, but there is a fair degree of diversity in how courts approach these claims. The reforms tested in medical malpractice to date have not presented the kind of full and direct elimination of jury trials that health courts would involve. As we have discussed, there is also some diversity in how courts approach right-to-jury claims, but the key issues are whether the right to have medical malpractice claims heard by a jury existed at common law at the time of constitutional adoption, and, if so, the extent to which the reform intrudes on that right.

Finally, open-courts claims have generally been fairly successful against other malpractice reforms, particularly those that preclude claims altogether, such as statutes of limitations. There has been greater judicial tolerance for schemes that place substantial obstacles in a litigant's path to trial but do not block it entirely, such as screening panels or pretrial mediation. In both jury-trial and open-courts cases, the crux of the courts' analyses has been whether the abrogation of the right to jury trial is compensated by an adequate quid pro quo. The jurisprudence of access-to-courts challenges to malpractice reforms is highly relevant to health courts and suggests the need to construct a strong quid pro quo defense.

V. IMPLEMENTING HEALTH COURTS BY CONSENT

An alternative to legislation creating a health court system in which participation is mandatory would be a program based on the voluntary participation of certain health care providers and the consent of the affected patients. Because constitutional rights can be waived by agreement (subject to some significant limitations discussed below), if patients agree to forego their existing rights to the tort system in favor of an administrative alternative, it would render moot many of the constitutional questions we have raised. In this Part, we consider how a consent-based approach might work. This alternative has the advantage of sidestepping a number of the potential constitutional objections noted above. On the other hand, it is likely to raise a different set of concerns.

A. *The Consent Process in a Voluntary Health Court System*

Voluntary health courts proposals contemplate that patients will be presented with two opportunities to consent to participation in the system.¹³⁹ The first would come when they sign on for care through a participating health insurance plan or health care provider (e.g., when they designate a physician to be their primary care doctor in a managed care plan). After

¹³⁹ See COMMON GOOD, *supra* note 10, at 15.

signing on, they would be provided with notice of what the system is and the implications of using it, and their consent would be implied from their decision to continue in the plan or with the provider. The second opportunity would come when patients seek medical care, i.e., when they have a first appointment with a participating physician or are first seen in a participating hospital. At this point, they would give express consent after again being provided with information about how their rights would be affected. Patients could opt out of the health court system by selecting another provider who does not participate in it.

The critical feature of both consent opportunities is that they take place before occurrence of the injury that would be covered by the scheme. Once the decision to receive care from a participating provider is made, any treatment injuries that occur in the hands of that provider will be within the health court's exclusive jurisdiction. Experience from the partial no-fault schemes for birth-related neurological injuries in Florida and Virginia suggests that allowing post-injury elections of compensation venue would create adverse selection problems. Strong candidates for large payouts under a negligence standard would try their luck in the tort system, at least in the first instance, while the rest likely would opt for the security, generosity, and speed of the no-fault system.¹⁴⁰

B. Potential Legal Problems with the Consent Process

These approaches to consent involve potential legal problems. The first opportunity, which occurs before the patient has an immediate need for medical care, implicates statutory and case law on pre-dispute contractual agreements to alternative dispute resolution. Nineteen states presently have statutes that bar pre-dispute agreements to arbitrate personal injury claims.¹⁴¹ Five prohibit such agreements in all personal injury or consumer cases (as opposed to business-to-business disputes).¹⁴² Fourteen target health care in particular.¹⁴³ In the latter group, the laws typically provide that pre-dispute

¹⁴⁰ David M. Studdert et al., *The Jury Is Still In: Florida's Birth-Related Neurological Injury Compensation Plan after a Decade*, 25 J. HEALTH POL. POL'Y & L. 499 (2000) (showing the lively persistence of expensive claims over severe neurological injury to infants in the tort system following enactment of Florida's tort replacement scheme).

¹⁴¹ These states are AL, AK, AR, CA, CO, GA, IL, KS, LA, MT, NE, NM, OH, SC, SD, TX, UT, VA, and VT.

¹⁴² ARK. CODE ANN. § 16-108-201(b)(2) (2006); KAN. STAT. ANN. § 5-401(c)(3) (2006); MONT. CODE ANN. § 27-5-114(2)(a) (2007); NEB. REV. STAT. ANN. § 25-2602.01(f)(1) (1995); N.M. STAT. ANN. § 44-7A-5 (1999).

