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A DOSE OF REALITY FOR SPECIALIZED COURTS: LESSONS FROM THE VICP

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The latest in a long line of reform proposals, health courts have been called "the best option for fixing our broken system of medical justice." And, if health courts' supporters are to be believed, these specialized courts are poised to revolutionize medical malpractice litigation: They would offer faster compensation to far more people, while restoring faith in the reliability of legal decisionmaking. But these benefits are, as some leading supporters have acknowledged, "hoped for, but untested." The question remains: Will health courts actually operate as effectively as proponents now predict?

The best evidence to answer that question comes, I suggest, from the Vaccine Injury Compensation Program (VICP)—a Program that employs very similar procedures to handle very similar claims and that had, at its birth, a very similar ambition. Mining nearly three decades of previously untapped material concerning the VICP's operation, this Article analyzes how an American compensation program that wrests jurisdiction from traditional courts has, in practice, fared. Findings are discouraging. Though the VICP and health courts share many of the same procedural innovations, those innovations, in the VICP context, have largely failed to expedite adjudications and rationalize compensation decisions. This fact carries significant implications for health courts, suggesting that they won't operate

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nearly as effectively as their proponents now predict. More broadly, this study of an American no-fault regime, in action and over time, enriches—and at times complicates—current understanding of the prospects, promise, and "perceived virtues" of other specialized courts and alternative compensation mechanisms.

INTRODUCTION

Health courts are the reform du jour.[1] Health court legislation—which would wrest medical malpractice cases from common law courts in favor of adjudication in specialized, dedicated tribunals—has been introduced in more than half a dozen states,[2] while bills to charter pilot projects have been introduced in both houses of Congress.[3] President Obama has expressed cautious support.[4] Health courts are, apparently, popular with the American

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1 In the words of the President of the American College of Obstetricians and Gynecologists, "[h]ealthcare courts are an idea whose time has come." COMMON GOOD, AN URGENT CALL FOR SPECIAL HEALTH COURTS 7 (2005).

2 States include Florida, Georgia, Illinois, New York, Oregon, Pennsylvania, and Virginia. *See* S.B. 1134, 2013 Leg., Reg. Sess. (Fla. 2013) (creating health courts); H.B. 897, 2013 Leg., Reg. Sess. (Fla. 2013) (same); S.B. 141, 2013–2014 Leg., Reg. Sess. (Ga. 2013) (same); H.B. 3166, 97th Gen. Assemb., Reg. Sess. (Ill. 2011) (same); Assemb. B. 8066-A, 2007–2008 Leg., Reg. Sess. (N.Y. 2007) (authorizing health court pilot projects); S.B. 655, 74th Leg., Reg. Sess. (Or. 2007) (establishing medical malpractice court); S.B. 678, 2007 Leg., Reg. Sess. (Pa. 2007) (proposing demonstration program); S.J. Res. 90, 2006 Leg., Reg. Sess. (Va. 2006) (authorizing continuation of subcommittee studying the feasibility of a pilot health court, and ultimately a system of health courts); H.R.J. Res. 183, 2006 Leg., Reg. Sess. (Va. 2006) (same); *see also* Freeman L. Farrow, *The Anti-Patient Psychology of Health Courts: Prescriptions from a Lawyer-Physician*, 36 AM. J.L. & MED. 188, 193 n.26 (2010) (citing additional state legislation).

3 Fair and Reliable Medical Justice Act, S. 1337, 109th Cong. (2005); Medical Liability Procedural Reform Act of 2005, H.R. 1546, 109th Cong. (2005); *see also* THE PATIENT CHOICE, AFFORDABILITY, RESPONSIBILITY, AND EMPOWERMENT ACT 8 (2015), *available at* http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/20150205-PCARE-Act-Plan.pdf (stating that states have the option to establish health courts presided over by a judge with expertise in health care).

4 President Obama's 2012 Federal Budget allocated funding for state medical justice reforms, including health courts. *See* Press Release, Common Good, President Obama's Budget Includes a Breakthrough to Address Medical Malpractice Reform and Move Beyond Partisanship (Feb. 16,

public.[5] And, the health court concept has been endorsed by the Institute of Medicine (IOM),[6] the U.S. deficit commission,[7] leading editorial boards,[8] powerful non-profits (including the American Medical Association (AMA)[9]), distinguished think tanks (including the nonpartisan Brookings Institute,[10] the left-leaning Progressive Policy Institute,[11] and the right-leaning Heritage

2011), *available at* http://www.prnewswire.com/news-releases/president-obamas-budget-includes-a-breakthrough-to-address-medical-malpractice-reform-and-move-beyond-partisanship-116313134.html. Further, the Affordable Care Act encourages states to "to develop and test alternatives to the civil litigation system" and authorizes $50 million in grants to develop such alternatives. *See Health Reform and Medical Malpractice Reform*, NAT'L CENTER FOR POL'Y ANALYSIS (Apr. 26, 2011), http://www.ncpa.org/sub/dpd/index.php?Article_ID=20587, *archived at* http://perma.cc/K6EV-SBFK.

5 Press Release, Common Good, Nationwide Clarus Poll Reveals that a Large Majority of U.S. Voters Think Legal System Increases Cost of Health Care (May 29, 2012), *available at* http://www.prnewswire.com/news-releases/nationwide-clarus-poll-reveals-that-a-large-majority-of-us-voters-think-legal-system-increases-cost-of-health-care-155365335.html (reporting that a 2012 survey funded by Common Good found that 66% of voters support the health court concept). *But cf.* Maxwell J. Mehlman & Dale A. Nance, The Case Against "Health Courts" 95-96 (Apr. 1, 2007) (unpublished manuscript), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1785383 (identifying problems with the design of similar surveys).

6 *See* COMM. ON RAPID ADVANCE DEMONSTRATION PROJECTS: HEALTH CARE FIN. & DELIVERY SYS., INST. OF MED., FOSTERING RAPID ADVANCES IN HEALTH CARE: LEARNING FROM SYSTEM DEMONSTRATIONS 10, 83 (Janet M. Corrigan et al. eds., 2002).

7 *See* Press Release, Common Good, Federal Deficit Commission Endorses Health Courts (Dec. 6, 2010), *available at* http://www.prnewswire.com/news-releases/federal-deficit-commission-endorses-health-courts-111387224.html.

8 *See, e.g.*, *Docs in the Dock: Why Not Set Up Special Courts for Malpractice Suits?*, FIN. TIMES, July 13, 2004, at 12; Editorial, *'Health Courts' Offer Cure*, USA TODAY, July 5, 2005, at 12A; Editorial, *Scalpel, Scissors, Lawyer*, ECONOMIST, Dec. 17, 2005, at 50-51; *see also* Editorial, *Guilty in Health Court: Cut Medical Bills by Clipping Wings of Ambulance Chasers*, WASH. TIMES, Dec. 7, 2010, at B2 ("The sensibility of health courts is so accepted that lawmakers seem to take their eventual adoption for granted.").

9 *See* AM. MED. ASS'N, HEALTH COURT PRINCIPLES 1 (2007) ("AMA policy indicates that health courts are a promising reform proposal that merits further investigation."); AM. MED. ASS'N, MEDICAL LIABILITY REFORM NOW!: THE FACTS YOU NEED TO KNOW TO ADDRESS THE BROKEN MEDICAL LIABILITY SYSTEM 31 (2014) (stating that "the AMA supports the testing and evaluation of health court pilot projects as an innovative way to address the medical liability problem").

10 *See* ENGELBERG CTR. FOR HEALTH CARE REFORM, BROOKINGS INST., BENDING THE CURVE: PERSON-CENTERED HEALTH CARE REFORM: A FRAMEWORK FOR IMPROVING CARE AND SLOWING HEALTH CARE COST GROWTH 32 (2013), *available at* http://www.brookings.edu/~/media/research/files/reports/2013/04/person%20centered%20health%20care%20reform/person_centered_health_care_reform.pdf (suggesting the federal government should help fund "innovative reform models" for medical liability).

11 *See* NANCY UDELL & DAVID B. KENDALL, PROGRESSIVE POLICY INST., HEALTH COURTS: FAIR AND RELIABLE JUSTICE FOR INJURED PATIENTS (2005).

Foundation[12]), respected academics,[13] and politicians from both sides of the proverbial aisle.[14]

Central to health courts' appeal is the contention that these tribunals—featuring specialized adjudicators, neutral experts, circumscribed damages, and a relaxed liability standard ("avoidability" rather than negligence)—will expedite medical malpractice adjudications, quell the adversarialism of dispute resolution, and provide consistent, rational rulings that would "restore faith in the reliability of medical justice."[15] Yet in more sober moments, health court advocates also acknowledge that these administrative benefits are not certain to materialize.[16]

Though it's rarely discussed, much rides on whether health courts will or won't achieve these lofty objectives. For one, health courts' ability to actually expedite, simplify, and rationalize compensation decisions is crucial to a fairness analysis, for if health courts are apt to resolve plaintiffs' claims in a speedy, streamlined, and reliable manner, all parties will derive a clear benefit from health courts' creation. On the other hand, if these "benefits" are illusory, health courts might start to look like a one-sided, rather than even-handed, reform. So, too, whether health courts will expedite and streamline adjudications is central to the cost question, for nearly all agree that far more injured patients will file claims in a health court system, as compared to the relative few who file claims currently. This means that if

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12 *See* RANDOLPH W. PATE & DEREK HUNTER, THE HERITAGE FOUND., CODE BLUE: THE CASE FOR SERIOUS STATE MEDICAL LIABILITY REFORM 12-14 (2006) (discussing the benefits of establishing special health courts).

13 *See* Philip G. Peters, Jr., *Health Courts?*, 88 B.U. L. REV. 227, 231-32 (2008) (listing health courts' distinguished academic supporters); Paul Barringer, *Let's Create Health Courts*, NAT'L L.J., May 2, 2005, at 22 (reporting that health courts have been endorsed by ten university presidents and eleven medical school deans).

14 For example, health courts have been endorsed by both the Senate Republican Policy Committee and the Democratic Leadership Council. *See* U.S. SENATE REPUBLICAN POLICY COMM., MEANINGFUL HEALTH CARE REFORM BEGINS WITH HEALTH COURTS (2006); *Health Courts for Fair and Reliable Justice*, DEMOCRATIC LEADERSHIP COUNCIL (June 30, 2008), http://web.archive.org/web/20060207071234/http://www.dlc.org/print.cfm?contentid=253435. Common Good, a nonprofit that has relentlessly championed health courts, boasts an Advisory Board that spans the political spectrum, from Bill Bradley on the left to Newt Gingrich on the right. *See Leadership*, COMMON GOOD, http://commongood.org/pages/leadership (last visited Apr. 24, 2015), *archived at* http://perma.cc/ATD8-PD79.

15 Philip K. Howard, *Just Medicine*, N.Y. TIMES, Apr. 2, 2009, at A27; *see also, e.g.*, UDELL & KENDALL, *supra* note 11, at 15 ("Health courts would make the malpractice system swift and reliable for all."); *infra* note 92 and accompanying text.

16 Michelle M. Mello et al., *Policy Experimentation with Administrative Compensation for Medical Injury: Issues Under State Constitutional Law*, 45 HARV. J. ON LEGIS. 59, 76 (2008) [hereinafter Mello et al., *Policy Experimentation*] (cataloging health courts' anticipated advantages, while recognizing that they are "hoped for, but untested").

the cost per adjudication does not plummet, the aggregate price of claim resolution could soar.[17]

Finally, but less obviously, health courts' capacity to expedite, streamline, and rationalize compensation decisions is critical to resolving simmering constitutional questions. Constitutional questions loom large because if health courts are enacted, opponents are sure to challenge these tribunals. Opponents will allege that, in curtailing victims' compensation and denying them the right to a trial by jury, health courts violate victims' rights to due process and equal protection and run afoul of many states' open court, separation of powers, and right-to-jury-trial guarantees.[18] Evaluating these constitutional claims, many reviewing courts will presumably ask the same question they've asked and answered on other occasions: In abrogating victims' common law remedy, did the legislature accompany the abrogation with a sufficient tangible benefit? Was there, in other words, an adequate quid pro quo?[19] So far, those defending health courts' constitutionality have suggested that a tangible benefit justifying the withdrawal is "the system's promise to deliver faster, more reliable compensation decisions."[20] Whether that "promise" is or is not realistic thus takes on weighty constitutional significance.

So the answer to the question—Will health courts *actually* expedite, streamline, and rationalize compensation decisions?—is profoundly

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17 Currently, some suggest that "creating reliable health courts . . . would save tens of billions of dollars a year." Philip K. Howard, Op-Ed., *Why We Need Health Courts for Medical Cases*, NEWSDAY (Feb. 17, 2013, 10:35 PM), http://www.newsday.com/opinion/oped/howard-why-we-need-health-courts-for-medical-cases-1.4665357, *archived at* http://perma.cc/69MZ-YMHM.

18 *See* Amy Widman, *Why Health Courts Are Unconstitutional*, 27 PACE L. REV. 55, 81 (2006) (asserting that health courts unconstitutionally "strip the right to redress in the courts without offering anything up in return"); Francine A. Hochberg, *The Injustice of Health Courts*, TRIAL, May 2008, at 42, 52 ("The most significant problem with the proposed health courts, and the true impediment to their widespread adoption . . . is constitutional."); *see also* Mehlman & Nance, *supra* note 5, at 107-11 (raising constitutional objections). If *Congress* were to enact health courts, additional constitutional issues would emerge. For a discussion of these issues, see generally E. David Elliott et al., *Administrative "Health Courts" for Medical Injury Claims: The Federal Constitutional Issues*, 33 J. HEALTH POL. POL'Y & L. 761 (2008); Amy Widman & Francine A. Hochberg, *Federal Administrative Health Courts Are Unconstitutional: A Reply to Elliott, Narayan, and Nasmith*, 33 J. HEALTH POL. POL'Y & L. 799 (2008).

19 *See, e.g.*, N.Y. Cent. R.R. Co. v. White, 243 U.S. 188, 201 (1917) (upholding New York's workers' compensation law against constitutional challenge because, though 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"); Samsel v. Wheeler Transp. Servs., Inc., 789 P.2d 541, 555 (Kan. 1990) ("Due process requires that the legislature substitute the viable statutory remedy of quid pro quo (this for that) to replace the loss of the right."). The U.S. Supreme Court has not yet clearly incorporated a quid pro test into its due process analysis, though it has toyed with the idea. *See* Widman, *supra* note 18, at 76.

20 Mello et al., *Policy Experimentation*, *supra* note 16, at 101-02.

important. Yet while many have taken sides on the broader health court controversy, *this* question has received remarkably little attention. Beyond referencing the positive experiences of a few somewhat analogous systems overseas,[21] and the decidedly mixed experiences of neurological birth injury funds in Florida and Virginia,[22] health court champions have said little

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21 Health court proponents have studied the no-fault experiences of New Zealand, Sweden, and Denmark because, they say, those nations' experiences "shed[] light" on how health courts would operate in the United States. MICHELLE M. MELLO ET AL., THE COMMONWEALTH FUND, PUB. NO. 1517, ADMINISTRATIVE COMPENSATION FOR MEDICAL INJURIES: LESSONS FROM THREE FOREIGN SYSTEMS 2 (2011), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/Jul/1517_Mello_admin_compensation_med_injuries.pdf; *see also* Allen B. Kachalia et al., *Beyond Negligence: Avoidability and Medical Injury Compensation*, 66 SOC. SCI. & MED. 387 (2008). Yet while there is value to this international study, I suggest that the experiences of these foreign systems are, for at least three reasons, of limited relevance. I say this, first, because, as compared to the countries proponents study, the United States has a unique "way of law"—including a far better-financed, more sophisticated, and more politically powerful plaintiffs' bar and a more deeply embedded preference for the adversarial resolution of claims. *See generally* ROBERT A. KAGAN, ADVERSARIAL LEGALISM: THE AMERICAN WAY OF LAW (2001). Shedding this adversarial culture is unlikely to be easy. Second, the countries' medical malpractice environments are notably dissimilar. At the time New Zealand enacted its transformative Accident Compensation Act, for example, New Zealand had almost no medical malpractice litigation to speak of, with fewer than 100 arguably serious claims filed each year. *See* Marc A. Franklin, *Personal Injury Accidents in New Zealand and the United States: Some Striking Similarities*, 27 STAN. L. REV. 653, 670 (1975). Or, at the time Sweden adopted its patient compensation system, medical malpractice compensation flowed to approximately ten patients annually. *See* Patricia M. Danzon, *The Swedish Patient Compensation System: Myths and Realities*, 14 INT'L REV. L. & ECON. 453, 454 (1994). Not so in the United States today. Third, the underlying provision of social services is strikingly different—meaning the job of accident compensation in New Zealand, Sweden, and Denmark is far less demanding than the same job within the United States. *See* Gregory C. Jackson, *Pharmaceutical Product Liability May Be Hazardous to Your Health: A No-Fault Alternative to Concurrent Regulation*, 42 AM. U. L. REV. 199, 228 n.193 (1992); *see also* FRANK A. SLOAN & LINDSEY M. CHEPKE, MEDICAL MALPRACTICE 302-03 (2008) (identifying additional differences between the tort systems of Sweden and New Zealand on the one hand and the United States on the other).

Of course, though, the question remains: Do these (and myriad other) differences matter when it comes to the on-the-ground performance of no-fault mechanisms? My intuition is they do. Indeed, the rocky vaccine injury experience recounted herein suggests that the United States is distinctive. Automobile no-fault legislation does as well—as our auto no-fault experiment was broadly seen as a bust as the system became bloated and bogged down (leading to its repeal in many states), while in New Zealand, for example, auto no-fault has been widely heralded as a success. *Compare* Nora Freeman Engstrom, *An Alternative Explanation for No-Fault's "Demise,"* 61 DEPAUL L. REV. 303 (2012) [hereinafter Engstrom, *An Alternative Explanation*] (tracing the rise and fall of the American experiment with automobile no-fault legislation), *with* TERENCE G. ISON, ACCIDENT COMPENSATION: A COMMENTARY ON THE NEW ZEALAND SCHEME 187 (1980) (discussing the success of automobile no-fault in New Zealand).

22 *See, e.g.*, Gil Siegal et al., *Adjudicating Severe Birth Injury Claims in Florida and Virginia: The Experience of a Landmark Experiment in Personal Injury Compensation*, 34 AM. J.L. & MED. 493 (2008); 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) [hereinafter Studdert et al., *The Jury Is Still In*]. The programs instituted in Florida and Virginia are much

about why and how health courts will achieve these all-important objectives. And health courts' many detractors, while raising strenuous objections to health courts' constitutionality,[23] cost,[24] fairness,[25] independence,[26] stinginess,[27] and susceptibility to political capture, have mostly surrendered on this score.[28] Meanwhile, *no one* has carefully assessed this question using the best evidence currently available. What is that best evidence? I suggest it comes from the Vaccine Injury Compensation Program (VICP or Program), which has been quietly compensating those suffering from vaccine injury in the United States since October 1, 1988.