¹⁴³ ALA. CODE § 6-5-485 (2006); ALASKA STAT. § 09.55.535(a) and (c) (2006); CAL. CODE CIV. PROC. § 1295 (2007) (validating agreements but with special requisites of form); COLO. REV. STAT. § 13-64-403(1) and (3) (2006); GA. CODE ANN. § 9-9-62 (2005); § 710 ILL. COMP. STAT. 15/9(c) (2005); LA. REV. STAT. ANN. § 9:4235 (2006); OHIO REV. CODE ANN. § 2711.24 (2006); S.C. CODE ANN. § 15-48-10(3) (2005); S.D. CODIFIED LAWS § 21-25B-1 (2005); TEX. CIV. PRAC. & REM. CODE ANN. § 74.451 (2005) (requiring signature of the patient's attorney as a condition of validity); UTAH CODE ANN. § 78-14-17 (2004); VT. STAT. ANN. tit. 12, § 7002 (2006); VA. CODE ANN. § 8.01-581.12 (2005).

agreements to arbitrate cannot be made a condition for issuing insurance or providing a service or that the agreement may be rescinded by the consumer within some number of days after the service is provided, or after injury occurs, or both.¹⁴⁴ Although there is good reason to believe that all of these statutes are preempted by the Federal Arbitration Act, which has no such limitations, the question is unresolved.¹⁴⁵

It seems unlikely that a state that has already proscribed pre-dispute contractual waivers of jury trials would be in the vanguard of states implementing health courts demonstration projects. If they did want to pursue such demonstrations, states might amend their arbitration statutes to make clear that they do not apply to the new initiative. Courts might reach such a finding on their own, even absent such an amendment, because a health court demonstration that assigned the adjudicative function to a state agency by statute probably would not constitute an arbitration process.

Arbitration is not defined in either the Federal Arbitration Act or the Uniform Arbitration Act, after which almost all state arbitration laws have been patterned.¹⁴⁶ By common understanding, the term encompasses almost any procedure that is consensual, adjudicative, and conducted by private rules apart from the courts and juries.¹⁴⁷ With rare exceptions, arbitrators are private individuals. If a health court demonstration project assigned its adjudicative functions, by statute, to a public administrative agency or tribunal and state-appointed judges rather than a privately-constituted body or private adjudicator, the legal analogy to arbitration would not hold. Politically, the

¹⁴⁴ See, e.g., COLO. REV. STAT. § 13-64-403(3) (2006) (“The patient has the right to seek legal counsel concerning this agreement, and has the right to rescind this agreement by written notice to the physician within ninety days after the agreement has been signed and executed by both parties unless said agreement was signed in contemplation of the patient being hospitalized, in which case the agreement may be rescinded by written notice to the physician within ninety days after release or discharge from the hospital or other health care institution.”); COLO. REV. STAT. § 13-64-403(7) (2006) (“No health care provider shall refuse to provide medical care services to any patient solely because such patient refused to sign such an agreement or exercised the ninety-day right of rescission.”).

¹⁴⁵ Compare *In re Nexion Health at Humble, Inc.*, 173 S.W.3d 67 (Tex. 2005) (holding that the Texas Arbitration Act’s limitation—that the arbitration agreement must be signed by a consumer’s attorney—is preempted by the Federal Arbitration Act) with *Allen v. Pacheko*, 71 P.3d 375 (Colo. 2003) (holding that the McCarran-Ferguson Act exempted the state health care arbitration act from federal preemption). In the only federal decision we found, the District Court for the Southern District of Georgia came down on the *Nexion* side, holding that the Federal Arbitration Act preempted a state medical arbitration statute, without discussing the McCarran-Ferguson argument in *Allen*. *Washburn v. Beverly Enterprises-Georgia, Inc.*, No. CV 106-51, 2006 U.S. Dist. LEXIS 73267, at *6 (S.D. Ga. Aug. 3, 2006).

¹⁴⁶ See American Arbitration Ass’n, RUA and UMA Legislation from Coast to Coast (Aug. 31, 2005), available at <http://www.adr.org/sp.asp?id=26600> (“The original Uniform Arbitration Act, adopted in 1955, provided the basic framework for arbitration law in 49 jurisdictions.”).

¹⁴⁷ See *Baravati v. Josephthal, Lyon & Rose, Inc.*, 28 F.3d 704, 709 (7th Cir. 1994) (“[I]ndeed, short of authorizing trial by battle or ordeal or, more doubtfully, by a panel of three monkeys, parties can stipulate to whatever procedures they want to govern the arbitration of their disputes; parties are as free to specify idiosyncratic terms of arbitration as they are to specify any other terms in their contract.”).

state's anti-arbitration position would be readily distinguishable. The judicial review likely would focus on questions of effective consent.