Adjudication within health courts mimics adjudication within the VICP along many relevant dimensions. In terms of substantive reach, both resolve medical claims, where technical evidence is common and causation questions loom large.[29] In terms of ambition, both health courts and the VICP seek to be generous, rather than tightfisted, with the articulated aim of providing adequate, though circumscribed, payments to a higher proportion of injured individuals. In terms of applicable law, both modify—and liberalize—the traditional tort standard of recovery. Health courts would apply an "avoidability" standard that straddles strict liability and negligence, while the VICP discards fault entirely. In terms of personnel, both dispense with lay juries and generalist judges in favor of adjudication

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smaller than the VICP. For example, as of 2007, Virginia's program had received only 192 claims. *See* Siegal et al., *supra*, at 502. For criticism of the programs' performance, see *infra* notes 318-19, 389 and accompanying text.

23 *See supra* note 18 and accompanying text.

24 *See* Maxwell J. Mehlman & Rebecca G. Maine, *Health Courts Will Not Cure All Liability Ills*, BULLETIN, Mar. 2013, at 32, 35 (assailing health courts as an "expensive bureaucracy that infringes on the rights of injured, vulnerable patients").

25 *See* Farrow, *supra* note 2, at 197 (opposing health courts because these courts "will inevitably be pro-medical industry and anti-patient in their operation").

26 *See* Emily Chow, Note, *Health Courts: An Extreme Makeover of Medical Malpractice with Potentially Fatal Complications*, 7 YALE J. HEALTH POL'Y L. & ETHICS 387, 410 (2007) (opposing health courts because, given the charged nature of malpractice decisions, "political pressures . . . would inevitably pervade the health court bench").

27 *See* Joanne Doroshow, *The Health Courts Facade*, TRIAL, Jan. 2006, at 20, 27 (opposing health courts because, inter alia, they would "result in severe undercompensation for most patients").

28 For limited exceptions, see, for example, Peters, *supra* note 13, at 260-68 (expressing skepticism that health courts could increase efficiency without sacrificing decisional accuracy and substantive fairness); Widman, *supra* note 18, at 79 (noting that "claims of efficiency and speed of process are belied by almost every other alternative compensation system, each of which is plagued with a host of bureaucratic . . . problems"); Doroshow, *supra* note 27, at 22 (stating, in passing, that "[c]laims that health courts would be more efficient at meting out justice are unfounded").

29 There is, in fact, literal overlap between claims adjudicated within the two systems as the Vaccine Act preempts certain claims against physicians. *See infra* note 162 and accompanying text.

by specialist triers of fact. In terms of procedure, both admit evidence pursuant to flexible and informal standards, encourage reliance on independent experts, and compel the publication of decisions. In terms of time to adjudication, both systems underscore the importance of speed. Health court advocates suggest that these tribunals would offer justice within a year, while the VICP imposes a hard statutory deadline requiring that compensation decisions "shall" be issued "not later than 240 days . . . after the date the petition was filed."[30] In terms of decision aids, both health courts and the VICP feature a special and highly touted innovation: accelerated compensation events (ACEs) and the Vaccine Injury Table, respectively. Created by experts and periodically updated in light of scientific evidence, both ACEs and the Table identify injuries that are caused by inadequate healthcare or vaccines, respectively, and then fast-track qualifying claims for easy resolution. Finally, at the tail end of litigation, both health courts and the VICP restrict damages, limit payments to petitioners' counsel, and permit appeals, though only pursuant to a highly deferential standard of review.

Given the systems' obvious similarities, and given that we have nearly three decades of experience with the VICP—a tribunal that has, so far, adjudicated over 14,000 petitions[31]—it seems essential that lessons from the VICP be brought to bear as we weigh whether to embark on the health court experiment.[32]

Furthermore, a study of the VICP does not just matter in its own right. The study contributes to two broader, and enduring, debates. The push to enact health courts can first be seen as part of a larger effort, dating back over a century, to shuttle categories of cases out of courts of general jurisdiction and into specialized, dedicated tribunals. Like health courts, these specialized courts (now numbering in the dozens) are often

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30 42 U.S.C. § 300aa-12(d)(3)(A)(ii) (2012). For more on this requirement, see *infra* note 154 and accompanying text.

31 *See* HEALTH RES. & SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL VACCINE INJURY COMPENSATION PROGRAM: MONTHLY STATISTICS REPORT (2015), *available at* http://www.hrsa.gov/vaccinecompensation/statisticsreport.pdf.

32 Others, in passing, have said as much. *See, e.g.*, MICHELLE M. MELLO & ALLEN KACHALIA, EVALUATION OF OPTIONS FOR MEDICAL MALPRACTICE SYSTEM REFORM: A REPORT TO THE MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC) 29 (2010) (suggesting that policymakers can make some predictions about health courts' likely administration based on study of, inter alia, the VICP); Randall R. Bovbjerg, *Reform of Medical Liability and Patient Safety: Are Health Courts and Medicare the Keys to Effective Change?*, 9 J. HEALTH CARE L. & POL'Y 252, 276-77 (2006) (observing that the VICP and health courts are similar in many respects and that the VICP "model deserves much more attention than it has received"). This is the first Article to offer the analysis.

championed for offering litigants increased efficiency, quality, and uniformity.[33] But, though the contention that judicial specialization expedites case resolution, elevates the quality of judicial decisionmaking, and breeds consistency is surely logical and intuitively appealing, it has, too often in the past, been accepted on faith. Much has been said—by health court proponents, as well as others—about what specialization *ought* to do. Relatively little has been said about what specialization *does* do.[34] Moving beyond the familiar incantation of specialized courts' "perceived virtues," this Article starts a grounded inquiry into what judicial specialization has actually, in context and over time, managed to achieve.[35]

Moreover, the VICP is not just a specialized court. It is also what some call a "replacement regime"—it is a regime that jettisons tort law, with its individualized consideration of fault and idiosyncratic calculation of damages, in favor of a government-administered no-fault alternative.[36] Replacement regimes are the go-to weapon in serious tort reformers'

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33 *See* LAWRENCE BAUM, SPECIALIZING THE COURTS 32-33 (2011) (dubbing these the "neutral virtues" of judicial specialization); Douglas H. Ginsburg & Joshua D. Wright, *Antitrust Courts: Specialists Versus Generalists*, 36 FORDHAM INT'L L.J. 788, 793 (2013) ("The conventionally claimed benefits of specialized courts go to their potential efficiency, subject matter expertise, and, if they are given a monopoly over the subject matter, uniformity of decisions."). While specialization is often celebrated for the reasons above, others identify potential pitfalls, including that specialized judges might, on average, display a tendency toward insularity or tunnel vision and be more susceptible to politicization, political capture, or outside influence. For more on these, and other, possible drawbacks, see STEPHEN H. LEGOMSKY, SPECIALIZED JUSTICE: COURTS, ADMINISTRATIVE TRIBUNALS, AND A CROSS-NATIONAL THEORY OF SPECIALIZATION 16 (1990); RICHARD A. POSNER, REFLECTIONS ON JUDGING 95 (2013); Edward K. Cheng, *The Myth of the Generalist Judge*, 61 STAN. L. REV. 519, 550-56 (2008); David P. Currie & Frank I. Goodman, *Judicial Review of Federal Administrative Action: Quest for the Optimum Forum*, 75 COLUM. L. REV. 1, 68-75, 84-85 (1975); Rochelle Cooper Dreyfuss, *Specialized Adjudication*, 1990 BYU L. REV. 377, 377-82; Chad M. Oldfather, *Judging, Expertise, and the Rule of Law*, 89 WASH. U. L. REV. 847, 857-65 (2012); Jeffrey W. Stempel, *Two Cheers for Specialization*, 61 BROOK. L. REV. 67, 88-109 (1995).

34 *See* BAUM, *supra* note 33, at 34, 218 (decrying the paucity of proof and stating, for example, that "efficiency is the virtue most closely associated with specialization . . . but there is little evidence on this issue"); *id. at* 210 ("To the extent that participants in the policy-making process think explicitly about how specialization might affect court outputs, they tend to act on the basis of folk theories that rest on common-sense notions of causality rather than on extensive and systematic analysis."); Lawrence Baum, *Judicial Specialization and the Adjudication of Immigration Cases*, 59 DUKE L.J. 1501, 1541 (2010) (observing that "effects that seem nearly certain to follow from specialization do not necessarily occur in practice"); Ginsburg & Wright, *supra* note 33, at 794 (recognizing that "there is still no empirical foundation for the proposition that specialized judges are more efficient than generalists in the production of judgments").

35 *See* Oldfather, *supra* note 33, at 849-50, 865 (observing that there "exists a relatively large body of literature" outlining specialized courts' "perceived virtues" but asserting that much of the literature is contradictory or inadequately supported).

36 For more on "replacement" regimes, see THOMAS F. BURKE, LAWYERS, LAWSUITS, AND LEGAL RIGHTS: THE BATTLE OVER LITIGATION IN AMERICAN SOCIETY 38-41 (2002).

collective arsenals. Over the past century, such schemes have been advocated dozens of times, proposed for everything from motor vehicle accidents,[37] to nuclear accidents,[38] to airline accidents,[39] to railway accidents,[40] to those who contract HIV after transfusion with tainted blood,[41] to those hurt in schoolyard play,[42] to those injured in athletic competition,[43] to those harmed following contact with (variously) prescription drugs,[44] medical devices,[45] contraceptives,[46] asbestos,[47] lead paint,[48] cigarettes,[49] and firearms.[50] Yet even as reformers frequently call for tort's replacement, and even though many reformers explicitly model their proposed regimes on existing no-fault mechanisms (including, frequently, the VICP itself),[51] surprisingly few have paused to consider how these no-fault

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37 *See, e.g.*, ROBERT E. KEETON & JEFFREY O'CONNELL, BASIC PROTECTION FOR THE TRAFFIC VICTIM: A BLUEPRINT FOR REFORMING AUTOMOBILE INSURANCE (1965).

38 *See, e.g.*, Price-Anderson Act, Pub. L. No. 85-256, 71 Stat. 576 (1957) (codified as amended in scattered sections of 42 U.S.C.).

39 *See, e.g.*, Gail Appleson, *Airlines Seek Reform of Compensation System*, 68 A.B.A. J. 1071 (1982).

40 *See, e.g.*, Arthur A. Ballantine, *A Compensation Plan for Railway Accident Claims*, 29 HARV. L. REV. 705 (1916).

41 *See, e.g.*, Keith M. Garza, *Administrative No-Fault Recovery for Transfusion-Related HIV Infection*, 60 DEF. COUNS. J. 384 (1993).

42 *See, e.g.*, JEFFREY O'CONNELL, ENDING INSULT TO INJURY: NO-FAULT INSURANCE FOR PRODUCTS AND SERVICES (1975).

43 *See, e.g.*, Paul Grant, *No-Fault Insurance for Sports Injuries*, FREE LANCE-STAR, Sept. 27, 1983, at 15.

44 *See, e.g.*, Jackson, *supra* note 21, at 237.

45 *See, e.g.*, JAMES R. COPLAND & PAUL HOWARD, MANHATTAN INST. FOR POLICY RESEARCH, PROJECT FDA REPORT NO. 1, IN THE WAKE OF *WYETH V. LEVIN*: MAKING THE CASE FOR FDA PREEMPTION AND ADMINISTRATIVE COMPENSATION (2009); Amalea Smirniotopoulos, *Bad Medicine: Prescription Drugs, Preemption, and the Potential for a No-Fault Fix*, 35 N.Y.U. REV. L. & SOC. CHANGE 793 (2011).

46 *See, e.g.*, Janet Benshoof, *Protecting Consumers, Prodding Companies, and Preventing Conception: Toward a Model Act for No Fault Liability for Contraceptives*, 23 N.Y.U. REV. L. & SOC. CHANGE 403, 405 (1997).

47 *See, e.g.*, Amchem Prods., Inc. v. Windsor, 521 U.S. 591, 628 (1997).

48 *See, e.g.*, DONALD G. GIFFORD, SUING THE TOBACCO AND LEAD PIGMENT INDUSTRIES: GOVERNMENT LITIGATION AS PUBLIC HEALTH PRESCRIPTION 228 (2010).

49 *See, e.g.*, *id.* at 222-23.

50 *See, e.g.*, Lucinda M. Finley & John G. Culhane, Op-Ed., *Make Gun Companies Pay Blood Money*, N.Y. TIMES, June 24, 2013, at A21.

51 *See, e.g.*, Garza, *supra* note 41, at 390-91 (proposing a compensation system for victims of transfusion-related HIV infection, explicitly modeled on the VICP); Jackson, *supra* note 21, at 235-36 (advocating a no-fault system for pharmaceuticals modeled on the VICP); Finley & Culhane, *supra* note 50 (calling for a government-administered fund to compensate victims of gun violence, explicitly modeled on the VICP); *see also* COPLAND & HOWARD, *supra* note 45 (promoting a compensation system for those injured by drugs and medical devices "modeled on" the VICP); Malika Kanodia, *The Fate of the Injured Patient in the Wake of* Riegel v. Medtronic*: Should Congress Interject?*, 32 HAMLINE L. REV. 791, 834 (2009) (same, while suggesting that such a system would

systems, long in operation in the United States, have thus far fared.[52] Drawing on previously untapped material, this Article offers a sustained empirical account of the VICP to begin the process of bridging that gap.[53]

The remainder unfolds as follows. Part I identifies the problems that plague the medical malpractice system, catalogs the various (misdirected) medical malpractice reforms initiated over the past four decades, and closes with a description of health courts—a new and seemingly promising reform designed to revolutionize the adjudication of medical injury claims within the United States. Part II shifts gears to focus on vaccines. It provides background on the problem of vaccine injury, which crested in the mid-1980s; discusses Congress's subsequent enactment of the National Childhood Vaccine Injury Act of 1986; and introduces the VICP, a specialized court which has, over the past three decades, adjudicated thousands of petitions for what is, essentially, medical injury. Part III then considers health courts and the VICP side-by-side. Detailing the systems' many similarities, Part III suggests that the VICP offers a near-ideal context to test whether health courts' many procedural innovations are apt to fulfill proponents' hopes of dramatically expediting adjudications (delivering

permit payments to be "made in a more even-handed, predictable, and timely fashion than the current tort system allows").

52 For example, in a recent *New York Times* op-ed, Professors Finley and Culhane propose a compensation fund for innocent victims of gun violence, modeled on the VICP. In so doing, they assert that the VICP "avoids the time, expense and inefficiencies of litigation." Finley & Culhane, *supra* note 50. As we shall see, a close study of the VICP casts doubt on that assertion. *See also, e.g.*, Garza, *supra* note 41, at 390 (stating that the VICP "has proved effective in administering compensation of injured vaccinees" and asserting "[b]ecause vaccinees and persons injured through blood transfusions are similarly situated, one can expect similar positive results"). Researchers have conducted a limited number of studies of American no-fault regimes in action. *See, e.g.*, JAMES M. ANDERSON ET AL., RAND INST. FOR CIVIL JUSTICE, THE U.S. EXPERIENCE WITH NO-FAULT AUTOMOBILE INSURANCE: A RETROSPECTIVE 7 (2010); JOINT LEGISLATIVE AUDIT & REVIEW COMM'N OF THE VIRGINIA GEN. ASSEMBLY, REVIEW OF THE VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION PROGRAM (2003) [hereinafter VIRGINIA AUDIT]; U.S. DEP'T OF TRANSP., DOT-P-30-84-20, COMPENSATING AUTO ACCIDENT VICTIMS: A FOLLOW-UP REPORT ON NO-FAULT AUTO INSURANCE EXPERIENCES (1985); U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-00-8, VACCINE INJURY COMPENSATION: PROGRAM CHALLENGED TO SETTLE CLAIMS QUICKLY AND EASILY 2 (1999) [hereinafter 1999 GAO REPORT]; U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-15-142, VACCINE INJURY COMPENSATION: MOST CLAIMS TOOK MULTIPLE YEARS AND MANY WERE SETTLED THROUGH NEGOTIATION 2 (2014) [hereinafter 2014 GAO REPORT]; Randall R. Bovbjerg & Frank A. Sloan, *No-Fault for Medical Injury: Theory and Evidence*, 67 U. CIN. L. REV. 53, 55 (1998); Siegal et al., *supra* note 22, at 497; Studdert et al., *The Jury Is Still In*, *supra* note 22, at 499.

53 Via Freedom of Information Act (FOIA) requests, I have obtained thousands of pages of transcripts from quarterly meetings of the Advisory Commission on Childhood Vaccines (ACCV). The ACCV is a nine-member commission charged by Congress with "advis[ing] the Secretary [of HHS] on the implementation of the Program," 42 U.S.C. § 300aa-19(f) (2012), and transcripts of their meetings offer a behind-the-scenes view of the VICP in action.

compensation decisions within one year of filing), quelling adversarialism, and eliminating decisional discrepancies.

With that prefatory work completed, Part IV reveals that, despite its many procedural innovations, the VICP has struggled to resolve claims consistently or quickly. Despite predictions at enactment that the VICP would "guarantee" equal treatment to similarly situated claimants, a lack of consistency continues to bedevil the Program.[54] Notwithstanding Congress's demand that special masters "shall," with limited exceptions, issue decisions within 240 days,[55] adjudications within the VICP often take years and, in fact, take *longer* than litigation, to judgment, within the traditional tort system.[56] And, notwithstanding the many procedural shortcuts the VICP employs to simplify damage calculations, the calculation of damages tends to tack on another year—or sometimes two—to the resolution of petitions.[57] Part IV further identifies concrete reasons why the VICP's challenges ought to give health court proponents pause, suggesting that the problems that have plagued the VICP seem just as likely to plague health courts going forward. To be sure, this analysis does not *prove* that health courts won't outperform the tort system.[58] Nor does it *prove*, more broadly, that health courts aren't worthwhile. But it does call into question certain crucial—and heretofore conventionally accepted—claims about health courts' ostensible administrative advantages.

Finally, Part V steps back to consider why the VICP has stumbled. This examination identifies four issues that have plagued the VICP since its inception, contributing to many of the concrete problems identified above. These include: the difficulty of establishing "actual causation" in certain (identifiable) contexts; the double-edged nature of decision-aids; the burden of boundary definition, especially in non-self-contained substantive areas; and creeping party adversarialism. Further, a careful analysis reveals that these four issues have not *only* bedeviled the VICP. Drawing on research concerning workers' compensation, neurological birth injury funds in Florida and Virginia, and state automobile no-fault plans, I show, instead,

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54 *See* Mary Beth Neraas, Comment, *The National Childhood Vaccine Injury Act of 1986: A Solution to the Vaccine Liability Crisis?*, 63 WASH. L. REV. 149, 162-63 (1988) (predicting that the VICP would "guarantee" equal treatment). For further discussion on decisional disparities, see *infra* Section IV.A.

55 42 U.S.C. § 300aa-12(d)(3)(A)(ii) (2012).

56 *See infra* Section IV.B and particularly *infra* note 253 and accompanying text.

57 For damage calculation difficulties, see *infra* Section IV.C.

58 Indeed, though this Article raises numerous concerns about the VICP, only rarely can I show that the VICP underperforms vis-à-vis the tort system when it comes to adjudicating similar claims.

that these problems have similarly and quite consistently plagued other American no-fault mechanisms. Identifying these persistent challenges—and, also, in certain instances, the conditions that tend to make them worse—the Article closes with insights that ought to inform not only our expectations for health courts, but also, and more generally, our design and deployment of future specialized courts and tort replacement mechanisms.