The second problem with almost any form of consensual model is the courts' traditional reluctance to enforce waivers of constitutional rights. That reluctance has been criticized as an unnecessary extension of criminal due process concerns into the realm of civil liability, and whether this reluctance persists in constitutional jurisprudence has itself been questioned.¹⁴⁸ Our own review of the case law suggests that in many jurisdictions this judicial reluctance is alive and well.¹⁴⁹

Many of the cases involving pre-dispute waivers of jury-trial rights arise in the setting of leases and employment contracts.¹⁵⁰ The employment contracts cases are characterized by endemic inequalities of bargaining power, which is also typical in health care relationships. With rare exceptions, courts have permitted pre-dispute waivers,¹⁵¹ but they often apply a level of scrutiny more intensive than that applied to other forms of ordinary contracts.¹⁵² Courts look closely at the intentionality of the waiver, focusing on the clarity of the waiver language. Phrases often seen in judicial opinions include "there must be clear evidence of an intent to waive";¹⁵³ the waiver must be "conspicuous";¹⁵⁴ waiver of jury-trial rights requires an "unequivocal act" and "every reasonable presumption against the waiver" will be indulged;¹⁵⁵ the waiver must be "knowing, intentional and voluntary";¹⁵⁶ and the waiver language must be "clear, unambiguous, unmistakable, and conspicuous."¹⁵⁷ Courts upholding waivers have relied on findings that both par-

¹⁴⁸ Stephen J. Ware, *Arbitration Clauses, Jury-Waiver Clauses, and Other Contractual Waivers of Constitutional Rights*, 67 LAW & CONTEMP. PROBS. 167 (2004).

¹⁴⁹ See *Lowe Enter. Residential Partners, L.P. v. Jones*, 40 P.3d 405 (Nev. 2002) (reviewing opinions from other jurisdictions); Jay M. Zitter, Annotation, *Contractual Jury Trial Waivers in State Civil Cases*, 42 A.L.R. 5TH 53 (1996) (exhaustively collecting and analyzing state and federal cases and concluding that while "the vast majority of courts have held, at least in the abstract, that . . . a jury trial waiver clause . . . will be enforced as not being unreasonable [S]uch view is qualified by the additional statement in many cases that since the right to a jury trial is highly favored, independent contractual waivers of jury trials, entered into independent of specific litigation, will be strictly construed and will not be lightly inferred or extended [In addition,] a few courts have ruled that jury trial waiver clauses are or may be invalid in general.").

¹⁵⁰ See Michael LeRoy, *Jury Revival or Jury Reviled? When Employees are Compelled to Waive Jury Trials*, 7 U. PA. J. LAB. & EMP. L. 767 (2005).

¹⁵¹ See, e.g., *Grafton Partners L.P. v. PriceWaterhouseCoopers*, 116 P.3d 479 (Cal. 2005) (holding that methods for waivers listed in statute are exclusive); but see *Bank South, N.A. v. Howard*, 444 S.E.2d 799 (Ga. 1994) (holding that waiver in a bank loan guarantee violated the guarantor's constitutional rights).

¹⁵² See *infra* notes 153–57.

¹⁵³ *L & R Realty v. Connecticut Nat'l Bank*, 715 A.2d 748, 755 (Conn. 1998).

¹⁵⁴ *Norton v. Commercial Credit Corp.*, No. CV9805784415, 1998 Conn. Super. LEXIS 2833, at *14 - 15 (Conn. Super. Ct. Oct. 6, 1998).

¹⁵⁵ *Pancakes of Hawaii, Inc. v. Pomare Properties*, 944 P.2d 97, 106 (Haw. 1997).

¹⁵⁶ *Carter v. Virginia*, 345 S.E.2d 5, 9–10 (Va. Ct. App. 1986). See also LeRoy, *supra* note 150, at 786.

¹⁵⁷ *Malan Realty Investors v. Harris*, 953 S.W.2d 624 (Mo. 1997); *Fairfield Leasing Corp. v. Techni-Graphics, Inc.*, 607 A.2d 703 (N.J. Super. Ct. Law Div. 1992).

ties were represented by counsel, that the complaining party was “sophisticated,” that the provision was obvious in the documents signed, and that there was no significant absence of bargaining power.¹⁵⁸ Bill stuffers and employee handouts, in short, may not suffice.¹⁵⁹ The case law on waivers suggests that consent that is merely deemed, rather than explicitly granted, is likely to face difficulty in court.¹⁶⁰

A second source of law on the validity of waivers adverts again to arbitration.¹⁶¹ Even under the Federal Arbitration Act, standard state-law contract principles—in this context, the law of unconscionability—apply.¹⁶²

A thorough review of the cases is beyond the scope of this Article, but we would note that among the key characteristics of procedural unconscionability is the presence or absence of meaningful choice;¹⁶³ and of substantive unconscionability, the qualities of the substituted process itself.¹⁶⁴ To be sure, most consumer arbitration agreements reported in the cases have been upheld.¹⁶⁵ The problem, however, is that unconscionability adjudication

¹⁵⁸ See, e.g., *Chase Commercial Corp. v. Owen*, 588 N.E.2d 705, 709 (Mass. 1992). See also Zitter, *supra* note 149.