I. THE ORIGINS AND STRUCTURE OF THE HEALTH COURT CONCEPT

A. *Origins: Medical Malpractice's Heavy Toll*

Viewed from any perspective, medical mistakes are a serious problem. Medical errors affect a significant proportion of patients. Indeed, the best evidence suggests that roughly 1% of hospitalized patients are victims of bona fide medical malpractice,[59] while another 1% to 1.5% of hospitalized patients are "preventably," though not necessarily negligently, hurt by the care they receive.[60] Because U.S. hospitals admit roughly 35 million patients each year, preventable errors affect as many as 700,000 Americans annually.[61] Further, some of these injuries are serious. Each year, 44,000 to 98,000 Americans die because of medical mistakes,[62] which means that

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[59] *See* PATRICIA M. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY 20 (1985) (reporting results of the 1974 California study, which estimated that the risk of negligent injury was 1 per 126 hospital admissions); PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 43 (1993) ("Our results indicate that in New York in 1984 . . . about 1 percent of all patients hospitalized suffered a negligent medical injury."); David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 MED. CARE 250, 253 (2000) [hereinafter Studdert et al., *Negligent Care and Malpractice*] (suggesting that the negligent injury rate in Utah and Colorado hospitals in 1992 was approximately 0.9% and 0.8%, respectively).

[60] *See* Lucian L. Leape et al., *The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II*, 324 NEW ENG. J. MED. 377, 378-79 (1991) (finding that, of 30,195 hospitalized patients, 1133 suffered adverse events and 58% of all adverse events stemmed from management errors—suggesting that roughly 2.2% of patients suffered preventable adverse events); Eric J. Thomas et al., *Costs of Medical Injuries in Utah and Colorado*, 36 INQUIRY 255, 259 (1999) (estimating that, of studied hospitalized patients in Utah and Colorado, approximately 1.9% suffered preventable adverse events).

[61] *See Hospital Admissions per 1,000 Population by Ownership Type*, HENRY J. KAISER FAM. FOUND., http://kff.org/other/state-indicator/admissions-by-ownership (last visited Apr. 24, 2015), *archived at* http://perma.cc/TQ8F-B2VS. (reporting annual admission data by state).

[62] *See* INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (Linda T. Kohn et al. eds., 2000). Even this may understate medical injury's toll, as the figures do not include deaths due to medical negligence that occur in nonhospital settings (including doctors' offices, nursing homes, and outpatient clinics). Additionally, the Institute of Medicine (IOM) derived its estimate from studies (including those cited above) that identified errors via medical records, though it is quite well established that medical records do not memorialize all medical mistakes. *See generally* Lori Andrews, *Studying Medical Error* in Situ*: Implications for Malpractice*

medical errors may cause more deaths per year than all other accident types combined.[63]

The medical malpractice system—which is to say the civil liability system's response to the above injuries—also takes a significant toll. The system's direct economic cost is substantial. Indeed, research suggests that administrative costs alone (in legal fees and insurer overhead) total more than $6 billion.[64] Its indirect costs are also considerable, as physicians report that fear of liability impacts the tests they perform, the medication they prescribe, and the referrals they make.[65] This contributes to "defensive medicine" (care provided solely, or primarily, to reduce the probability of litigation), which, studies suggests, adds billions of dollars to the nation's annual healthcare bill.[66] And, by all accounts, the physicians who are sued are deeply, and negatively, affected. Charges of malpractice are associated with depression, anger, and frustration, and doctors who have been sued are significantly more likely to consider an early retirement, advise their children not to practice medicine, and stop seeing the patients they perceive as more likely to sue going forward.[67]

Further, the system has, in recent decades, imposed greater and greater costs. Though lawsuits have dropped in recent years,[68] viewed from a longer time horizon, the picture reflects sharply increased activity. Malpractice insurance premiums have spiraled upward over the past few decades, from just under $500 million in 1960 (in inflation-adjusted dollars) to roughly $10

Law and Policy, 54 DEPAUL L. REV. 357 (2005) (finding, on the basis of a hospital observational study, a sizable gap between reported and actual errors).

63 *See* WEILER ET AL., *supra* note 59, at 55 ("Medical injury . . . accounts for more deaths than all other types of accidents combined . . . .").

64 *See* Michelle M. Mello et al., *National Costs of the Medical Liability System*, 29 HEALTH AFF. 1569, 1570 (2010) [hereinafter Mello et al., *National Costs*].

65 *See, e.g.*, David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 J. AM. MED. ASS'N 2609, 2612 (2005) (reporting that 93% of surveyed physicians in high-risk specialties admitted altering their clinical behavior because of the risk of malpractice liability).

66 There is little consensus concerning just how widespread defensive medicine is or how large of a toll it takes, though most agree its cost is substantial. *See, e.g.*, Mello et al., *National Costs*, *supra* note 64, at 1572-74 (estimating that defensive medicine accounted for $45.6 billion in healthcare costs in 2008).

67 *See* Peters, *supra* note 13, at 256-57 (synthesizing relevant evidence).

68 *See* CYNTHIA G. LEE & ROBERT C. LAFOUNTAIN, NAT'L CTR. FOR STATE COURTS, MEDICAL MALPRACTICE LITIGATION IN STATE COURTS 1, 3 (2011), *available at* http://www.courtstatistics.org/~/media/microsites/files/csp/highlights/18_1_medical_malpractice_in_state_courts.ashx (showing a steep drop in medical malpractice case filings in courts of general jurisdiction from 1999 to 2008).

billion today,[69] while physicians' likelihood of facing a claim has also ballooned. Prior to 1960, only one in seven physicians was named in a malpractice claim in an entire career, while in recent years, one in fourteen faces a malpractice claim *annually*.[70] Further, the medical malpractice system touches, in some direct way, nearly every doctor. By retirement age, "75% of physicians in low-risk specialties and 99% of those in high-risk specialties [a]re projected to face a [malpractice] claim."[71] And, because claims take so long to resolve, the average physician spends more than four years—or roughly 11% of her career—practicing medicine under the shadow of an open and unresolved malpractice allegation.[72]

Finally, and many think worst of all, the situation has never been particularly satisfactory from the injured patients' perspective. A tiny fraction of those hurt by medical error (on the order of 2% to 3%) ever even attempt to claim compensation.[73] Of those who do initiate claims, many fall short: Doctors prevail in roughly three-quarters of medical malpractice jury trials,[74] and, overall, approximately 40% of patients who retain counsel never

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[69] In 1960, medical malpractice insurance premiums totaled $60 million. *See* Robert H. Brook et al., *The Relationship Between Medical Malpractice and Quality of Care*, 1975 DUKE L.J. 1197, 1197. Adjusted for inflation, this would be approximately $476 million. *See CPI Inflation Calculator*, BUREAU OF LAB. STAT., http://www.bls.gov/data/inflation_calculator.htm (last visited Apr. 24, 2015), *archived at* http://perma.cc/BC9C-U9EY. In 2012, premiums totaled $10 billion. *See* NAT'L ASS'N OF INS. COMM'RS, STATE INSURANCE REGULATION: KEY FACTS AND MARKET TRENDS (2013). It is worth noting, however, that premiums have not soared on an inflation-adjusted, per-physician basis, particularly when compared to other practice expenses. *See* Marc A. Rodwin et al., *Malpractice Premiums and Physicians' Income: Perceptions of a Crisis Conflict with Empirical Evidence*, 25 HEALTH AFF. 750, 751-52 (2006).

[70] *Compare* KENNETH S. ABRAHAM, THE LIABILITY CENTURY: INSURANCE AND TORT LAW FROM THE PROGRESSIVE ERA TO 9/11, at 105 (2008) ("Before 1960, only one out of every seven physicians experienced a malpractice claim in an entire career."), *with* Anupam B. Jena et al., *Malpractice Risk According to Physician Specialty*, 365 NEW ENG. J. MED. 629, 632 (2011) (reporting that, in any given year, from 1991 through 2005, 7.4% of all studied physicians experienced a malpractice claim).

[71] Jena et al., *supra* note 70, at 633. By age 65, 71% of physicians in high-risk specialties can be expected to make an indemnity payment. *See id.* at 634.

[72] *See* Seth A. Seabury et al., *On Average, Physicians Spend Nearly 11 Percent of Their 40-Year Careers with an Open, Unresolved Malpractice Claim*, 32 HEALTH AFF. 111, 111 (2013).

[73] *See, e.g.*, Andrews, *supra* note 62, at 370 (reporting that, of patients who were seriously affected by medical mistakes, only 2.2% initiated claims for compensation); Studdert et al., *Negligent Care and Malpractice*, *supra* note 59, at 253-55 (finding that only 2.5% of patients injured due to medical error filed a malpractice lawsuit).

[74] *See* LYNN LANGTON & THOMAS H. COHEN, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NJC 223851, CIVIL BENCH AND JURY TRIALS IN STATE COURTS, 2005, at 4 tbl.5 (2009) (reporting that plaintiffs won only 22.7% of medical malpractice trials); David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2026 (2006) [hereinafter Studdert et al., *Claims, Errors, and Compensation Payments*] (reporting that plaintiffs prevailed in 21% of trials). Note, however, that some losing

recover a penny.[75] Even when compensation does come, it comes slowly,[76] and it is often inadequate, particularly for the catastrophically injured.[77] And even when an injured patient does recover, friction costs are substantial. For every dollar that reaches the plaintiff, another dollar is spent getting it there.[78]

B. *Reform Initiatives So Far*

Understandably unsatisfied with the status quo, the past three decades have witnessed a flurry of med-mal-related legislative activity. Typically spearheaded by physician groups and liability insurers, reforms have generally ignored (or stubbornly denied) the well-documented problems of widespread injury and pervasive under-claiming and have instead sought to limit physician and hospital liability. Undertaken by every state, these initiatives have taken a number of forms, including caps on noneconomic (and sometimes total) damages, modifications to joint and several liability, the elimination of the collateral source rule, caps on contingency fees, the imposition of certificate-of-merit requirements, restrictions on statutes of limitations, and the creation of professional screening panels.[79] The stated justification for these initiatives has been to deter frivolous claims and reduce the size and curb the unpredictability of large (often dubbed "windfall") payments.[80] Just as important—if less often articulated—by

plaintiffs do not walk away empty-handed, as some proceed to trial against one defendant having already settled with another. *See* Neil Vidmar, *Juries and Medical Malpractice Claims: Empirical Facts Versus Myths*, 467 CLINICAL ORTHOPAEDICS & RELATED RES. 367, 368 (2009).

75 WEILER ET AL., *supra* note 59, at 5 (reporting that approximately 60% of represented claimants "receive some settlement or award"); Studdert et al., *Claims, Errors, and Compensation Payments*, *supra* note 74, at 2026 (reporting that, of all patients who filed a medical malpractice claim—defined merely as a written demand for compensation—roughly 56% received compensation).

76 *See infra* note 256 and accompanying text.

77 *See* Frank A. Sloan & Chee Ruey Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?*, 24 LAW & SOC'Y REV. 997, 1028-29 (1990).

78 *See* Studdert et al., *Claims, Errors, and Compensation Payments*, *supra* note 74, at 2031. Finally, no discussion of the medical malpractice system's woes would be complete without noting that the system itself sometimes errs. Some injury victims with meritorious claims get nothing, while some individuals with non-meritorious claims get paid. I address this problem below at notes 240-41 and accompanying text.

79 For more on these initiatives, see generally F. Patrick Hubbard, *The Nature and Impact of the "Tort Reform" Movement*, 35 HOFSTRA L. REV. 437 (2006).

80 In so doing, reformers have sought to increase physician supply, curb defensive medicine, and lower medical malpractice insurance premiums (and, indirectly, healthcare costs). Reforms' actual effects on the above are "mixed." *See generally* Theodore Eisenberg, *The Empirical Effects of Tort Reform*, *in* RESEARCH HANDBOOK ON THE ECONOMICS OF TORTS 513, 520-37 (Jennifer Arlen ed., 2013).

limiting the expected value of claims (and attorneys' fees earned thereon), proponents have sought to dampen plaintiffs' desire and capacity to sue.

Notwithstanding their popularity, these incremental reforms are susceptible to serious criticism.[81] For starters, traditional reforms do nothing to help (and, in fact, likely exacerbate) the two most pressing problems when it comes to medical injury: (1) the prevalence of medical mistakes, and (2) the paucity of adequate compensation for those hurt. Further, to the extent one actually believes that the worst thing about medical malpractice is the lawsuits it engenders, when it comes to those lawsuits, existing reforms just fiddle at the margins, leaving intact the basic structure for the compensation of medical mistakes. To the extent the medical malpractice system *is* truly broken, in other words, limiting damages doled out by juries or capping the fees lawyers can earn does not *fix* the system, it merely offers "less of the same."[82] Then, as a final kicker, to the extent existing reforms *do* have an effect, that effect is unevenly, and often unfairly, felt—disproportionately targeting those who are grievously hurt and those who are particularly disempowered and especially vulnerable, such as women, children, and the elderly.[83]

C. *Health Courts: The Basics*

Breaking with the status quo, health courts would offer not incremental, but wholesale, reform,[84] targeting not merely medical malpractice *litigation*

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[81] *See, e.g.*, TOM BAKER, THE MEDICAL MALPRACTICE MYTH 3 (2005) (arguing that "the real problem is too much medical malpractice, not too much litigation"); Michael J. Saks, *Medical Malpractice: Facing Real Problems and Finding Real Solutions*, 35 WM. & MARY L. REV. 693, 694 (1994) (book review) ("[L]egislative reforms of the past two decades have been aimed at shielding health care providers, especially doctors, from the principal legal device designed to deal with accidental injuries, thereby assuring that injuries and deaths remain high and compensation inadequate.").

[82] Laurence R. Tancredi & Randall R. Bovbjerg, *Rethinking Responsibility for Patient Injury: Accelerated-Compensation Events, A Malpractice and Quality Reform Ripe for a Test*, 54 LAW & CONTEMP. PROBS. 147, 148 (1991) ("[R]eforms need to offer a demonstrable improvement, not merely 'less of the same,' like conventional tort reform's pro-defendant changes in legal rules.").

[83] *See* Maxwell J. Mehlman, *Promoting Fairness in the Medical Malpractice System* (calling certain reforms "transparently unfair"), *in* MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 137, 142-43 (William M. Sage & Rogan Kersh eds., 2006); Saks, *supra* note 81, at 722 ("Caps are a cruel and perverse solution."). *See generally* Lucinda M. Finley, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 EMORY L.J. 1263 (2004) (finding that noneconomic damage caps impose a disproportionate burden on women, children, and the elderly); David M. Studdert et al., *Are Damage Caps Regressive? A Study of Malpractice Jury Verdicts in California*, HEALTH AFF., July–Aug. 2004, at 54 (finding that noneconomic damage caps most severely restrict the compensation of those victims with the most catastrophic injuries).

[84] Health courts are the most recent in a long line of scholarly calls for fundamental reorientation of the medical injury compensation system. Other bold reform proposals have called, inter

but the far more serious epidemic of medical injury. In crafting this reform initiative, health court architects have specifically seized on four problems with the current system: the negligence standard, victims' low rate of claiming, the inaccuracy and inconsistency of judgments, and the system's sometimes interminable delays.[85]

First, health court proponents take issue with the negligence standard, which traditionally governs lawsuits alleging medical injury. This standard, they say, defies easy administration, contributing to decisional inaccuracy; is fundamentally misdirected, as many medical injuries arise not from the personal "fault" of any individual physician but rather from broader "systems failures" within hospitals and healthcare organizations;[86] and, owing to its connotation of "moral misbehavior," inhibits physicians' willingness to disclose errors, which, in turn, impairs providers' ability to learn from their mistakes.[87]

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alia, for states to adopt enterprise liability, *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, 398-401 (1994), and base liability on contract, rather than tort, principles, *see, e.g.*, Richard A. Epstein, *Medical Malpractice: The Case For Contract*, 76 AM. B. FOUND. RES. J. 87, 93-94 (1976). Health courts themselves are an outgrowth of two earlier proposals. The first called for the creation of an administrative entity to resolve liability disputes pursuant to a list of "compensable events." Clark C. Havighurst & Laurence R. Tancredi, *"Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance*, 51 MILBANK Q. 125, 131-34 (1973). The second, from the AMA, sited adjudications within "an expert administrative agency," altered applicable legal standards, and curtailed damages. MEDICAL LIABILITY PROJECT, AM. MED. ASS'N / SPECIALITY SOC'Y, A PROPOSED ALTERNATIVE TO THE CIVIL JUSTICE SYSTEM FOR RESOLVING MEDICAL LIABILITY DISPUTES: A FAULT-BASED, ADMINISTRATIVE SYSTEM at i, 17-60 (1988). Health courts differ from these other reform ideas, in part, because they have actually made the leap out of the academy and into policy debates and (to a lesser extent) popular consciousness.

85 A number of health court proposals exist, and plans vary on the particulars. The foregoing discussion attempts to distill the core features of the leading plans, focusing, when possible, on the model set forth in Michelle M. Mello et al., *"Health Courts" and Accountability for Patient Safety*, 84 MILBANK Q. 459 (2006) [hereinafter Mello et al., *"Health Courts"*]. For a detailed discussion of how various plans differ, see generally Mehlman & Nance, *supra* note 5, at 15-28.

86 *See* INST. OF MED., *supra* note 62, at 49 ("The problem is not bad people; the problem is that the system needs to be made safer.").

87 On this latter point, health court proponents reason: (1) we cannot reduce mistakes without disclosing them, (2) the tort system's naming and blaming culture inhibits disclosure, and (3) the "avoidability" standard, by eliminating any connotation of moral misbehavior, would encourage physicians to reveal, and learn from, their mistakes. *See, e.g.*, Mello et al., *"Health Courts," supra* note 85, at 472-74. Not surprisingly, others are not convinced. Some question the syllogism's second step, arguing that, rather than inhibiting disclosure, medical malpractice lawsuits "reveal[] valuable information about weaknesses in hospital policies, practices, providers, and administration." Joanna C. Schwartz, *A Dose of Reality for Medical Malpractice Reform*, 88 N.Y.U. L. REV. 1224, 1224 (2013). Zeroing in on the third step in the syllogism, others show that there is little evidence that error reporting fluctuates alongside the threat of liability. *See, e.g.*, George J. Annas, *The Patient's Right to Safety—Improving the Quality of Care Through Litigation*

Second, health court proponents target medical malpractice victims' very low rate of claiming (of 2% to 3%) and seek to expand the pool of compensated claimants, while limiting payouts thereto. Broadening compensation, proponents say, would be both salutary in its own right (in keeping with tort's compensation ambition) and would also amplify tort's (currently muffled) deterrent signal.[88] Reduced payouts, they reason, are needed to keep costs from skyrocketing.[89]

Third, health court proponents aim their fire at the medical malpractice system's "unreliable" judgments, which they liken to a lottery—or worse.[90] According to health court advocates, many of the most serious problems plaguing the medical malpractice system have their roots in decisional inaccuracy and inconsistency. This lack of reliability, they say, contributes to defensive medicine (as doctors, uncertain about what care is required, pile on unnecessary precautions) and also interferes with the tort system's ability to deter mistakes (as physicians believe that litigation outcomes are untethered to the underlying merit of the claim).[91] Thus, health court proponents seek to "eliminate," or at least dramatically reduce, decisional disparities.[92] This they would accomplish by basing decisions, whenever

Against Hospitals, 354 NEW ENG. J. MED. 2063, 2065 (2006) (pointing out that error reporting rates are similar in the United States and New Zealand); David A. Hyman & Charles Silver, *Believing Six Improbable Things: Medical Malpractice and "Legal Fear*," 28 HARV. J.L. & PUB. POL'Y 107, 110 (2004) ("[T]he empirical literature indicates that there is massive underreporting of errors throughout the health care system, regardless of the level of liability risk that providers face."); Lucian L. Leape, *Reporting of Adverse Events*, 347 NEW ENG. J. MED. 1633, 1635 (2002) ("No link between [error] reporting and litigation has ever been demonstrated.").

88 *See* Mello et al., *"Health Courts," supra* note 85, at 465 ("A primary goal of health court proposals is to expand the pool of injured patients who are eligible for compensation."). For how infrequent claiming muffles tort's deterrent signal, see Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1618-20 (2002).

89 *See* Mello et al., *"Health Courts," supra* note 85, at 470 ("Although more claims would be filed, the average award would likely be considerably lower."). Curbing payouts also eradicates windfall awards and promotes horizontal equity. *See id.* at 469-70.

90 For proponents' assertions about the system's unreliability (as well as a critique of certain overheated rhetoric), see *infra* subsection IV.A.2.

91 *See* Mello et al., *"Health Courts," supra* note 85, at 469, 472 ("[T]he malpractice case tends to be compared to a lightning strike as simply a random event not associated with quality."). For the link between unpredictability and defensive medicine, see Philip K. Howard, *Special Health Courts: The Cure for Defensive Medicine*, ATLANTIC (Feb. 24, 2010), http://www.theatlantic.com/national/archive/2010/02/specialhealthcourtsthecurefordefensivemedicine/36564, *archived at* http://perma.cc/Y69D-CWH4.

92 *See* Howard, *supra* note 17 (asserting that "unreliable justice" can "be eliminated by creating specialized administrative health courts"); *accord* UDELL & KENDALL, *supra* note 11, at 4 ("The health court system would thus provide an essential benefit where our current system of medical justice fails: it would provide consistent, rational rulings . . . ."); Mello et al., *"Health Courts," supra*

possible, in objective evidence and vesting decisionmaking authority in trained and specialized experts.[93]

Fourth and finally, health court proponents zero in on the sometimes interminable delays that attend contemporary medical malpractice litigation. Charging that these delays exacerbate stress on doctors, deny compensation to needy and deserving claimants, encourage malingering, complicate insurance pricing, and impede physicians' efforts to learn from their mistakes, health court architects seek to speed up case resolution considerably.[94] In fact, proponents assert, health courts would resolve cases within one year of the date of filing.[95]

To achieve the above objectives, health courts would alter the traditional tort system in seven fundamental respects. First and most importantly, health courts would alter the substantive standard pursuant to which physicians and hospitals are judged, substituting a new "avoidability" standard for negligence. Straddling strict liability and negligence, this "avoidability" standard would render compensable all injuries that would not have occurred but for the physician's failure to follow "best practices" or the hospital's failure to impose "an optimal system of care."[96] (This differs from the negligence standard, which turns on whether a physician's care fell below the "customary," rather than the "best," standard within the profession.)

Second, health courts would impose on hospitals a new outreach obligation. Health courts would compel hospitals to determine whether each patient's iatrogenic injury (injury arising out of medical treatment) was avoidable and, if it was, to notify the patient of his or her possible

note 85, at 469 (suggesting that health court innovations will "reduce the incidence of liability determinations that do not match the underlying merits of the claim").

93 *See* Mello et al., *"Health Courts," supra* note 85, at 461, 465.

94 *See* William M. Sage, *Malpractice Reform as a Health Policy Problem* (cataloging these concerns), *in* MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM, *supra* note 83, at 30, 37.

95 *See, e.g.,* AM. MED. ASS'N, HEALTH COURT PRINCIPLES, *supra* note 9, at 2 (suggesting that a key principle for health court architects is that resolution should be "expeditious . . . with a goal of resolving all claims within one year from the filing date"); COMMON GOOD, *supra* note 1, at 5 ("Most cases would be resolved within months."); Philip K. Howard, *Beyond Obamacare: How to Fix Our Enormous, Inefficient Health-Care System*, ATLANTIC (May 7, 2012), http://www.theatlantic.com/health/archive/2012/05/beyondobamacarehowtofixour-enormousinefficienthealthcaresystem/256765, *archived at* http://perma.cc/9Y8R-B6FD ("Patients injured by mistakes can get justice within a year, not the five years it takes today."); *accord* Mello et al., *"Health Courts," supra* note 85 at 465 (predicting that, even if cases are contested, the ALJ could hold a hearing and "make a decision within a few weeks").

96 Mello et al., *"Health Courts," supra* note 85, at 461, 464, 474. Not all who endorse health courts accept the avoidability standard. The AMA, for instance, would retain negligence as the threshold for patient compensation. *See* AM. MED. ASS'N, HEALTH COURT PRINCIPLES, *supra* note 9, at 2.

entitlement to relief.[97] (Currently, despite various exhortations to share this information, such notifications are exceptional.[98])

Third, health courts would limit damage awards. Though health courts would continue to reimburse victims' entire economic loss,[99] these tribunals would eliminate the collateral source rule (thereby excluding compensation for expenses covered by other plans, programs, or health insurance)[100] and award noneconomic damages only pursuant to a schedule or sliding scale tied to injury severity.[101]

Fourth, health courts would create a new layer of pre-adjudication expert review. Immediately upon a claim's receipt, health courts would compel the hospital or physician's insurer (the "respondent") to convene a group of neutral experts to review the claim and render a judgment as to its compensability. If this "expert panel" determined that the claim was entitled to compensation, it would supply the claimant an offer of compensation; if not, the expert panel would provide "a written report" outlining reasons for its denial.[102] If *either* the claimant or the health care provider were

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97 *See* Mello et al., *"Health Courts," supra* note 85, at 462. To ensure compliance, health courts could impose fines or "surcharges" on hospitals that shirk their notification obligation. *Id.* For more on this reporting obligation, see Mehlman & Nance, *supra* note 5, at 63-65.

98 *See* Andrews, *supra* note 62, at 371.

99 Most health court plans envision the full recovery of economic loss. *See, e.g.*, AM. COLL. OF PHYSICIANS, EXPLORING THE USE OF HEALTH COURTS—ADDENDUM TO "REFORMING THE MEDICAL PROFESSIONAL LIABILITY SYSTEM" 6 (2006) (stating that the "ACP strongly supports a health court model that pays 100% of the patient's economic damages"); AM. MED. ASS'N, HEALTH COURT PRINCIPLES, *supra* note 9, at 2; Mello et al., *"Health Courts," supra* note 85, at 467 (indicating that health courts would award full economic damages, subject to a collateral-source offset rule); Howard, *supra* note 15 ("With a special health court, damages would consist of all lost income and medical costs . . . ."). Some, however, envision cabining both economic and noneconomic damages. *See, e.g.*, Barringer, *supra* note 13 at 247-48 (describing a "schedule of benefits" for both economic and noneconomic damages); UDELL & KENDALL, *supra* note 11, at 11 (same).

100 Mello et al., *"Health Courts," supra* note 85, at 467. A caveat is that this may be easier said than done, as federal law protects the status of certain entities as secondary payors. *See* 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, 251 (2001) (cautioning that "fairly well-established statutory and common law will restrict opportunities for state sponsors of no-fault experimentation programs to adopt offset arrangements against Medicare and Medicaid as a means for saving resources").

101 Proponents explain: "The schedule would consist of a number of injury-severity tiers based on an existing injury-severity scale . . . . Dollar value ranges (both floors and ceilings) would be assigned to each tier based on decision-science research about how the public values various utility losses and public deliberation about reasonable compensation." Mello et al., *"Health Courts," supra* note 85, at 468 (citation omitted).

102 *Id.* at 464.

dissatisfied with the expert panel's eligibility determination or damage calculation, a formal health court adjudication would ensue.[103]

Fifth, in the course of these adjudications, health courts would take two new steps to promote predictability. First, and most fundamentally, health courts would remove medical malpractice cases from generalized courts and locate them, instead, in a specialized tribunal overseen by an ALJ schooled in, and devoted to, medical injuries.[104] Appointed by a board assembled by the governor or other appropriate body, these ALJs "would have special training and experience in medical matters, but would not typically be trained as physicians."[105] Meanwhile, health courts would arm ALJs with decision aids dubbed "accelerated compensation events" (ACEs). Identified ex ante by an expert body (and periodically updated as new evidence becomes available), ACEs would identify certain injuries that would not typically occur if a doctor provided optimal care. If a claimant sustained an injury matching "the specifications and clinical circumstances of an item on an ACE list," she would be adjudged presumptively eligible for compensation, thus eliminating individual fact-finding.[106]

Sixth, health courts would take steps to abridge and expedite proceedings: Live hearings would be convened only at a party's or the ALJ's request, and hearings themselves would be simplified; evidence, for example, would be admitted pursuant to "basic but relaxed" rules.[107]

Last but not least, health courts would limit appeals and regulate payments to petitioners' counsel. Though either party could appeal—first to a higher-level administrative tribunal, then to a judicial court—this review would be limited: The ALJ's decision would be affirmed unless it was "arbitrary and capricious."[108] Meanwhile, in regards to payments to petitioners' counsel: "Claimants would pay their attorneys on a contingent basis (i.e., only if the claim resulted in a compensation payment), but the

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103 *See id.*

104 *See* Mello et al., *Policy Experimentation*, *supra* note 16, at 64-65.

105 *Id.* at 65.

106 For a description of ACEs, see Mello et al., *"Health Courts," supra* note 85, at 461, 466-67; Tancredi & Bovbjerg, *supra* note 82, at 149-53. It is not clear what proportion of cases ACEs would cover. *Cf.* RANDALL R. BOVBJERG & ROBERT A. BERENSON, URBAN INST., SURMOUNTING MYTHS AND MINDSETS IN MEDICAL MALPRACTICE 8 (2005), *available at* http://webarchive.urban.org/UploadedPDF/411227_medical_malpractice.pdf (suggesting that "[a]voidable classes of events (ACEs) would probably cover most injuries").

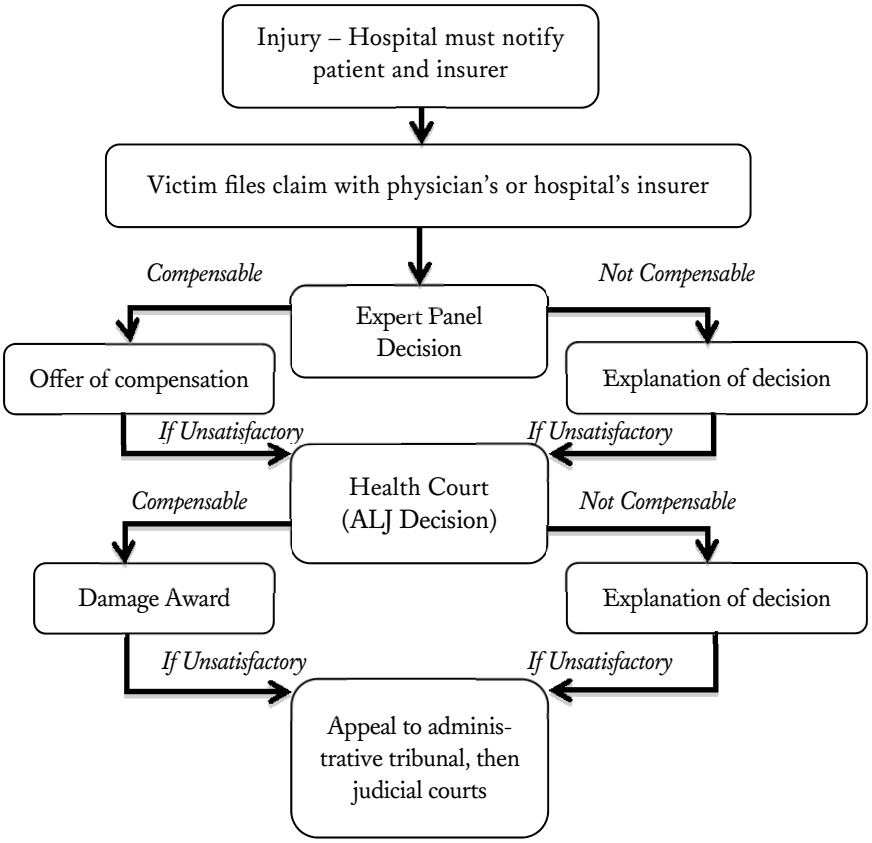
107 Mello et al., *"Health Courts," supra* note 85, at 465.

108 Mello et al., *Policy Experimentation*, *supra* note 16, at 69.

fee would be based on a multiple of hours worked rather than a percentage of the award."[109]

Figure 1 below offers a visual depiction of claims' path through the health court system.

Figure 1: Health Court Process



109 Mello et al., *"Health Courts," supra* note 85, at 463. Other health court proponents have rejected this lodestar idea, in favor of contingency fees subject to a 20% cap. *See* COMMON GOOD, *supra* note 1, at 5.

II. THE ORIGINS AND STRUCTURE OF THE VICP

Today, reformers complain that the medical malpractice system is too selective in its compensation, too unpredictable in its decisions, and too slow in its judgments—and they hold up specialized courts as the much-needed cure. As we shall see, in the mid-1980s, many voiced near-identical complaints about the vaccine injury litigation environment. And, like health court proponents, policymakers settled on a specialized court as the necessary reform.

A. *Origins: Mounting Dissatisfaction and Litigation's Rising Tide*

Vaccines are a triumph of modern medicine.[110] Yet for all the good they do and all the lives they save, vaccines cause a small proportion of those inoculated to sustain grievous, and sometimes fatal, injury. These side effects received little attention until the 1970s when three unrelated events seemed to conspire to unsettle the status quo. The first was the "notably troublesome" case of Anita Reyes.[111] While an infant living near the Mexican border, Reyes received a dose of Wyeth's polio vaccine and, shortly thereafter, contracted polio, resulting in her near-complete paralysis. Her parents initiated suit on her behalf, a jury ruled in her favor, and, in 1974, the Fifth Circuit affirmed.[112] Both the Fifth Circuit's holding and its reasoning were, for vaccine companies, ominous. *Reyes v. Wyeth*, that is, substantially expanded liability for vaccine manufacturers and also explicitly invoked enterprise liability principles to justify that expansion—suggesting that, going forward, between victims and vaccine manufacturers, the latter should bear the loss.[113]

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110 "For each group of vaccinated children born during a given year [in the United States], an estimated . . . 33,500 premature deaths are prevented over the course of a lifetime." Press Release, CDC, Most U.S. Parents are Vaccinating According to New CDC Survey: Vaccine Coverage Rates for Children Remain High (Sept. 4, 2008), *available at* http://www.cdc.gov/media/pressrel/2008/r080904.htm.

111 Edmund W. Kitch, *Vaccines and Product Liability: A Case of Contagious Litigation*, REG., May–June 1985, at 11, 12.

112 Reyes v. Wyeth Labs., 498 F.2d 1264 (5th Cir. 1974).

113 Even if the manufacturer was not at fault, the court reasoned, "a strong argument can be advanced that the loss ought not lie where it falls (on the victim), but should be borne by the manufacturer as a foreseeable cost of doing business." *Id.* at 1294. In terms of doctrine, the court carved out a new exception to the learned intermediary rule, holding that Wyeth should have warned Anita or her parents (not just the nurse who administered the vaccine), even though the polio vaccine was not administered as part of a mass immunization program. *See id.* at 1277. In so doing, it was later said, the *Reyes* court "seeded the clouds for a downpour of litigation." ARTHUR ALLEN, VACCINE: THE CONTROVERSIAL STORY OF MEDICINE'S GREATEST LIFESAVER 266 (2007).

Then, on the heels of the *Reyes* decision, came the swine flu faux epidemic of 1976. There, forty-five million Americans (one-third of the adult population) subjected themselves to a flu shot at President Gerald Ford's stern urging only to learn, later, that the flu was not particularly dangerous, but the shot itself was—causing in some small proportion of patients Guillain-Barré syndrome, a usually reversible but occasionally fatal form of paralysis. A flood of litigation and withering press attention followed.[114]

Rounding out this troubling trilogy, on April 19, 1982, an NBC affiliate aired an Emmy-winning, hour-long television documentary titled *DPT: Vaccine Roulette*.[115] With footage of dead infants and convulsing children, the broadcast charged that the pertussis component in the DTP vaccine (which protects against whooping cough) had not been adequately tested and could cause "damage to a devastating degree."[116] Publicity from the program resulted in the immediate formation of a citizens lobby called Dissatisfied Parents Together, kicked off congressional hearings into the pertussis vaccine's safety, and, more generally, stirred growing skepticism about the broader vaccination project.[117]

Whether buoyed by the *Reyes* decision, emboldened by the swine flu debacle, or galvanized by the *Vaccine Roulette* documentary, it is clear that, starting in the early 1980s, those hurt following vaccination started filing suit, for the first time, in significant numbers. In 1980, only twenty-four suits were filed alleging vaccine injury; by 1985, that number had spiraled upward to 144.[118] Indeed, in 1985 alone, plaintiffs filed a total of 100 lawsuits against just one manufacturer, Lederle Laboratories, claiming injury

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114 For more on this episode, which generated some 1600 lawsuits (all of which, for complicated reasons, were lodged against the United States), see *Alvarez v. United States*, 495 F. Supp. 1188 (D. Colo. 1980); RICHARD E. NEUSTADT & HARVEY V. FINEBERG, THE SWINE FLU AFFAIR: DECISION-MAKING ON A SLIPPERY DISEASE (1978); David Brown, *A Shot in the Dark: Swine Flu's Vaccine Lessons*, WASH. POST, May 27, 2002, at A9.

115 *DPT: Vaccine Roulette* (NBC television broadcast Apr. 19, 1982). The vaccine protects against diphtheria, tetanus, and pertussis. Though many call the vaccine DPT, DTP is the abbreviation utilized by the Vaccine Injury Table (and therefore herein). *See* 42 C.F.R. § 100.3 (2014).

116 Okianer Christian Dark, *Is the National Childhood Vaccine Injury Act of 1986 the Solution for the DTP Controversy?*, 19 U. TOL. L. REV. 799, 839 (1988); *see also* ALLEN, *supra* note 113, at 251.

117 *See* ALLEN, *supra* note 113, at 251-55. Though the documentary first aired on an NBC affiliate, it was later shown on the NBC program *Today*. Within three weeks of the program's transmission, a Senate Subcommittee held its first hearing on the pertussis vaccine's safety and efficacy. *See id.* at 278.