¹⁵⁹ See, e.g., *Quiles v. Financial Exch. Co.*, 879 A.2d 281 (Pa. Super. Ct. 2005) (finding that provisions in an employee handbook that were not brought to employees’ attention and were not conspicuous were inadequate).

¹⁶⁰ Deemed consent raises its own set of questions in cases where a sophisticated agent binds a group of unsophisticated individuals to a particular agreement unless they opt out—for example, when an employer bargaining with health insurance providers contracts on behalf of its employees. Outside of the arbitration and unionized labor contexts, the case law on this issue is sparse.

¹⁶¹ Interestingly, an advantage to characterizing a consensual model as an arbitration is that judicial hostility toward jury trial waivers generally does not apply to arbitration agreements, which are essentially waivers of jury trials. The explanation may be that arbitration is statutory, though the statutes do not provide much by way of consumer protection. This anomaly has provoked scholarly debate in the field of waiver. See Ware, *supra* note 148. See also Brian D. Weber, *Contractual Waivers of a Right to Jury Trial—Another Option*, 53 CLEV. ST. L. REV. 717 (2006) (discussing jury trial waivers and arbitration in the employment context).

¹⁶² See, e.g., *Doctors’ Assoc. v. Casarotto*, 517 U.S. 681, 687 (1996) (“Generally applicable contract defenses, such as fraud, duress, or unconscionability, may be applied to invalidate arbitration agreements without contravening section 2 [of the FAA].”).

¹⁶³ RESTATEMENT (SECOND) OF CONTRACTS § 208 cmt. D (1981) (“Gross inequality of bargaining power, together with terms unreasonably favorable to the stronger party, may confirm indications that the transaction involved elements of deception or compulsion, or may show that the weaker party had no meaningful choice, no real alternative, or did not in fact assent or appear to assent to the unfair terms.”).

¹⁶⁴ See Edward Dauer, *Judicial Policing of Consumer Arbitration*, 1 PEPPERDINE DISP. RESOL. L.J. 91, 98 (2000) (citing *Hooters of Am., Inc. v. Phillips*, 173 F.3d 933, 938–39 (4th Cir. 1999); *Randolph v. Greentree Fin. Corp.*, 178 F.3d 1149 (11th Cir. 1999); *Duffield v. Robertson-Stephens & Co.*, 144 F.3d 1182 (9th Cir. 1997); *Broomer v. Abortion Servs. of Phoenix*, 840 P.2d 1013 (Ariz. 1992); and *Patterson v. ITT Corp.*, 18 Cal. Rptr. 2d 563 (Cal. Ct. App. 1993)).

¹⁶⁵ See generally *Gilmer v. Interstate Johnson Lane Corp.*, 500 U.S. 20 (1991) (upholding an arbitration agreement in light of the FAA’s “liberal federal policy favoring arbitration agreements”).

tends to be individualized.¹⁶⁶ A contract held valid in one setting might be set aside in another.

Clearly, one circumstance in which unconscionability principles are implicated is where patients in need of medical care are asked to waive their rights to jury trial. For patients without insurance, there would be only one opportunity to consent to inclusion in a health court system: when they present for care. Given that consent would be a precondition to receiving the care the patient had come for, the agreement may be viewed as coercive and unconscionable.

It is important to bear in mind that health care providers can, in most circumstances, place a variety of preconditions on the delivery of medical services: patients can be required to pay for their care before they are seen, for example, and physicians may refuse to care for particular patients for a range of personal reasons.¹⁶⁷ However, if the patient is in urgent need of medical care, courts will view any waiver of rights with a high degree of suspicion. For instance, a federal appeals court recently held that a patient in active labor could not give meaningful informed consent to the hospital's request to share her drug test information with law enforcement officers — an act that would, in effect, waive the patient's Fourth Amendment protections against unreasonable searches.¹⁶⁸ There would be significant questions about consent to participate in health courts given by a patient in medical distress; an exemption from health courts coverage would probably need to be carved out for such patients in a consent-based system.

Patients presenting for non-emergency care present a different situation. As long as other health care providers who do not participate in the health court are reasonably accessible, it is much less likely that the request for consent would be viewed as coercive. The case law suggests that the court will look at whether patients have had clear notice of what they were waiving and a meaningful choice in the matter.¹⁶⁹ These conditions are most likely to be met where their consent is given explicitly; where they receive detailed, clear information about the health court system at a time and place where they are able to digest and deliberate about it; and where patients can

¹⁶⁶ For example, in *Broemmer*, the Arizona Supreme Court, in invalidating an agreement to arbitrate a malpractice claim, stressed the “realities present in this case” as the basis for its finding of unconscionability. 840 P.2d at 1018.

¹⁶⁷ Their discretion is circumscribed by antidiscrimination laws and by the terms of their contracts with health insurers. Recent reports indicate that some physicians in “malpractice crisis” areas have attempted to require patients to sign a waiver of their right to sue for negligence as a condition of care. Jane Spencer, *Signing Away Your Right to Sue*, WALL ST. J., Oct. 1, 2003, at D1. Such agreements, in addition to violating the terms of insurance contracts, have been held to be unenforceable because of the necessity of medical care. See Allen Kachalia et al., *Physician Responses to the Malpractice Crisis: From Defense to Offense*, 33 J.L. MED. & ETHICS 417, 422–23 (2005). Health courts do not involve a waiver of the right to legal redress, only an agreement to engage in an alternative process.

¹⁶⁸ *Ferguson v. City of Charleston*, 308 F.3d 380 (4th Cir. 2002).

¹⁶⁹ See Zitter, *supra* note 149, at § 8[a].

“vote with their feet” by selecting another provider if the idea of being covered by the health court is not appealing.

C. *The Value of “Safe Harbor” Provisions*

Setting aside the group of patients who are both uninsured and in need of emergency care, one approach to facilitate the use of small-scale, consent-based demonstration projects of health courts would be to include “safe harbor” provisions in the legislation. Such provisions would describe the requisites for patient consent to coverage by the system and provide that any agreement fulfilling the stated requisites could not be found unconscionable or otherwise invalid under state law. A safe harbor law would almost certainly be necessary for a system that treated patient consent as deemed rather than requiring explicit consent. Although such a statute would not remove all of the constitutional questions,¹⁷⁰ it would be valuable both in ensuring that patients receive due process in the notice and consent aspects of the health court (by mandating a required process that all participating health plans and providers must follow) and as a bulwark against state law claims that focus on ineffective consent. Safe harbor laws of this kind are not unknown; several states provide that a contract having prescribed terms and promulgated in the prescribed way “shall not be deemed contrary to the public policy of this state”¹⁷¹ or “is not a contract of adhesion, nor unconscionable nor otherwise improper,”¹⁷² or “shall be presumed valid . . . [absent] a preponderance of the evidence [proving] fraud.”¹⁷³ We conclude that no matter how a consent-based system is designed, a statutory safe harbor is highly desirable and, in some states, necessary.

¹⁷⁰ A court might, for example, find a due process violation if the terms of the safe harbor infringed on fundamental fairness guarantees. Right-to-jury-trial and open-courts issues, however, would likely be muted, as the agreement would thereby be deemed a valid contractual waiver of the right to jury trial. Constitutional aspects of other kinds of deemed consent statutes are discussed in Gary L. Boland, *The Doctrines of Lack of Consent and Lack of Informed Consent in Medical Procedures in Louisiana*, 45 LA. L. REV. 1 (1984); Charity Scott, *Why Law Pervades Medicine: An Essay on Ethics in Health Care*, 14 N.D. J.L. ETHICS & PUB. POL'Y 245, 273 (2000) (discussing presumptive validity of medical informed consent); Joseph F. Stanton, *SJC Steers Off Course: DUI Breath Test Refusals Inadmissible*, 28 NEW ENG. L. REV. 1169 (1994) (discussing deemed consent to breath analyzer testing); and Tina L. Wilson, *Please Leave Your Constitutional Protections at the Door: A Challenge to Louisiana's Mandatory Drug Testing Statutes*, 60 LA. L. REV. 585 (2000) (discussing deemed consent to drug testing in schools by athletes).

¹⁷¹ COLO. REV. STAT. § 13-64-403 (2007).

¹⁷² CAL. CIV. PROC. CODE § 1295 (Deering 2007).

¹⁷³ OHIO REV. CODE ANN. §2711.24 (West 2007).

VI. RECONSIDERING THE CONSTITUTIONAL IMPLICATIONS OF HEALTH COURTS

When all of the foregoing is considered, what is the constitutional bottom line for health courts proposals? In this Part, we draw some general conclusions from the applicable law, emphasizing again that the analysis will vary across states. Our overall conclusion is that the view that the health courts proposal is a non-starter from a constitutional perspective is not well-founded. On the contrary, our reading of the case law and analysis of states' experience with similarly ambitious tort replacement schemes suggests that, given appropriate design, health courts have a very real chance of passing constitutional muster in some states.

We have shown that courts in the past have considered and adopted tort reforms that mirror or resemble a number of the features of health courts. These tort reforms have raised potential issues under state constitutions (Table 1). Periodic payment, collateral-source offset, limitations on damages, and restrictions on who may serve as an expert witness are familiar components of tort-reform packages, and have been widely upheld against constitutional challenges. We believe that for these features, the state's precedents regarding similar medical malpractice reforms will be reasonably reliable predictors of how a health court would fare. In other words, we anticipate that states with a history of unsuccessful tort reform challenges would have analogous outcomes for corresponding features of the health courts.