118 *See* Theodore H. Davis, Jr. & Catherine B. Bowman, *No-Fault Compensation for Unavoidable Injuries: Evaluating the National Childhood Vaccine Injury Compensation Program*, 16 U. DAYTON L. REV. 277, 297 n.126 (1991).

following the administration of its DTP vaccine, which eclipsed the number of lawsuits filed against Lederle in the previous three years combined.[119]

As the number of lawsuits ticked upward, so did manufacturers' dismay. In 1984, for example, Lederle's President went on record declaring that "[t]he present dollar demand of DTP lawsuits against Lederle is 200 times greater than our total sales of DTP vaccine in 1983."[120] Then, the following year, he complained the situation had deteriorated: "All but two of the more than ninety" DTP cases filed against Lederle—in more than forty years of distributing the vaccine—had been filed since 1982.[121] Another vaccine manufacturer—Connaught Laboratories—faced a similar plight, as suits filed against it in 1985 and 1986 sought a combined billion dollars in damages.[122]

Spooked by this increased liability, some manufacturers raised their prices—the wholesale price of the DTP vaccine increased some 6000% during the period—while others exited the market altogether.[123] 1984 was a particularly eventful year in this regard. On June 13, 1984, Wyeth announced it was stopping production of its whooping cough vaccine after thirty years of production, blaming "dramatic increases in the cost of participating in this market."[124] Then, six months later, Connaught also announced plans to stop the vaccine's production, citing a sharp increase in the cost of insurance against lawsuits—a decision *The New York Times* dubbed a "side effect of the side effects."[125]

As manufacturers ceased production, possible vaccine shortages loomed, and physicians and public health officials warned of the potential return of epidemic infectious disease. Said Martin H. Smith of the American

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119 *See Funding of the Childhood Vaccine Program: Hearing Before the Subcomm. on Select Revenue Measures of the H. Comm. on Ways & Means*, 100th Cong. 16 (1987) [hereinafter *1987 House Hearing*] (statement of Dennis E. Ross, Tax Legislative Counsel, U.S. Dep't of Treasury).

120 *Vaccine Injury Compensation: Hearings on H.R. 5810 Before the Subcomm. on Health & the Env't of the H. Comm. on Energy & Commerce*, 98th Cong. 229 (1984) [hereinafter *1984 House Hearings*] (statement of Robert B. Johnson, President, Lederle Labs.).

121 *National Childhood Vaccine Injury Compensation Act of 1985: Hearing on S. 827 Before the Sen. Comm. on Labor & Human Res.*, 99th Cong. 245 (1985) [hereinafter *1985 Senate Hearing*] (statement of Robert B. Johnson, President, Lederle Labs.).

122 *See 1987 House Hearing*, *supra* note 119, at 104 (letter from David J. Williams, Vice President & General Manager, Connaught Labs.).

123 *See* Richard L. Manning, *Changing Rules in Tort Law and the Market for Childhood Vaccines*, 37 J.L. & ECON. 247, 248 (1994) (reporting that the wholesale price of the DTP vaccine "increased by over 6,000 percent from 1970 to 1987").

124 Philip M. Boffey, *Vaccine Liability Threatens Supplies*, N.Y. TIMES, June 26, 1984, at C1.

125 Richard Levine, *Risk Forces Out Vaccine Maker*, N.Y. TIMES, Dec. 16, 1984, at E7. Subsequently, on April 25, 1985, Connaught resumed DTP distribution. *See 1985 Senate Hearing*, *supra* note 121, at 265 (statement of David J. Williams, Vice President & General Manager, Connaught Labs.).

Academy of Pediatrics in 1984: "At the present time, we are sitting on an explosive situation and it could have a short fuse."[126] Seemingly validating Smith's dire warning, on December 13, 1984, the CDC requested that doctors postpone DTP "booster shots" for older children in order to ensure an adequate supply for infants.[127] And by 1986, the number of DTP manufacturers had dwindled from eight to two,[128] while vaccines for measles, mumps, and rubella (the MMR vaccine) and polio were made by only a single manufacturer,[129] prompting Congress to observe that "the withdrawal of even a single manufacturer would present the very real possibility of vaccine shortages, and, in turn, increasing numbers of unimmunized children, and, perhaps, a resurgence of preventable diseases."[130]

On the other side of the "*v*," meanwhile, parents of vaccine-injured children were themselves unsatisfied. True, throughout the 1980s, more parents were suing. But many of these suits ended in defeat, as plaintiffs could not necessarily pinpoint which manufacturer made a particular child's vaccine, and, even if they could, often faltered when it came time to prove that the vaccine was, in fact, defective or the injury was actually caused by the vaccine at issue.[131] Moreover, even when compensation did come, it came slowly, after wrenching delays and often bitter litigation. As Congress explained, "Lawsuits and settlement negotiations can take months and even years to complete. Transaction costs—including attorneys' fees and court payments—are high. And in the end, no recovery may be available. Yet futures have been destroyed and mounting expenses must be met."[132]

B. *The Legislative Solution: The National Childhood Vaccine Injury Act*

By 1986, as worries about a litigation "crisis" swirled, manufacturers' demand for protection grew more insistent, and parents' pleas for more

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126 *1984 House Hearings*, *supra* note 120, at 119 (statement of Martin H. Smith, President-Elect, Am. Acad. of Pediatrics).

127 *See* Elizabeth Wehr, *Concern in Congress: Looming Vaccine Shortage Blamed on Threat of Lawsuits*, 42 CONG. Q. WKLY. REP. 3146, 3146 (1984).

128 *See* Dark, *supra* note 116, at 801.

129 *See* H.R. REP. NO. 99-908, at 7 (1986).

130 *Id.* To be sure, it is difficult to rule out the possibility that vaccine manufacturers, eager for liability protection, were exaggerating the precariousness of their plight and that price hikes and vaccine shortages were orchestrated to force Congress's hand. *See* Amy Tarr, *DTP Vaccine Injuries: Who Should Pay?*, NAT'L L.J., Apr. 1, 1985, at 1 ("[S]ome plaintiffs' lawyers charge that the move to scale down production of the [DTP] vaccine is little more than an industry effort to blackmail Congress and the public.").

131 For more on challenges facing plaintiffs, see 1999 GAO REPORT, *supra* note 52, at 4.

132 H.R. REP. NO. 99-908, at 6.

reliable, predictable, and prompt compensation gained urgency, the table was set for a legislative solution.[133] In time, Congress obliged. The final legislation was, to be sure, nobody's ideal. As Representative Henry Waxman, the Act's chief sponsor, explained in the summer of 1986:

> I recognize that the bill I have introduced is probably not the first choice of most parties to this controversy. Manufacturers would undoubtedly prefer greater insulation from liability. Parents of injured children would certainly prefer larger compensation and fewer restrictions on court activity. The Reagan administration would, I am sure, prefer legislation that spends no money.[134]

Yet with just *enough* for all stakeholders, the National Childhood Vaccine Injury Act ultimately received broad and bipartisan support, passing on the final hours of the 99th Congress.[135]

As enacted, the Vaccine Act had two parts. Part one (less important for our current purposes) sought to upgrade the nation's immunization program by perfecting vaccines and monitoring adverse reactions thereto.[136] Part two, meanwhile, sought to shield manufacturers from tort liability, while providing "simple justice" to vaccine-injured children.[137] Toward that end, Congress established the Vaccine Injury Compensation Program (VICP), a no-fault scheme run out of the U.S. Court of Federal Claims and jointly administered by the Department of Health and Human Services (HHS) (which serves as the respondent and therefore represents the Fund's

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133 Congress may also have been influenced by legislative activity, both here and abroad. California created a limited compensation program to provide modest benefits to vaccine-injured children in 1977, and by 1986, a number of other nations, including Germany, France, Switzerland, Denmark, Japan, and the United Kingdom, also provided payments to vaccine-injured children. *See* Wendy K. Mariner, *Compensation Programs for Vaccine-Related Injury Abroad: A Comparative Analysis*, 31 ST. LOUIS U. L.J. 599, 605-07 (1987).

134 *Vaccine Injury Compensation: Hearing on H.R. 1780, H.R. 4777, and H.R. 5184 Before the Subcomm. on Health & the Env't of the H. Comm. on Energy & Commerce*, 99th Cong. 2 (1986) (statement of Rep. Henry A. Waxman); *accord* Henry A. Waxman, *When a Vaccine Injures a Child: A No-Fault Way to Compensate*, WASH. POST, Oct. 9, 1986, at A27 (declaring the legislation a "compromise bill" supported by "[a] broad array of conservatives and liberals, consumer advocates and pharmaceutical lobbyists").

135 For more on the Act's enactment, see BURKE, *supra* note 36, at 142-70.

136 *See* National Childhood Vaccine Injury Act of 1986, Pub. L. No. 99-660, sec. 311(a), §§ 2101–2106, 100 Stat. 3755, 3756-58 (codified as amended at 42 U.S.C. §§ 300aa-1 to -6 (2012)).

137 *National Childhood Vaccine-Injury Compensation Act: Hearing on S. 2117 Before the S. Comm. on Labor & Human Res.*, 98th Cong. 290-91 (1984) [hereinafter *1984 Senate Hearing*] (statement of Sen. Paula Hawkins) ("[T]hese children have an urgent need and deserve simple justice quickly."); Martin H. Smith, *National Childhood Vaccine Injury Compensation Act*, 82 PEDIATRICS 264, 269 (1988) ("The intent of the Academy for years has been to secure a better and simpler form of justice for children as well as to ensure a more secure vaccine supply.").

interests in all VICP proceedings) and the Department of Justice (DOJ) (which represents HHS).[138] Financed by a seventy-five-cent excise tax on each vaccine dose administered (which creates the Fund upon which injury victims draw), the VICP is intended to provide adequate, though abridged, compensation to all individuals injured by covered vaccines via "less-adversarial, expeditious, and informal proceeding[s]."[139]

C. *The VICP: The Basics*

To mete out this "simple justice," the VICP utilizes procedures strikingly similar to the procedures health courts would employ. Below, Section II.C outlines the VICP's core features. Then, Part III reviews the myriad ways in which health courts and the VICP are alike.

First, the VICP replaces tort's negligence standard with a standard of strict liability. Pursuant to this standard, the petitioner is entitled to compensation as long as her injuries were more likely than not caused or significantly aggravated by a covered vaccine. She need not show that the doctor erred in the vaccine's administration or preparation, that the vaccine was accompanied by an inadequate warning, or that the vaccine itself was defectively manufactured or designed. This means that the Vaccine Act winnows down a traditional tort action so that, instead of the many elements typically considered, only two must be addressed: (1) actual causation (did this vaccine cause this injury?) and (2) damages (how much compensation is due?).

Then, having winnowed down the inquiry to just two elements, the Vaccine Act simplifies proof for each. Causation questions are simplified by the Vaccine Injury Table—an innovative decision aid designed "to remove much of the burden of proof required in traditional tort proceedings."[140] Initially created by Congress, and periodically amended by the Secretary of HHS, the Table lists all covered vaccines, as well as the injuries widely recognized as caused thereby, alongside a specific timeframe for each injury's onset.[141] If a claimant can show that she suffered an injury listed on the Table within the time period specified (so, for example, that she suffered

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138 For more on the VICP's funding and personnel, see MOLLY TREADWAY JOHNSON ET AL., FED. JUDICIAL CTR., USE OF EXPERT TESTIMONY, SPECIALIZED DECISION MAKERS, AND CASE-MANAGEMENT INNOVATIONS IN THE NATIONAL VACCINE INJURY COMPENSATION PROGRAM 11-12 (1998).

139 42 U.S.C. § 300aa-12(c)(1), (d)(2)(A) (2012).

140 H.R. REP. NO. 106-977, at 8 (2000).

141 For more on the Table's creation, see JOHNSON ET AL., *supra* note 138, at 13-14. For the Table itself, see 42 C.F.R. § 100.3 (2014). For information on Table modifications, see 42 U.S.C. § 300aa-14(c) and *infra* Section V.B.

anaphylaxis within four hours of receiving the DTP vaccine), she will have suffered an "on-Table" injury. On-Table injuries are *presumed* to have been caused by the vaccine and are thus presumptively entitled to compensation. HHS (serving as respondent) may rebut this presumption, but it bears the burden of doing so.[142] Only if an injury falls outside the Table must the traditional actual cause question be addressed.

Free-wheeling damages calculations are also avoided. Compensation in the event of a vaccine-related death is automatically set at $250,000,[143] while payments to injured claimants are also standardized. Injured claimants, that is, are entitled to (1) lost wages, (2) payment for pain and suffering, and (3) actual medical and rehabilitation expenses. But, of those three damage categories, only the third (medical and rehabilitation expenses) is consistently calculated on an individualized basis. Minors' lost wages are pegged to the average gross weekly earnings of workers in the private, non-farm sector,[144] while damages for pain and suffering payments are capped at $250,000.[145]

In addition to simplifying the questions to be addressed, the Vaccine Act alters the site of injury adjudication. As in health courts, entitlement and compensation decisions are relocated from generalist courts to specialized, dedicated tribunals, as decisional authority is vested in eight special masters (seven associates and one chief), who serve renewable four-year terms and work in (and are appointed by judges on) the U.S. Court of Claims.[146] Considered "experts," these special masters work exclusively on vaccine cases and are, according to Congress, to be "well-advised on matters of health, medicine, and public health."[147]

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142 42 U.S.C. § 300aa-13(a)(1)(B).

143 *Id.* § 300aa-15(a)(2) (establishing damages in the event of a vaccine-related death). As of 2006, deaths accounted for roughly 14% of VICP claims. *See* Geoffrey Evans, *Update on Vaccine Liability in the United States: Presentation at the National Vaccine Program Office Workshop on Strengthening the Supply of Routinely Recommended Vaccines in the United States, 12 February 2002*, 42 CLINICAL INFECTIOUS DISEASES S130, S133 (2006).

144 *See* 42 U.S.C. § 300aa-15(a)(3)(B) (simplifying calculation of minors' lost wages). Adults are entitled to their "actual and anticipated loss of earnings." *Id.* § 300aa-15(a)(3)(A).

145 *See id.* § 300aa-15(a)(4).

146 Because terms are renewable, some special masters serve for long periods. For example, one associate special master has served since 1991. *See Laura D. Millman*, U.S. CT. FED. CLAIMS, http://www.uscfc.uscourts.gov/laura-d-millman (last visited Apr. 24, 2015), *archived at* http://perma.cc/H4YA-ZTBQ.

147 H.R. REP. NO. 101-386, at 515 (1989) (Conf. Rep.); *see* Munn v. Sec'y of Dep't of Health & Human Servs., 970 F.2d 863, 871 (Fed. Cir. 1992) (declaring that, because special masters are "experts," they shall be entitled to the "statutory deference in fact-finding normally reserved for specialized agencies"). For more on special masters' qualifications, see JOHNSON ET AL., *supra* note 138, at 14-15.

Furthermore, the Vaccine Act seeks, to the extent possible, to root decisions in scientific evidence—to base decisions on experts' interpretation of the leading scientific literature.[148] This ambition is clearly evident in the Vaccine Act's creation of, and reliance on, the Vaccine Injury Table (discussed above). It is also evident in the Act's delegation of decisional authority to eight special masters who are schooled in, and devoted to, the resolution of vaccine-injury claims. It is apparent in other innovations as well. Namely, as in health courts, experts are called upon to assess claims' scientific validity—and chart claims' course—from the very beginning. As soon as a VICP petition is filed, that is, the petition is routed to HHS for evaluation by a medical expert within HHS's Division of Vaccine Injury Compensation (DVIC). This expert reviews the petition and determines whether it meets medical criteria for compensation. If he or she concludes it does and the DOJ concurs, the petition will be conceded, and, with the special master's permission, will move directly to the damages phase.[149] Only if the DVIC expert determines that the petition does *not* meet the medical criteria for compensation will an adjudication ensue. Then, once a hearing is in full swing, expert opinion can again be sought: Congress has empowered—and encouraged—special masters to retain neutral experts to inform their consideration of complex medical questions.[150]

The VICP also takes many steps to abridge and expedite proceedings. Or, as two commentators have explained: "The overriding guideline of th[e]se proceedings is simplification."[151] Toward that end, the Vaccine Act

148 DIVISION OF VACCINE INJURY COMPENSATION, NATIONAL VACCINE INJURY COMPENSATION PROGRAM STRATEGIC PLAN 24 (2006) [hereinafter DVIC STRATEGIC PLAN] (stating that a "strength" of the VICP is that the program "endeavors to be science-based in its assessment of claims").

149 *See* OFFICE OF INSPECTOR GEN., DEP'T OF HEALTH & HUMAN SERVS., THE NATIONAL VACCINE INJURY COMPENSATION PROGRAM: A PROGRAM REVIEW 4 (1992); 1999 GAO REPORT, *supra* note 52, at 30.

150 Congress has declared that special masters would "be well-advised to retain independent medical experts to assist in the evaluation of medical issues." H.R. REP. NO. 101-247, at 513 (1989). Despite Congress's exhortation, in practice, few special masters retain independent experts. *See* OFFICE OF SPECIAL MASTERS, GUIDELINES FOR PRACTICE UNDER THE NATIONAL VACCINE INJURY COMPENSATION PROGRAM 26 (2014) ("In unusual instances, special masters may suggest the hiring of a neutral medical expert to render an opinion on a medical dispute, such as the appropriate diagnosis or prognosis."); JOHNSON ET AL., *supra* note 138, at 32-33 (reporting that, of interviewed special masters, none "had . . . actually appointed an expert" and providing tentative explanations for special masters' forbearance, including special masters' respect for the adversarial system, their uncertainty of how to locate and compensate a court-appointed expert, and their heavy reliance on medical textbooks (which potentially take independent experts' place)).

151 Victor E. Schwartz & Liberty Mahshigian, *National Childhood Vaccine Injury Act of 1986: An Ad Hoc Remedy or a Window for the Future?*, 48 OHIO ST. L.J. 387, 394 (1987).

discards the Federal Rules of Civil Procedure, permits neither pretrial discovery nor cross-examination as of right, relaxes rules for the admission of evidence, and eliminates the need to provide live testimony (instead permitting the parties to introduce evidence by affidavit, sworn declaration, or via telephone or videotape).[152] Rather than sitting passively on the sidelines, the Act empowers special masters to take an active, inquisitorial role—to question witnesses, demand additional documentation, and inform parties what further proof is necessary to facilitate case resolution.[153] And finally, the Act tops off its desire for speed with a hard deadline: By statute, special masters "shall" issue decisions within 240 days of the petition's filing, exclusive of suspended time.[154]

At the tail end of litigation, the VICP limits appeals and cabins payments to petitioners' counsel. Within the VICP, either party (HHS or the petitioner) may appeal—first to the U.S. Court of Claims, then to the Federal Circuit. Appeals, however, proceed pursuant to a highly deferential standard of review: Special masters' findings of fact and conclusions of law are set aside only if they are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."[155] Petitioners' counsel, meanwhile, is compensated via a unique payment mechanism. The VICP compensates petitioners' counsel out of the Fund via a lodestar calculation (reasonable hours worked times a reasonable hourly wage) and will do so even if the petitioner fails in his quest to obtain compensation. The sole requirement is that the petition was brought pursuant to a "reasonable basis" and "in good faith."[156]

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152 *See* 42 U.S.C. § 300aa-12(d)(3)(B)(v) (2012) (limiting discovery and granting the special master discretion to conduct hearings); *id.* § 300aa-12(d)(2)(B) (advising that evidence is to be admitted pursuant to "flexible and informal standards"); *see also* OFFICE OF SPECIAL MASTERS, *supra* note 150, at 41 (offering alternatives to live testimony).