For health court features that are novel to medical malpractice reform, the outcome of constitutional challenges is less predictable. We focus the remainder of our discussion on these features: restricted eligibility and coverage, transfer of claims to an administrative agency, elimination of juries, elimination of the negligence standard, exclusivity of remedy, and the making of initial determinations on some claims without a live hearing (the so-called "accelerated-compensation event" claims¹⁷⁴). As outlined in Table 1, the key constitutional provisions implicated by these features are equal protection, separation of powers, procedural due process, right to a jury trial, and access to courts. In our view, the last two of these claims would present the strongest challenges to health courts.

For these claims, our review suggests that two determinations will prove critical. First, did the legislature properly document how a health court of the particular design proposed would address an important public policy problem? Second, was there an adequate quid pro quo?

A. *The Need for Legislative Findings*

In any constitutional analysis involving interest balancing, the court's evaluation of the legislature's rationale for adopting the reform and the rea-

¹⁷⁴ See *supra* note 22.

sonableness of the legislature's conclusion that the reform would effectively serve the purpose articulated will be critical. We have noted interstate variation in the degree to which courts search for evidence of these legislative findings and scrutinize them, but it is clear that regardless of the standard of scrutiny applied, it will behoove the legislature to document its public policy rationale as explicitly and credibly as possible. Appointment of a study commission, and incorporation of its report by reference, is an ideal mechanism for doing so.

Particularly for open-courts claims, it will be important for a legislature adopting a health courts demonstration to identify an important public policy purpose for limiting access to the judicial system. One form such arguments could take would be to focus on the need to ameliorate the conditions of a malpractice crisis, or to prevent another one from occurring. This particular rationale has particularly impressed courts in adjudicating challenges to tort reforms. The potential for health courts to stabilize liability insurance premiums by bringing greater predictability to the claims process and limiting noneconomic damages would be the cornerstone of such an argument. The legislature should also make specific findings about the adverse effects of a malpractice crisis on health care providers and patients,¹⁷⁵ emphasizing the state's strong interest in avoiding these effects.

The other line of justification that could be spelled out, potentially in tandem with the first, is that the health court addresses other, more fundamental and enduring problems with the malpractice system—problems in which the state also has an important interest. As alluded to earlier,¹⁷⁶ these include the waste arising from massive transaction costs;¹⁷⁷ inaccuracy in directing compensation to meritorious claims,¹⁷⁸ which blunts the incentives for safety improvement;¹⁷⁹ and, especially, the failure of the system to compensate the vast majority of patients who are injured by substandard care.¹⁸⁰ If the gravity of these problems can be identified and documented, then it should not be difficult to sustain the argument that the state has a legitimate interest in acting to address the problems—failing to address these problems would promote unsafe care, would waste scarce judicial and economic resources, and would provide inappropriate compensation for avoidably in-

¹⁷⁵ Although we do not describe these effects herein, they are comprehensively examined in Mello, *supra* note 4.

¹⁷⁶ See *supra* note 2 and accompanying text.

¹⁷⁷ Patricia M. Danzon, *Liability for Medical Malpractice*, in HANDBOOK OF HEALTH ECONOMICS 1339, (Anthony J. Culyer & Joseph P. Newhouse eds., 2000).

¹⁷⁸ David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 254 NEW ENG. J. MED. 2024 (2006).

¹⁷⁹ Mello & Brennan, *supra* note 10.

¹⁸⁰ A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245 (1991) (finding that only about two percent of New York patients injured by negligence filed a malpractice claim); David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 MED. CARE 250 (2000) (replicating this finding for patients in Utah and Colorado).

jured patients. We have elsewhere outlined the various ways in which a health court would be likely to mitigate these problems, and the empirical evidence from similar models of administrative compensation that could be cited to support legislative findings along these lines.¹⁸¹ This information would be a useful starting point for sponsors of a demonstration project. Specific linkage to local conditions would bolster its force.

It is somewhat odd for a legislature to assert that it is limiting the remedy for some injured patients (those who would have sued in tort and may have recovered more damages there) in order to expand access to compensation for others (those who would have faced barriers to bringing or winning tort claims). However, a strong argument can be made that health courts do rectify the undercompensation problem of the tort system in the aggregate because they lower procedural and practical barriers to claims and liberalize the compensation standard.

Legislative documentation of the public policy goals that health courts are intended to serve will help courts consider claims that patients' due process, equal protection, open-courts, and jury-trial rights have been abridged without adequate justification. It will also serve a second purpose—establishing that the health court offers an adequate quid pro quo for the curtailment of traditional rights.

B. *The Adequacy of the Quid Pro Quo*

In some states, the quid pro quo analysis may be functionally identical to the interest-balancing analysis just described because the courts will accept a general societal benefit as an adequate quid pro quo. Legislative findings that the health court will likely be effective in calming liability insurance markets and improving the quality and safety of health care will constitute a strong defense to open-courts and jury-trial challenges.

In other states, previous tort reform cases establish that the quid pro quo must be made out in relation to the class of claimants affected by the reform (actual plaintiffs) or the larger class of potential claimants (patients receiving care from providers covered by the reform). Proof of benefit to actual and potential claimants must focus on the system's promise to deliver faster, more reliable compensation decisions, and, especially, the extent to which a move from negligence to avoidability as the compensation standard would expand the pool of injured patients who have a remedy at law.¹⁸² Evidence from epidemiological studies of medical injury suggests that the pool of

¹⁸¹ Mello et al., *supra* note 20.

¹⁸² Again, though we do not rehearse these arguments here, extensive discussion can be found in Mello et al., *supra* note 20; Studdert & Brennan, *supra* note 8; and Mello & Brennan, *supra* note 10.

avoidable injuries is likely about twice as large as the group of injuries that are due to negligence.¹⁸³

Precedent from the litigation over workers' compensation suggests that courts will view a liberalized compensation standard as a very significant benefit to claimants. To be sure, health courts do not offer the degree of liberalization that workers' compensation did; avoidability is not strict liability. Nevertheless, more often than not, a rational patient who has experienced a serious medical injury should prefer to proceed under an avoidability standard rather than a negligence standard. All else being equal, chances of recovery will be greater, and compensation will be recovered much more quickly.¹⁸⁴ In addition, because this standard is less punitive and stigmatizing than negligence, and therefore less likely to provoke defensiveness and adversarialism among physicians,¹⁸⁵ patients should also prefer to receive care in a health care system that is governed by this liability standard.

The panoply of societal and claimant benefits offered by health courts, summarized in Table 6, should be sufficient to mount a strong *quid pro quo* argument in response to jury-trial, open-courts, and other legal challenges.

C. Other Considerations

Our review points to a number of additional, specific suggestions for health courts legislation, beyond the documentation of legislative purpose and *quid pro quo* described above. Including particular design features in the legislation will help prevent and overcome challenges based on equal protection, procedural due process, and separation of powers.

First, demonstrations will be on stronger constitutional footing if they do not treat patients who have similar injuries differently. Equal protection is an obvious line of attack against demonstrations that, for example, cover only a single clinical specialty. For example, subjecting mothers who sustain injuries during childbirth to a health court while allowing other patients with injuries of similar severity to proceed in tort would invite these attacks. Our review suggests that equal protection challenges have sometimes succeeded

¹⁸³ Mello et al., *supra* note 20, at 467 (citing Eric J. Thomas et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado*, 38 MED. CARE 261 (2006)). See also Allen B. Kachalia et al., *Beyond Negligence: Avoidability and Medical Injury Compensation*, 65 SOC. SCI. MED. (forthcoming 2007) (describing the two standards in detail and listing examples of injuries that would be compensable under an avoidability standard but not in tort).

¹⁸⁴ Consider, for example, a medical injury that, unfortunately, is not uncommon: a woman undergoing a hysterectomy experiences ligation of her urethra, resulting in a prolonged hospital stay, pain, additional surgery, and several months away from work. Ordinarily, this injury is unlikely to be compensable under a negligence standard. Under an avoidability standard, on the other hand, it would be. In an optimal system of care, this injury should never occur.

¹⁸⁵ See Mello et al., *supra* note 20, at 474.

TABLE 6. HEALTH COURTS' QUID PRO QUO

Benefited Party	Benefits
Claimants	<ul style="list-style-type: none"> • Expanded eligibility for compensation due to “avoidability” standard • Greater speed of claims adjudication • Incentives for providers to disclose medical injuries to patients and make offers of compensation • Enhanced ability to determine the likely value of a claim (accelerated-compensation event list, noneconomic damages schedule) • Enhanced ability to file a claim without assistance of attorney • Lower costs associated with pursuing a claim • Greater accuracy in decision making (i.e., meritorious claims more likely to receive compensation) • Less adversarial process; greater chance of preserving relationships with physician defendants
Society	<ul style="list-style-type: none"> • Lower risk to insurers due to greater predictability of judgments (may mean lower premiums) • Fewer uncompensated patients seeking support from other insurance and social welfare programs • Reduction in spending on litigation process • Improved patient safety and potential for lower total injury costs over time • Lower health care costs due to reduction in defensive medicine • Improved physician-patient relationships

against traditional tort reforms, and thus should be taken seriously as a challenge to health courts.

However, we also determined that most states will apply rational basis review to the legislative scheme. If appropriate legislative findings are present in the record, specifically addressing the reasons for the legislative classification scheme, equal protection challenges should be surmountable in most jurisdictions. Thus, for example, if a demonstration project is limited to obstetrics, the legislature should make specific findings about the necessity of addressing instability in malpractice premiums for obstetrician/gynecologists, the difficulties of recovering under the negligence standard for many obstetrical injuries given murkiness about the standard of care, and so on. Nonetheless, the safer course for a health courts demonstration project would be to design away the grounds for such a challenge and the need for such a defense from the outset.