153 *See* H.R. REP. NO. 101-247, at 513 ("The system is intended to allow the proceedings to be conducted in what has come to be known as an 'inquisitorial' format, with the Master conducting discovery (as needed), cross-examination (as needed), and investigation.").

154 42 U.S.C. § 300aa-12(d)(3)(A)(ii). As initially enacted, the Act set a 365-day deadline. *See* National Childhood Vaccine Injury Act of 1986, Pub. L. No. 99-660, sec. 311(a), § 2112, 100 Stat. 3755, 3762. Congress subsequently amended that provision to require judgment within 240 days in most cases. *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, sec. 6601, § 2112, 103 Stat. 2106, 2288 (codified at 42 U.S.C. § 300aa-12(d)(3)(A)(ii)). If a special master fails to enter judgment within the prescribed period, the petitioner may withdraw her petition and file the action in state or federal court. *See* 42 U.S.C. § 300aa-12(g). It appears, however, that "petitioners rarely exercise this option." 2014 GAO REPORT, *supra* note 52, at 12.

155 42 U.S.C. § 300aa-12(e)(2)(B); *see also* Hibbard v. Sec'y of Health & Human Servs., 100 Fed. Cl. 742, 749 (2011) ("If the special master's decision is based on evidence in the record that is not wholly implausible, the Court will uphold the finding as not being arbitrary and capricious." (internal quotation marks omitted)).

156 42 U.S.C. § 300aa-15(e)(1)(B).

Finally, at a case's conclusion, the Vaccine Act supplies a tort opt-out provision. Specifically, the Act compels all individuals with vaccine-injury claims to first adjudicate their claims within the VICP. But the Act also gives unsatisfied petitioners the right to reject the special master's judgment and file a traditional tort claim against the vaccine manufacturer or healthcare provider in state or federal court, where the claim is considered anew. This tort opt-out provision, however, is very narrow, as the Act both restricts the kind of claims that can be asserted and limits the damages that may be awarded. Specifically, per the 2011 Supreme Court ruling in *Bruesewitz v. Wyeth LLC*, the Vaccine Act preempts all design defect claims against vaccine manufacturers.[157] And, the Act unambiguously creates a presumption of adequacy for all warnings that comply with FDA standards (thereby preventing state courts from performing an independent assessment of a warning's sufficiency),[158] codifies the "learned intermediary doctrine" (thereby eliminating claims based on the vaccine manufacturer's failure to furnish direct warnings to patients),[159] and erects a heightened standard for the provision of punitive damages.[160]

Figure 2 offers a visual depiction of a petition's path through the VICP system.

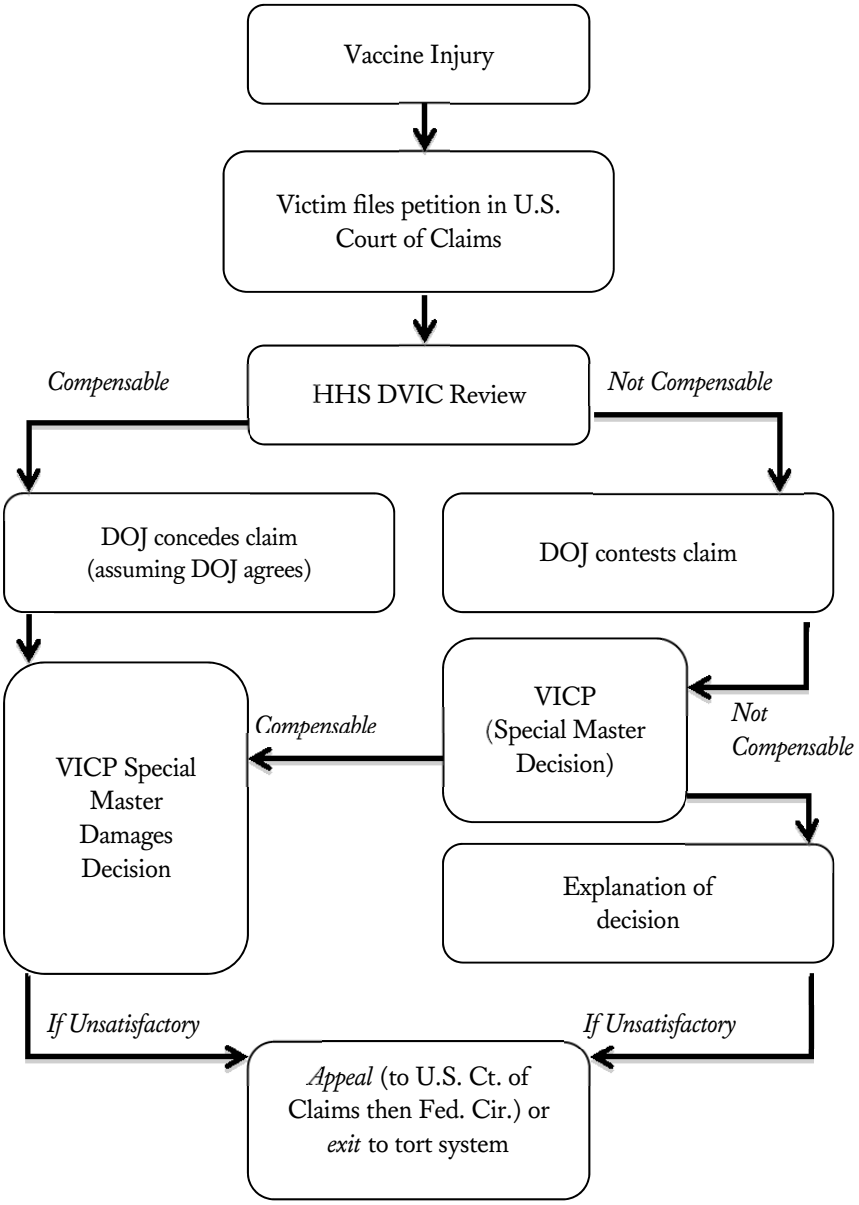
157 131 S. Ct. 1068, 1082 (2011).

158 *See* 42 U.S.C. § 300aa-22(b)(2).

159 *Id.* § 300aa-22(c).

160 *Id.* § 300aa-23(d)(2) (barring punitive damages except if the manufacturer engaged in fraud, intentional wrongdoing, or other illegal activity).

Figure 2: VICP Process



III. A CASE OF INSTITUTIONAL DÉJÀ VU: SIMILARITIES BETWEEN HEALTH COURTS AND THE VICP

As should by now be clear, health courts and the VICP share underlying motivations and critical characteristics. This Part will review the two reforms' many similarities (and highlight their occasional differences) to show, ultimately, that a study of the VICP sheds light on health courts' likely performance upon adoption. To begin, Table 1 offers a visual depiction of the two systems' key characteristics, with the systems' few differences highlighted in gray.

Table 1: Similarities and Differences Between the VICP and Health Courts

		VICP	*Health Courts*
Eligibility	Severity threshold excludes those with minor injuries?	Yes (Injury lasts six months or results in hospital stay, surgery, or death)	Yes (Claimant misses four weeks of work or incurs $3000+ in medical costs)
	Outreach to potential claimants?	Yes (HHS to inform public; attorneys have ethical obligation to advise)	Yes (Hospitals must notify patients of avoidable iatrogenic injury)
Personnel	Respondent(s)	HHS, represented by DOJ	Physician(s) and Hospital(s) (sometimes multiple)
	Specialized adjudicators?	Yes (Special Masters)	Yes (ALJs)
	Juries?	No	No
Proof	Petitioner must prove fault?	No	Kind of ("Avoidability")
	Petitioner must prove causation?	Yes	Yes

		VICP	*Health Courts*
Procedures	Decision aid fast-tracks claims involving signature events?	Yes (Table)	Yes (ACEs)
	Respondent's response to claim informed by expert review?	Yes (DVIC Expert)	Yes ("Expert Panel")
	Adjudicator empowered to hire neutral experts?	Yes	Yes
	Relaxed rules of evidence and procedure?	Yes	Yes
	All decisions published?	Yes	Yes
Damages	Full economic loss (subject to abrogation of CSR)?	Yes (though death benefits and minors' lost wages standardized)	Yes
	Limit on noneconomic damages?	Yes ($250,000 cap)	Yes (sliding scale)
Appeals	Appeals permitted?	Yes (U.S. Ct. of Fed. Claims then Fed. Cir.)	Yes (Admin. panel then judicial court)
	Deferential appellate standard of review?	Yes ("Arbitrary and Capricious")	Yes ("Arbitrary and Capricious")
Attorney Compensation	Petitioner's attorney compensated via lodestar?	Yes (From VICP Fund)	Yes (From Claimant)

		VICP	*Health Courts*
	Petitioner's attorney paid if claim denied?	Yes (subject to limited exception)	No
Exclusive Remedy	Tribunal exclusive remedy?	No (limited tort opt-out provision)	Yes

A. *Similarities, Revisited*

As Parts I and II suggested and Table 1 illustrates, health courts and the VICP share many similarities. They both address similar claims: serious personal injury claims of those injured in the course of a medical intervention.[161] These claims raise similar questions, generate similar conflicts, and compel the consideration of similar evidence. And indeed, rather than mere similarity, there is actual overlap between claims within the two systems as, prior to the Vaccine Act's preemption of these claims, vaccine-injured children would sometimes sue doctors, alleging that that the vaccine at issue was contraindicated or improperly administered.[162]

Next, health courts and the VICP both embody a similar ideology concerning the nature of, and proper response to, accidents. Conceptualizing accidents as either the result of larger "system failures" (as in the case of health courts) or altogether inevitable (as in the case of the VICP), both systems view injuries as a poor fit for traditional liability actions, which tend to emphasize the personal fault of the ostensible tortfeasor.[163] Operationalizing this perception, both systems jettison tort's

161 The word "serious" reflects the fact that, in order to control cost and keep caseloads in check, both health courts and the VICP use injury-severity thresholds to exclude those with small losses. Health court compensation would likely be available only to those who miss four weeks of work or incur $3000 (or perhaps $4000) in medical expenses. *See* Mello et al., *"Health Courts," supra* note 85, at 467. To be eligible for compensation within the VICP, the effects of petitioner's injury must last for more than six months, result in a hospital stay or surgery, or culminate in death. *See* 42 U.S.C. § 300aa-11(c)(1)(D)(i)-(iii).

162 *See, e.g.*, Caron v. United States, 548 F.2d 366 (1st Cir. 1976) (involving a lawsuit against a physician for the improper administration of a vaccine). The Vaccine Act preempts such lawsuits. *See* 42 U.S.C. § 300aa-11(a)(3).

163 *Compare* Michelle M. Mello & David M. Studdert, *Deconstructing Negligence: The Role of Individual and System Factors in Causing Medical Injuries*, 96 GEO. L.J. 599, 600 (2008) (discussing "system failures"), *with* S.A. Sturges, Comment, *Vaccine-Related Injuries: Alternatives to the Tort Compensation System*, 30 ST. LOUIS U. L.J. 919, 934 & n.125 (1986) (reporting that events that culminate in a vaccine-related injury have been labeled "dyspractice," rather than "malpractice," which "pertains to an undesirable, yet unavoidable, result").

"fault" concept in favor of a less punitive finding—"avoidability" in health courts, no-fault in the VICP.

Next, both reforms strive to be even-handed.[164] Unlike the modern tort reform movement, which, in its support of contingency fee caps and damage limits, transparently benefits defendants and their insurers at injured plaintiffs' expense[165]—health courts and the VICP offer benefits, and impose burdens, on those on both sides of the "*v*." And, perhaps as a consequence, both reforms have received broad and bipartisan support.[166]

Further, both health courts and the VICP are born of frustration with the lack of predictability within the traditional tort system.[167] And both seek to reduce decisional disparities in the same way: by demanding the publication of decisions, and by placing power, whenever possible, in the hands of experts.[168] On the former, to promote consistency, both systems compel the publication of ALJ and special master decisions, facilitating the creation of a databank of written decisions upon which future physicians, litigants, and decisionmakers can draw.[169] On the latter, both exemplify the "expertise model" of decisionmaking.[170] As such, they both call upon neutral experts to assess claims' scientific validity as soon as claims are filed (the "expert panel" within health courts and DVIC review within the VICP).[171] They both vest decisionmaking authority in dedicated, independent, expert

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164 *Compare* Peters, *supra* note 13, at 253 (observing that health courts "demonstrate[] an evenhandedness that is uncommon among tort reformers"), *with* BURKE, *supra* note 36, at 149-58 (discussing the VICP's bipartisan lineage). To be sure, some question health courts' commitment to even-handedness. *See generally* Mehlman & Nance, *supra* note 5.

165 *See* Robert L. Rabin, *Some Reflections on the Process of Tort Reform*, 25 SAN DIEGO L. REV. 13, 22 (1988) (referring to most modern tort reforms as "victim take-away programs").

166 *Compare* sources cited *supra* notes 5-17 (describing widespread support for health courts), *with* BURKE, *supra* note 36, at 149-58 (noting the VICP's bipartisan lineage).

167 *Compare* Howard, *supra* note 15 (championing health courts because they would "deliver[] fair and reliable decisions"), *with infra* notes 203-05 and accompanying text (showing that support for the VICP came, in part, from a desire to inject predictability into the system for compensation for vaccine injury).

168 *See* Stephen H. Legomsky, *Learning to Live with Unequal Justice: Asylum and the Limits to Consistency*, 60 STAN. L. REV. 413, 437 (2007) (noting that "reasoned written opinions should, all else equal, enhance consistency").

169 *Compare* Mello et al., *"Health Courts," supra* note 85, at 465 (proposing that "[t]he health court's written decision would be recorded in a keyword-searchable electronic database that could be accessed by adjudicators in future cases"), *with* 42 U.S.C. § 300aa-12(d)(4)(B) (2012) (compelling the publication of VICP decisions, except if disclosure would reveal a trade secret or would "constitute a clearly unwarranted invasion of privacy").

170 For discussion of the "expertise model," see Robert L. Rabin, *The Vaccine No-Fault Act: An Overview*, 8 IND. HEALTH L. REV. 269, 271 (2011).

171 *Compare* Mello et al., *"Health Courts," supra* note 85, at 468 (describing the role of the "expert panel" in proposed health courts), *with* sources cited *supra* note 149 (concerning review by experts within the DVIC).

adjudicators (ALJs and special masters, respectively). They both arm these expert decisionmakers with powerful decision aids (ACEs and the Table), which were, themselves, created by experts.[172] And, when a claimant's eligibility for compensation turns on complex scientific issues, both reforms empower decisionmakers to retain still other independent experts to guide their judgments.[173]

Next, both reforms also arise out of impatience with the tort system's sometimes intolerable delays—and thus aim to expedite proceedings considerably. In fact, both reforms promise to resolve all, or nearly all, entitlement decisions within one year from the date of filing.[174] Pursuing that objective, both systems streamline the substantive determinations that must be made, site the adjudication of claims within a specialized court (as specialists are thought to resolve cases more quickly than generalists),[175] impose injury-severity thresholds (to ensure tribunals do not become clogged resolving the claims of those with only minor impairments),[176] and abridge and simplify procedures that must be followed.

Finally, both reforms seek to expand but also limit compensation, believing more claimants should recover, but successful claimants should recover less. To accomplish the former, both systems relax the fault standard, conduct affirmative outreach to notify potential injury victims of their possible entitlement to relief,[177] and (again) streamline filing and

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172 Notably, a leading ACE architect recognizes that the Table is "akin to ACEs." Bovbjerg, *supra* note 32, at 277.

173 *See* Mello et al., *"Health Courts," supra* note 85, at 465 (noting that an ALJ's determinations should be guided by "court-appointed medical experts"); H.R. REP. NO. 101-247, at 513 (1989) (recommending that VICP special masters "retain independent medical experts"). Like the VICP, health courts would also, it appears, permit parties to retain and utilize their own experts. *See Medical Liability: New Ideas for Making the System Work Better for Patients: Hearing on S. 1337 Before the S. Health, Educ., Labor, & Pensions Comm.*, 109th Cong. 40 (2006) [hereinafter *2006 Senate Hearing*] (statement of Philip K. Howard, Founder and Chair, Common Good) (clarifying that "parties could have their own experts as well").

174 *Compare supra* note 95 (compiling claims by health court proponents), *with supra* note 154 and *infra* notes 245-50 (compiling claims by supporters of the VICP).

175 *See* BAUM, *supra* note 33, at 32-33 ("[J]udges who regularly handle a single class of cases are expected to dispose of their work in less time than their counterparts on generalist courts who see that class of cases less frequently.").

176 *See supra* note 161 and accompanying text (describing health courts' and the VICP's injury-severity thresholds).

177 As noted, health courts would compel hospitals to notify patients if the patient sustains a compensable injury. *See supra* note 97 and accompanying text. The Vaccine Act also contains an outreach obligation, as it directs HHS to undertake "reasonable efforts to inform the public of the availability of the Program" and simultaneously imposes an "ethical obligation" on *all* attorneys who are consulted "with respect to a vaccine-related injury or death" to explain "that compensation may be available under the program." 42 U.S.C. § 300aa-10(b) to (c) (2012).

adjudication procedures (which should, logically, entice more to enter the claims system). To accomplish the latter, both systems abridge and standardize damages. Specifically, both offer only partial compensation for noneconomic loss (health courts utilize a sliding scale, the VICP imposes a $250,000 cap). And, both permit the full recovery of economic loss only to the extent those losses are not elsewhere compensated.[178]

B. *A Few Differences*

Still, for all their similarities, health courts and the VICP are not identical. In fact, they differ in a number of respects, including: (1) In the VICP, the HHS, represented by the DOJ, is the respondent, whereas in health courts, the culpable party or parties remain on the hook; (2) the VICP is a true no-fault scheme, whereas health courts continue to require an assessment of whether the physician or hospital erred; (3) the VICP is a non-exclusive remedy, whereas the health court system would completely preempt the medical malpractice field; and (4) in the VICP, petitioner's counsel is paid from the Fund, regardless of whether or not the petitioner prevails, whereas, in health courts, attorneys' fees come from the petitioner and are contingent on success. Below, I explore these differences in greater detail, while forecasting their probable effects.

1. The Respondent: Government Versus Physician or Hospital

First, unlike health courts, the VICP is a true alternative compensation mechanism. It is funded by a seventy-five-cent per dose surcharge on each vaccine dose administered, and the respondent in VICP adjudications is the Secretary of HHS, represented by staff attorneys in the Torts Branch of the DOJ. The potentially culpable party (the erring physician or maker of the errant vaccine) is not present, is not represented, and is not *in any way* affected if a decision is made to compensate the petitioner.

By contrast, in health courts, the potentially responsible party or parties will be present, represented, and financially responsible. If the physician or hospital is found to be liable (albeit under the relaxed avoidability standard), the physician or hospital will have to pay the claimant and, depending on whether reporting obligations to the National Petitioner Data Bank (NPDB) are or are not modified, the physician might need to report

178 For more on damage calculations, see *infra* Section IV.C.

the payment to the NPDB and, subsequently, disclose the fact of payment to licensing authorities, affiliated hospitals, and insurance carriers.[179]

When forecasting the likely effect of this distinction, one might predict that the active participation of the potentially culpable and financially responsible party within the health court system would render those proceedings more adversarial and combative, as compared to proceedings within the VICP.[180] The effect would be particularly stark if NPDB reporting requirements remain in place or insurance premiums are experience-rated, because if premiums are experience-rated (i.e., if they fluctuate based on claims experience), claim payment would carry for physicians or hospitals a clear financial penalty.[181]

2. Liability Standard: No-Fault Versus "Avoidability"

Second, the VICP is a true no-fault remedy, while health courts relax the fault element without eliminating it. Even under the liberalized avoidability standard, a health court claimant must still prove, by a preponderance of the evidence, that the care she received was suboptimal and that her doctor or hospital neglected to utilize "best practices."[182] This won't always be easy. For example, health court proponents have said that "the avoidability standard could result in liability in some situations in which hospitals could have improved their systems at reasonable cost, but opted not to."[183] This means that, to assign liability in at least these cases, the ALJ will have to determine what constitutes or does not constitute "reasonable cost"—which, in turn, means that health courts will, at least sometimes, confront precisely the same vexing questions frequently confronted in the tort liability system.

Once again, the difference between health courts and the VICP is significant. And, on balance, one might expect the difference to complicate

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179 Currently, if a claim is paid on behalf of a physician (either by judgment or settlement), the payment must be reported to the NPDB. Then, the fact of payment dogs the physician going forward, resurfacing whenever she fills out forms from state licensing boards or seeks to renew her liability insurance, managed care contracts, or hospital privileges. Peters, *supra* note 13, at 256. It is not clear whether health court payments would trigger the same reporting obligation, though health court proponents have cautioned against it. *See* Mello et al., *"Health Courts," supra* note 85, at 484-87.

180 *Cf.* Danzon, *supra* note 21, at 460 (stating that "the key to low litigation expense [in the Swedish patient compensation insurance system] is that individual providers have no personal stake in the outcome").

181 Health court proponents advocate rating hospitals' or care units' premiums to their claims experience. *See* Mello et al., *"Health Courts," supra* note 85, at 475.

182 *Id.* at 461.

183 Siegal et al., *supra* note 22, at 496.

proceedings within health courts relative to the VICP, perhaps dramatically.[184]

3. Remedy: Non-Exclusive Versus Exclusive

Third, the Vaccine Act contains a tort opt-out provision: Though all seeking compensation for vaccine-related injury must initially file in the VICP, unsatisfied petitioners can reject the special master's judgment and file a traditional (albeit restricted) tort claim against the vaccine manufacturer or healthcare provider in state or federal court. Health courts, by contrast, would offer an exclusive remedy: Though a health court claimant might ultimately *appeal* an ALJ's denial to a judicial court, there is no *de novo* exit from the health court system.

Highlighting the availability of the VICP's opt-out option and its concomitant unavailability within health courts, some have argued that the former "is not an apt analogy" for the latter "for the simple reason" that dissatisfied VICP petitioners "may pursue a civil action for damages."[185] This characterization, however, exaggerates the practical importance of the VICP's civil action possibility. As noted above, the petitioner's ability to file a civil suit for vaccine injury is circumscribed by law—and, perhaps more importantly, it is rarely exercised in practice. Even before the Supreme Court's recent (and further limiting) *Bruesewitz* decision, fewer than 0.5% of vaccine claimants who received an award within the VICP rejected their award in favor of a civil action.[186] Furthermore, also prior to *Bruesewitz*, "virtually all" unsuccessful VICP claimants acquiesced to the rejection, rather than initiating lawsuits in state or federal court.[187] No matter its on-paper possibilities, in other words, the VICP typically functions as an exclusive remedy—minimizing the practical effect of this formal distinction.

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184 MELLO & KACHALIA, *supra* note 32, at 31 (recognizing that, as compared to an avoidability standard, a no-fault standard is "easier to administer").

185 Mehlman & Nance, *supra* note 5, at 78.

186 Brief for the United States as Amicus Curiae Supporting Respondents at 28, Bruesewitz v. Wyeth, Inc., 131 S. Ct. 1068 (2011) (No. 09-152) ("Department of Justice records indicate that 99.8% of successful Compensation Program claimants have accepted their awards, foregoing any tort remedies against vaccine manufacturers.").

187 STANLEY A. PLOTKIN ET AL., VACCINES 1673 (5th ed. 2008); *see* Katherine M. Cook & Geoffrey Evans, *The National Vaccine Injury Compensation Program*, 127 PEDIATRICS S74, S76 (2011) ("The program is aware of only a small number of VICP claims that go on to the civil (tort) system.").

4. Attorneys' Fees: Fund Versus Petitioner

Fourth and finally, both systems are similar in that both restrict fees to claimants' counsel and also calculate those fees using the lodestar method (hours worked times a reasonable hourly rate).[188] The systems differ, however, when it comes to claimants' attorneys' fees' source and certainty. The VICP pays from the Fund, and the sole prerequisite for payment is that the petition was brought pursuant to "a reasonable basis" and "in good faith."[189] By contrast, leading advocates suggest that in health courts a claimant's lawyer's fee would come from the claimant's recovery and would be conditional upon her success.[190]

At first glance, it might appear that this difference is significant—that health court counsel, paid only if successful, would have a much greater incentive to screen clients prior to retention and zealously (maybe overzealously) advocate on clients' behalf. On the other hand, VICP lawyers, paid hourly irrespective of victory, might be more likely to accept dubious claims and, once retained, drag their heels, possibly prolonging litigation even after the case appears doomed.[191] Yet while these incentives surely exist to some extent—and might well promote both the filing of non-meritorious claims and protracted contestation in the VICP context, relative to the health court context—differences between the systems should not be overstated. In reality, VICP special masters award higher fees to counsel for prevailing as compared to non-prevailing petitioners, partially bridging the incentive gap between the two systems.[192]

IV. THE VICP IN ACTION: HEALTH COURTS ARE UNLIKELY TO RESOLVE CLAIMS AS PREDICTABLY OR AS QUICKLY AS PROPONENTS NOW SUGGEST

Health court proponents have pointed to the above design innovations—pre-adjudication review, specialized ALJs, neutral experts, ACEs, the avoidability standard, published decisions, and streamlined damage

188 *See supra* notes 109 (for health courts), 156 (for the VICP) and accompanying text.

189 42 U.S.C. § 300aa-15(e)(1) (2012).

190 *See* Mello et al., *"Health Courts," supra* note 85, at 463 ("Claimants would pay their attorneys on a contingent basis (i.e., only if the claim resulted in a compensation payment) . . . .").

191 *See generally* Brandon L. Boxler, *Fixing the Vaccine Act's Structural Moral Hazard*, 12 PEPP. DISP. RESOL. L.J. 1 (2012).

192 One study showed a mean of $22,052 to successful counsel, compared to $14,053 to unsuccessful counsel. *See* Derry Ridgway, *No-Fault Vaccine Insurance: Lessons from the National Vaccine Injury Compensation Program*, 24 J. HEALTH POL. POL'Y & L. 59, 74 (1999). In addition, it should be noted that this "difference" is entirely a product of the health court model, as it currently exists. There is no inherent impediment to treating attorneys' fees identically in both regimes.

determinations—and have asserted that these innovations will ensure that health courts will expedite adjudications (resolving nearly all claims within one year of the date of filing), quell the adversarialism of dispute resolution, and provide consistent, rational rulings that would "restore faith in the reliability of medical justice."[193] Indeed, as noted at the outset, achieving these administrative gains is central to health courts' appeal—and, upon adoption, health courts' ability to withstand inevitable constitutional attack.[194] The $64,000 question, though, is *whether* health courts' procedural innovations will usher in those salutary consequences. How confident, in other words, can we be of the above predictions?

The VICP offers a near-ideal laboratory to consider that question. As seen above, the VICP shares most of the design innovations health court proponents now enthusiastically tout. Furthermore, echoing current predictions of health court processes, back when the VICP was created, Congress expressed confidence that the Program would resolve claims "quickly, easily, and with certainty and generosity,"[195] while contemporary commentators predicted that the VICP would "offer prompt justice"[196] to vaccine-injured children while "guarantee[ing]" equal compensation to "similarly situated individuals."[197]

So, what do we learn when we assess health court advocates' claims through the prism of VICP experience? The picture is bleak. The VICP has simply failed to offer compensation as consistently, as quickly, as easily, or as simply as its proponents had predicted. Indeed, the U.S. Government Accountability Office (GAO) has studied the Program and concluded: "While [the Program] was expected to provide compensation for vaccine-related injuries quickly and easily, these expectations have often not been met."[198] A leader in the parents' lobby, instrumental in the Act's passage, has concluded that the VICP's administration has constituted "a betrayal of the promise that was made to parents about how the compensation program

193 *See supra* note 15 and accompanying text.

194 *See supra* notes 18-20 and accompanying text.

195 H.R. REP. NO. 99-908, at 3 (1986).

196 Editorial, *A Way Out of the Vaccine Morass*, N.Y. TIMES, Oct. 31, 1986, at A34; *see also, e.g.*, Barbara J. Connolly, Note, *The Necessary Complement to Mandatory Immunizations: A National Vaccination Compensation Program*, 8 CARDOZO L. REV. 137, 155 (1986) ("A no-fault, nonadversarial national program will assure expedited, just compensation, at low transaction costs for those who have sustained vaccine-related injuries."); Neraas, *supra* note 54, at 164 ("The Act . . . guarantees prompt compensation."); *id.* at 165 ("In no case should a petitioner have to wait more than a year to receive compensation.").

197 Neraas, *supra* note 54, at 163.

198 1999 GAO REPORT, *supra* note 52, at 19.

would be implemented."[199] And, the man who served for over two decades as the VICP's chief special master has publicly lamented: "[L]itigating causation cases has proven the antithesis of Congress's desire for the Program."[200] Below, I dissect the above contentions and identify what concrete lessons the VICP offers for health courts going forward.

A. *Predictability Remains Elusive*

Predictability has long been touted as a prime advantage of judicial specialization.[201] And increasing the reliability and accuracy of medical liability judgments is inarguably key to health courts' appeal.[202] So, too, in the VICP. As the Vaccine Act was debated, predictability was prominent. Vaccine Act proponents criticized the tort system for its unpredictability.[203] They attributed the tort system's unpredictability to its reliance on "lay judgments."[204] And, they expressed faith that the VICP's predictability-promoting innovations—most prominently, a small set of specialized, experienced adjudicators and the Vaccine Injury Table (which mirrors ACEs, in many respects)—would "eliminate[] the tremendous discrepancies of injury awards under the tort recovery system."[205]

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199 Barbara Loe Fisher, *Vaccine Injury Compensation: A Failed Experiment in Tort Reform?*, VACCINE AWAKENING (Nov. 20, 2008, 7:37 AM), http://vaccineawakening.blogspot.com/2008/11/vaccine-injury-compensation-failed.html, *archived at* http://perma.cc/7BEC-YCUX; *see also* Telephone Interview with Jeffrey H. Schwartz, former President, Dissatisfied Parents Together (Aug. 25, 2014) ("Q: If you had to do it over again, would you support the VICP? A: If I knew then everything I know now, I would not support the enactment of the VICP compensation system. . . . It does not provide simple justice for children as we had hoped and been told that it would.").

200 Stevens v. Sec'y of Dep't of Health & Human Servs., No. 99-594V, 2001 WL 387418, at *7 (Fed. Cl. Mar. 30, 2001). For the fact that the author of the *Stevens* decision, Gary Golkiewicz, served as chief special master for more than two decades, see Advisory Comm'n on Childhood Vaccines, Dep't of Health & Human Servs., Transcript of Meeting of June 10, 2010, at 3, *available at* http://www.hrsa.gov/vaccinecompensation/accvtranscript61010.pdf. Still, the system has its defenders. *See, e.g.*, James R. Copland, *Administrative Compensation for Pharmaceutical- and Vaccine-Related Injuries*, 8 IND. HEALTH L. REV. 277, 285 (2011) ("In general, the VICP must be judged as an unqualified success.").

201 *See supra* note 33 and accompanying text.

202 *See supra* notes 15, 92 and accompanying text.

203 *See, e.g.*, *1984 Senate Hearing*, *supra* note 137, at 277 (statement of John E. Lyons, President, Merck Sharp & Dohme, Division of Merck & Co., Inc.) ("The existing tort system poses a number of problems, the most significant of which is its unpredictability."); *1984 House Hearings*, *supra* note 120, at 237 (statement of Robert B. Johnson, President, Lederle Labs. Division, American Cyanamid Co.) (identifying "unpredictability" as "the fundamental problem facing the U.S. industry in these cases").

204 *1984 House Hearings*, *supra* note 120, at 235 (statement of Robert B. Johnson).

205 Neraas, *supra* note 54, at 164; *see also* BURKE, *supra* note 36, at 168-169 (observing that the tort system's "uncertainty" was "a consistent theme in the vaccine litigation debate" and that the

1. The VICP Experience

Yet in reality, in the vaccine injury context, those innovations have fallen far short of expectations. A working group convened by HHS's Division of Vaccine Injury Compensation has acknowledged that "[t]he decisions of the Court are inconsistent."[206] The Program's long-serving chief special master has criticized the program for "inconsistent decision-making . . . even for similarly situated litigants."[207] And lawyers have also observed that VICP special masters sometimes decide cases differently. In an interview, I asked one prominent lawyer to identify the biggest challenge an attorney encounters while representing petitioners within the VICP. The lawyer replied: "The lack of consistency between special masters: When we file a case, we know that if we receive a particular special master, we're not going to win on the causation issue."[208] When the Federal Judicial Center conducted a survey of petitioners' counsel, it found much the same. For example, one lawyer complained that "outcome often depends on assignment," while another lamented that "the biggest factor in winning or losing a case in this program is which special master is assigned your case."[209]

The one empirical study on the matter lends support to these anecdotal reports. In 1999, a researcher studied all published VICP opinions, yielding a dataset of 786 claims. He found significant variability when it came to the special masters themselves. Among those who had decided more than fifty claims, petitioners' success rate ranged from a low of 32.8% to a high of 65.8%.[210] This is surprising, since cases are usually randomly assigned.[211]

VICP's promise to deliver "much more reliable compensation" was critical to the Vaccine Act's passage).

206 DVIC STRATEGIC PLAN, *supra* note 148, app. H at 25.

207 Stevens v. Sec'y of Dep't of Health & Human Servs., No. 99-594V, 2001 WL 387418, at *11 (Fed. Cl. Mar. 30, 2001); *see also* Advisory Comm'n on Childhood Vaccines, Dep't of Health & Human Servs., Transcript of Meeting of Mar. 5, 2003, at 76 [hereinafter March 5, 2003 ACCV Transcript] (on file with author) ("Though we see many of the same cases day after day, same vaccines, same injury, same literature, extensive litigation continues and different results occur." (quoting Gary Golkiewicz, Chief Special Master, VICP)); *id*. at 73 (observing that "cases that look very similar are decided very differently" (quoting Gary Golkiewicz)); U.S. Court of Fed. Claims, Transcript of the 17th Judicial Conference, Nov. 9, 2004, at 62 (observing that, if two petitioners have "different attorneys and different experts" the petitioners "can get very different results" (quoting Richard B. Abell, Special Master, VICP)); *id*. ("[W]e're looking for consistency, and, of course, quite clearly, that isn't always there." (quoting Richard B. Abell)).

208 Telephone Interview with Attorney for VICP Petitioners (Oct. 1, 2014).

209 JOHNSON ET AL., *supra* note 138, at 38.

210 *See* Ridgway, *supra* note 192, at 66.

There was also variability based on attorney representation; of the attorneys who had represented more than twenty claimants, claimants' success rates ranged from 37.9% to 72%.[212] All told, after crunching the numbers, the study concluded that, despite the VICP's many predictability-promoting innovations, "idiosyncratic differences among judges and litigators" continue to "influenc[e] the outcome of cases."[213]

2. Prospects for Health Courts?

Will health courts—which have staked much of their success on their ability to "eliminate," or at least substantially reduce, decisional discrepancies—also disappoint when it comes to rationalizing compensation decisions? The answer, it seems, is almost certainly yes.

a. *Health Courts Face Additional Impediments*

The first reason health courts seem poised to disappoint is that theory concerning judicial specialization and decisionmaking suggests that the VICP ought to *outperform* health courts when it comes to reducing decisional disparities. Part of the reason is structural. According to Professor Stephen Legomsky, a leading expert on judicial specialization: All else equal, the fewer adjudicators there are in a given area, the more consistent their decisions, as "[i]t is easier to monitor and conform to the decisions of one's colleagues when they are few in number than it is when they are many."[214] Applying that principle, the VICP consists of only eight special masters (one chief and seven associates), who toil in close quarters, over extended periods.[215] By contrast, owing to case volumes, health courts would necessarily require many more—and many more far-flung—decisionmakers, disadvantaging it along this dimension.

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211 Most claims are randomly assigned, though it is possible for claims to be directed to a particular special master if he or she has particularly relevant expertise. *See* 2014 GAO REPORT, *supra* note 52, at 6 n.20.

212 *See* Ridgway, *supra* note 192, at 66. This statistic ought to be viewed with caution, as it could say more about case inputs than case outputs. Some counsel, that is, might be better at identifying clients with stronger claims. Or, some counsel might specialize in off-Table claims, which (as noted below) face longer odds.

213 *Id.* at 68. Even so, of course, it is possible that the VICP represents an improvement over the traditional tort system. Making that apples-to-apples comparison is impossible with available evidence. *See* BAUM, *supra* note 33, at 218 (discussing relevant challenges).

214 Legomsky, *supra* note 168, at 429.

215 *See* 42 U.S.C. § 300aa-12(c)(1) (2012).

Second, Legomsky suggests that consistency suffers as cases become more plentiful in number and complex in substance.[216] This, too, cuts in favor of the VICP, as compared to health courts, VICP review is quite circumscribed. VICP special masters handle relatively few petitions (only about 500 VICP petitions are filed per year).[217] They only adjudicate certain *kinds* of petitions—namely, petitions alleging serious injury following inoculation from one of about two-dozen covered vaccines. And, since the VICP is a true no-fault remedy, special masters only ask one question when making entitlement decisions: Was the petitioner's injury caused, more-likely-than-not, by a covered vaccine? Health courts, by contrast, are apt to adjudicate more claims and wrestle with a far wider array of injuries—considering everything from prescription-drug side effects, to hospital infections, to birth injuries, to drug overdoses, to diagnostic mistakes, to surgical mishaps, to physicians' failure to obtain informed consent. Additionally, because the quality of care remains an issue, health court ALJs must determine, not just whether the physician *caused* the claimant's injury, but also whether the injury was avoidable, which (as noted above) seems destined to complicate the relevant analysis.