Second, adoption of safe harbor provisions in the authorizing statute for a voluntary health court demonstration project would be highly desirable. It would help ensure both that patients do receive meaningful opportunities to provide informed consent to participation and that providers and insurers are

not ensnared in contractual-type disputes about consent and unconscionability.

Third, in both a voluntary and a mandatory health court system, procedural due process challenges should not pose a major barrier if the statute (1) provides for clear and prominent notice of the procedures through which claims can be brought; (2) makes clear that although some claims may initially be decided through an expedited process, any claim may receive a live hearing at the request of one of the parties; and (3) specifies an appeals process that includes ultimate recourse to the judicial courts. With respect to at least the second and third of those requisites, the prognosis in any particular state should be predictable from longstanding rules of administrative procedure, often gathered together in a state's general administrative procedure act. Although deferential review and expedited processes can raise due process questions, there need be nothing new about these features of health courts. To the extent that the health court procedures track those of other administrative agencies in the state, we believe they are not likely to succumb to any special scrutiny.

Fourth, it would be preferable for the statute to provide for appointment of health court judges by the state. In some states, the political difficulties of passing a bill that may result in a larger number of public employees may encourage legislators to contemplate the use of private adjudicators. While this approach may be politically attractive, it would have the additional complication of subjecting the health court to the uncertainties of unconscionability law under the Federal Arbitration Act.¹⁸⁶

Finally, when considering how to frame the health courts legislation, legislators should carefully examine the separation of powers jurisprudence in their state. If the state's jurisprudence reflects the notion that it is more constitutionally sound for a legislature to abolish a common law right entirely and replace it with a remedy than to modify an existing remedy, the health court should be described in those terms.¹⁸⁷ The legal review may also suggest that it would be desirable to house the health court within the judicial branch, rather than in the Department of Health or another executive agency.

¹⁸⁶ Using private adjudication in a private process would make the adjudication look much more like an arbitration than it would if the adjudicators were state-appointed agents acting under a state judicial or administrative warrant. Arbitration agreements are subject to invalidation on unconscionability grounds.

¹⁸⁷ It is not uncommon to find in workers' compensation cases a holding describing the right in question as a new right (any former analogous rights having been abolished), allowing the legislature to condition the new rights without access-to-courts or jury-trial requirements. *See, e.g.,* *Goodrum v. Asplundh Tree Expert Co.*, 824 S.W.2d 6 (Mo. 1992); *Nev. Indus. Comm'n v. Reese*, 560 P.2d 1352 (Nev. 1977); *McKay v. N.H. Comp. Appeals Bd.*, 732 A.2d 1025 (N.H. 1999); and *Kline v. Arden H. Verner Co.*, 469 A.2d 158 (Pa. 1983).

D. Concluding Reflections: Medical Injury Compensation and Governance of Health Care Quality

Compared with most other areas of law, we know a great deal about how well the medical malpractice system works. Existing empirical research suggests tremendous room for improvement.¹⁸⁸ The system's ability to promote careful behavior—arguably, tort law's principal functional objective—is particularly moribund.¹⁸⁹ If its proponents are to be believed, the health court represents an alternative governance structure for medical injury with high potential to breathe life into this critical social function. At a time when the government and the public are keenly aware of the prevalence of medical injury and are in search of ways to make health care safer, such a feat would surely be welcomed.

The alterations in governance arrangements needed to test this promise, however, are not trivial. A number of entrenched features of the tort system would require modification. Therefore, the promise of a medical injury compensation system that is more efficient and effective must be weighed against the importance of traditional attachments to tort litigation, not the least of which is Americans' high regard for the civil jury and the idea of each citizen's "day in court." Legislatures will conduct that weighing exercise as they decide whether to embrace the health court model and launch demonstration projects. Eventually, courts will repeat the exercise as they adjudicate the inevitable constitutional challenges.

If health courts are carefully designed and their perceived public benefit is forcefully articulated, we believe that their prospects in constitutional litigation are likely to be slightly worse than, but not substantially different from, those of the raft of tort reforms that moved through state courts in the 1970s and 1980s. The core features of the model are likely to survive constitutional challenge in some, perhaps even most, jurisdictions. Whether their constitutionality proves durable over time will depend on the track record they develop. If close evaluation of their performance suggests that few of the promised gains are materializing, courts will and should revisit the social bargain presented by health courts. But there is good reason to be sanguine about the prospects for health courts to pass constitutional muster at the outset. Policy experiments with health courts should not be impeded by trepidation about potential legal challenges.

¹⁸⁸ See Studdert et al., *supra* note 2, at 285–86.

¹⁸⁹ Mello & Brennan, *supra* note 10, at 1607–15.