Finally, the structure of appellate review also favors the VICP. In general, Legomsky explains, appellate review enhances consistency if review is lodged within a single, centralized tribunal.[218] Lodging appellate review within myriad generalist tribunals, he cautions, tends to have the opposite effect.[219] The VICP takes the former tack—consolidating appeals in specialized courts: the U.S. Court of Federal Claims, then the Federal Circuit. Health courts, by contrast, take the latter (disfavored) approach—offering one layer of specialized review (to a higher-level administrative tribunal), but relegating to generalist courts all subsequent appeals.[220]

b. *Some Other Specialized Tribunals Have Failed to Achieve Consistency*

A second problem for health court proponents is that, in failing to eliminate decisional disparities, the VICP is not alone. In other (diverse)

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216 *See* Legomsky, *supra* note 168, at 432 (concerning case number effects); *id.* at 441-42 (concerning complexity).

217 *See* HEALTH RES. & SERVS. ADMIN., *supra* note 31 (revealing that 386 claims were filed in fiscal year 2011, 401 claims were filed in fiscal year 2012, 503 claims were filed in 2013, and 633 claims were filed in 2014).

218 *See* Legomsky, *supra* note 168, at 436-37; *cf.* Harold H. Bruff, *Specialized Courts in Administrative Law*, 43 ADMIN. L. REV. 329, 339 (1991) ("[A]llocations of subject matter should avoid combining generalists and specialists in ways that erode gains from specialization.").

219 *See* Legomsky, *supra* note 168, at 436-37.

220 *See* Mello et al., *"Health Courts," supra* note 85, at 465.

areas of law, specialized adjudicators have labored to create consistency—strongly suggesting that specialization is no predictability-promoting panacea.[221] For example, immigration courts are specialized; they are all part of a single national Executive Office for Immigration Review, and immigration judges, who devote themselves to immigration adjudications, must all meet the same qualifications.[222] But asylum decisions are inconsistent. Indeed, a groundbreaking 2007 study examined 140,000 decisions rendered by immigration judges over a four-and-a-half-year period and found stunning disparities. These disparities existed between courts: For instance, Chinese nationals seeking asylum in the United States had a 7% chance of success in Atlanta, but a whopping 76% chance of success in Orlando.[223] Disparities also existed between judges *on the same court*: In New York, for example, one judge granted asylum in only 6% of the relevant cases before him, while another's grant rate was 91%, even though petitions were randomly assigned.[224]

Decisions by the Department of Veterans Affairs (VA) offer another exemplar. By law, veterans are entitled to compensation for disabling conditions incurred or aggravated during military service. To award and calculate payment, trained specialists within the VA (called Rating Veterans Service Representatives) evaluate claims, determine eligibility, and, if the veteran's disability is service related, assign a disability percentage rating.[225] Once again, however, though they are made by specialists, judgments are

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221 Others would add that the experience of the Federal Circuit also "cautions against assuming that concentration of cases in a single court will produce a high level of uniformity in the law." Baum, *supra* note 34, at 1557. The Federal Circuit was created, in large part, to promote consistency in patent law. *See* S. REP. NO. 97-275, at 2-7 (1981) (noting that the creation of the United States Court of Appeals for the Federal Circuit would "improve the administration of the patent law by centralizing appeals in patent cases"). In action, however, many suggest the Federal Circuit has labored on this score. *See, e.g.*, Paul R. Gugliuzza, *The Federal Circuit as a Federal Court*, 54 WM. & MARY L. REV. 1791, 1802 (2013) ("It is not clear whether the Federal Circuit has brought uniformity, quality, or efficiency to patent law.").

222 *See* Baum, *supra* note 34, at 1546-47 (reporting that immigration judges are highly specialized and extremely knowledgeable); Jaya Ramji-Nogales et al., *Refugee Roulette: Disparities in Asylum Adjudication*, 60 STAN. L. REV. 295, 380 n.146 (2007) (outlining relevant qualifications of immigration judges).

223 *See* Ramji-Nogales et al., *supra* note 222, at 329-30. The authors acknowledge that the disparity may be partially explained by unidentified differences within certain cities' migrant populations. But they also note that any hypothesized difference in migrant populations "could not possibly explain the differences in grant rates from officer to officer within regional asylum offices." *Id.* at 321-22.

224 *See id.* at 334.

225 *See* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-13-89, VETERANS' DISABILITY BENEFITS: TIMELY PROCESSING REMAINS A DAUNTING CHALLENGE 4 (2012) (outlining the process of veterans' disability compensation claims).

not consistent. To the contrary, the Veterans' Disability Benefits Commission reports that the program has "long struggled with timeliness, accuracy, and consistency,"[226] while the GAO reports that "nearly one-third of decisions are incorrect or have technical or procedural errors."[227]

The Social Security Disability System, which provides monetary benefits to persons with disabilities, offers another case in point. Within the system, disability decisions are initially made by state agencies, using federal guidelines. Then, if benefits are denied, claimants may request a hearing before an ALJ.[228] These ALJs are specialized; they do nothing but adjudicate social security disability determinations. But their decisions, too, are marred by glaring inconsistencies. In fact, one recent study found that, nationally, ALJs' "allowance rates" (determinations that were at least partly favorable to the claimant) ranged from a meager 4% to a whopping 98%,[229] while stark variations existed between ALJs *within the same office*. In Atlanta, for example, one ALJ's allowance rate was 19%, while a colleague's rate was 89%, even though claims were randomly assigned.[230]

Perhaps most dishearteningly, theorists suggest that these adjudicatory inconsistencies are, to some degree, inescapable. Returning, again, to Professor Legomsky:

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226 VETERANS' DISABILITY BENEFITS COMM'N, HONORING THE CALL TO DUTY: VETERANS' DISABILITY BENEFITS IN THE 21ST CENTURY 327 (2007); *see also* U.S. GENERAL ACCOUNTING OFFICE, GAO/T-HEHS/AIMD-00-146, VETERANS BENEFITS ADMINISTRATION: PROBLEMS AND CHALLENGES FACING DISABILITY CLAIMS PROCESSING 5 (2000) [hereinafter Bascetta Testimony] (statement of Cynthia A. Bascetta, Associate Director, Veterans Benefits Admin.) (discussing a "perception of inconsistency in decisions made by different regional offices"). This "perception" has been difficult to test empirically, as the VA has repeatedly failed to conduct planned reviews. *See* OFFICE OF INSPECTOR GEN., DEP'T OF VETERANS AFFAIRS, NO. 08-02073-96, AUDIT OF VETERANS BENEFITS ADMINISTRATION COMPENSATION RATING ACCURACY AND CONSISTENCY REVIEWS, at i (2009).

227 Bascetta Testimony, *supra* note 226, at 1.

228 *See* ADMIN. CONFERENCE OF THE U.S., ADMINISTRATIVE CONFERENCE RECOMMENDATION 2013-1, IMPROVING CONSISTENCY IN SOCIAL SECURITY DISABILITY ADJUDICATIONS 2 (2013) (discussing the Social Security disability claims adjudication process).

229 HAROLD J. KRENT & SCOTT MORRIS, STATISTICAL APPENDIX TO REPORT ON ACHIEVING GREATER CONSISTENCY IN SOCIAL SECURITY DISABILITY ADJUDICATION: AN EMPIRICAL STUDY AND SUGGESTED REFORMS 13-14 (2013). Some variation may be attributable to regional variations in the claimant population (i.e., certain injuries are particularly common in certain regions of the country). *See* Harold J. Krent & Scott Morris, *Inconsistency and Angst in District Court Resolution of Social Security Disability Appeals* 12 (Chi.-Kent Coll. of Law, Research Paper No. 2014-30, 2014), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2530158 (making this observation).

230 *See* Krent & Morris, *supra* note 229, at 13; *id.* at 19 (concluding "the percentage of disability claims awarded by ALJs differ markedly from region to region and from ALJ to ALJ").

> As long as adjudicators are flesh-and-blood human beings, as long as the subject matter is ideologically and emotionally volatile, and as long as limits to the human imagination constrain the capacity of legislatures to prescribe the specific results for every conceivable fact situation, there will be large disparities in adjudicative outcomes . . . .[231]

Particularly worrisome for health courts, leading theorists have suggested that inconsistency may be particularly inescapable when the area is highly charged (as medical malpractice is)[232] and when cases hinge on witness credibility (as medical malpractices cases often do).[233]

c. *Some Inconsistency Is Inevitable in Medical Evaluation*

When it comes to certain health court proponents' pledge to "eliminate" decisional disparities, the third obstacle is that eliminating disparities in *medical valuation* is, by all accounts, impossible. When passing judgment on physician conduct, even trained and independent experts, it turns out, have difficulty determining whether physicians erred and whether a given physician's error precipitated or aggravated a given patient's injury. Or, to quote a 2001 study published in the *Journal of the American Medical Association*: "In all general medical and surgical chart review studies to date, reviewers have had a difficult time agreeing on whether an error caused an adverse event or even on whether something was an error at all."[234] One recent study, for example, found that when independent reviewers (insurer-retained physicians) evaluated closed medical malpractice insurer claims files, they disagreed with one another "in 34.3% of the cases."[235] Another

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231 Legomsky, *supra* note 168, at 415-16. Gary Golkiewicz, the VICP's long-serving chief special master, has said much the same: "Wherever there is human involvement, you will have variance in outcome." March 5, 2003 ACCV Transcript, *supra* note 207, at 81.

232 *See* Legomsky, *supra* note 168, at 442 (cautioning that "subjects that inspire ideological or emotional fervor would seem to have the greatest potential for disparate outcomes"); *cf.* W. John Thomas, *The Medical Malpractice "Crisis": A Critical Examination of a Public Debate*, 65 TEMP. L. REV. 459, 460 (1992) ("Medical malpractice is perhaps the most controversial tort in the American legal system.").

233 *See* Baum, *supra* note 34, at 1543 (suggesting that specialization confers no benefit when it comes to assessing witness credibility); *cf.* NEIL VIDMAR, MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS, AND OUTRAGEOUS DAMAGE AWARDS 175 (1995) ("[Q]uestions bearing on credibility of witnesses—different versions of events between patient and doctor or between medical personnel—pervade many malpractice disputes.").

234 Rodney A. Hayward & Timothy P. Hofer, *Estimating Hospital Deaths Due to Medical Errors: Preventability Is in the Eye of the Reviewer*, 286 J. AM. MED. ASS'N 415, 419 (2001) (footnotes omitted).

235 Ralph Peeples et al., *The Process of Managing Medical Malpractice Cases: The Role of Standard of Care*, 37 WAKE FOREST L. REV. 877, 884 (2002); *see also, e.g.*, A. Russell Localio et al.,

recent study discerned little agreement among experts as to whether a patient's death was preventable: "If one reviewer rated a death as definitely or probably preventable," the researchers found, "the probability that the next reviewer would rate that case as definitely not preventable (18%) was actually slightly higher than the probability that the second reviewer would agree with the first (16%)."[236]

d. *A Sober Look at the Status Quo*

Finally, it is wise to recall the admonition of David P. Currie and Frank I. Goodman in their classic article on judicial specialization. "[B]efore drastic alterations are made in the present jurisdictional system in the name of removing disuniformity," they advise, "a serious effort should be made to determine the extent of the problem."[237] Such an effort, it turns out, reveals that the current medical malpractice system is not the whimsical lottery that some health court proponents accuse it of being.

While some health court champions declare, for example, that "[m]alpractice law has become so muddled that going to court is like rolling the dice,"[238] or, worse, that the malpractice system "resembles Russian Roulette,"[239] decades of research indicates, to the contrary, that the current system does a fairly good, though not perfect, job sorting between meritorious and non-meritorious claims. A 2006 study by David Studdert and co-authors found, for example, that "[c]laims without merit were generally resolved appropriately: only one in four resulted in payment."[240] Other evidence likewise shows that jury verdicts *and* medical malpractice

Identifying Adverse Events Caused by Medical Care: Degree of Physician Agreement in a Retrospective Chart Review, 125 ANNALS INTERNAL MED. 457, 460 (1996) (finding relatively frequent "extreme disagreement on the occurrence of an adverse event"); Karen L. Posner et al., *Variation in Expert Opinion in Medical Malpractice Review*, 85 ANESTHESIOLOGY 1049, 1051 (1996) (finding that when participating anesthesiologists reviewed claimants' original medical records, they disagreed about the appropriateness of care—whether the care was "reasonable and prudent by the standards of anesthetic care at the time of the event"—38% of the time).

236 Hayward & Hofer, *supra* note 234, at 417.

237 Currie & Goodman, *supra* note 33, at 66.

238 UDELL & KENDALL, *supra* note 11, at 1.

239 *2006 Senate Hearing*, *supra* note 173, at 44 (statement of Philip K. Howard); *see also* U.S. SENATE REPUBLICAN POLICY COMM., *supra* note 14, at 2 ("The current system for compensating injured patients operates somewhat like a lottery; jury verdicts are characterized more by their random nature than by good medicine."); Jeffrey D. Pariser, *Specialized Health Care Courts: Could They Create Clear Standards and Greater Reliability?*, MED. MALPRACTICE L. & STRATEGY, Aug. 2004, at 3 ("Medical justice today, studies show, is worse than random."). For criticism of tort reformers' persistent use of the lottery metaphor, see Timothy D. Lytton et al., *Tort as a Litigation Lottery: A Misconceived Metaphor,* 52 B.C. L. REV. 267 (2011).

240 Studdert et al., *Claims, Errors, and Compensation Payments*, *supra* note 74, at 2029.

settlement decisions generally comport with expert determinations.[241] So the question is not whether health courts will rationalize a hopelessly irrational system. The question is whether health courts will substantially improve an already fairly rational system. That is a much tougher task. And when assessing whether it is doable, it is worrying that (1) the VICP, which is, theory would suggest, better positioned to reduce decisional disparities, has seemingly struggled on this score; (2) in other contexts, specialized tribunals have failed to create consistency; and (3) even experts sometimes disagree about preventability and causality questions, in the course of medical record review.

B. *"Challenged to Settle Claims Quickly"*[242]

Next, specialized courts have long been championed for expediting compensation decisions.[243] And, as noted above, speeding payments is touted as one of health court's principal advantages.[244] Speed was also central to the VICP plan. In the run-up to the Vaccine Act's enactment, many of the Act's backers emphasized the need to expedite adjudications. For example, the main parents' group supporting the legislation (Dissatisfied Parents Together) implored congressional leaders: "There needs to be an up or down decision within a reasonable time . . . . The compensation process must not drag on for years while the children are left uncared for."[245] Representatives from vaccine manufacturers emphasized that the Act's "most important" objective was to "ensure that injured children and their parents are fairly compensated, with a minimum of delay."[246] And the President-Elect of the American Academy of Pediatrics

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241 *See generally* Philip G. Peters, Jr., *Doctors & Juries*, 105 MICH. L. REV. 1453 (2007) (sifting through three decades of empirical research on jury decisionmaking in the medical malpractice context and concluding that jury decisions generally comport with expert determinations); Mehlman & Nance, *supra* note 5 (analyzing empirical evidence that undermines claims that the medical malpractice system resembles a lottery). The above evidence is at odds with a frequently cited finding of the Harvard Medical Practice Study. However, as many have discussed, that study was not designed to assess adjudication accuracy. *See generally, e.g.*, Tom Baker, *Reconsidering the Harvard Medical Practice Study Conclusions About the Validity of Medical Malpractice Claims*, 33 J.L. MED. & ETHICS 501 (2005).

242 1999 GAO REPORT, *supra* note 52.

243 *See supra* note 33 and accompanying text.

244 *See supra* note 95 and accompanying text.

245 *1987 House Hearing*, *supra* note 119, at 80 (statement of Jeffrey H. Schwartz, President, Dissatisfied Parents Together).

246 *Id.* at 93 (statement of Douglas MacMaster, President, Merck Sharp & Dohme Division, Merck & Co., Inc.).

joined the chorus, calling "a prompt settlement of claims . . . fundamental to any improved system."[247]

Establishing a statutory 240-day deadline for all VICP adjudication decisions, Congress appeared to take these pleas seriously.[248] Indeed, explaining this deadline, the House Report accompanying the Vaccine Act provided that, whereas "[l]awsuits and settlement negotiations" under the traditional tort system took "months and even years to complete," "[t]he entire [VICP] proceeding . . . is to take place as expeditiously as possible."[249] Expediting compensation, Congress continued, was vital, because "much of the equity in limiting compensation and limiting other remedies arises from the speed and reliability with which the petitioner can expect judgment; without such quick and certain conclusion of proceedings, the compensation system would work an injustice upon the petitioner."[250]

1. The VICP Experience

So, how has the VICP fared when it comes to the expeditious resolution of petitions? Not well. Indeed, despite Congress's high hope and clear demand, the VICP in action is notable not for its speed but rather for its long times to decision. Few petitions (less than 5%) satisfy the statutory 240-day deadline.[251] Most exceed it by a wide margin. Of petitions filed prior to 1999, only 14% were decided within one year, 19% took between one and two years, 39% took between two and five years, and 18% dragged on for five years or more.[252] From there, things got worse. Of petitions filed between 1999 and March 31, 2014, the Program's average adjudication time clocked in at about *five-and-a-half years*, while most petitions (51%) remained pending for over a half-decade.[253]

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247 *1984 Senate Hearing*, *supra* note 137, at 148 (statement of Martin H. Smith).

248 *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6601, 103 Stat. 2106, 2288 (codified at 42 U.S.C. § 300aa-12(d)(3)(A)(ii) (2012)).

249 H.R. REP. NO. 99-108, at 6, 17 (1986).

250 *Id*. at 17; *see also* WENDY K. MARINER, INNOVATION AND CHALLENGE: THE FIRST YEAR OF THE NATIONAL VACCINE INJURY COMPENSATION PROGRAM 9-10 (1991) ("[A] prompt award was the major justification for limiting the compensation payable to recipients.").

251 *See* Mitch Weiss et al., *AP IMPACT: "Vaccine Court" Keeps Claimants Waiting*, ASSOCIATED PRESS, Nov. 17, 2014, *available at* http://bigstory.ap.org/article/637dbaa7b9934549813209o7b0972cf6/ap-impact-vaccine-court-keeps-claimants-waiting (concluding, as of January 2013, that just 4.5% of petitions were resolved within Congress's 240-day framework).

252 *See* 1999 GAO REPORT, *supra* note 52, at 8 fig.1.

253 The fact that most petitions remained pending for over five years logically means that the VICP's median time to resolution also exceeded five years during the period. *See* 2014 GAO REPORT, *supra* note 52, at 10 fig.1 (showing that 51% of VICP claims filed between 1999 and March 31, 2014 required more than five years to resolve); *id.* at 9 (reporting that the roughly 8800 claims filed as of 1999 and resolved as of March 31, 2014 took an average of about 5.5 years to

Critically, it takes more time, on average, to process claims within the Program than it does to process claims, *through judgment*, within the traditional tort system: approximately 66 months within the VICP, as compared to 25.6 months for tort cases that terminate in a judgment or verdict.[254] VICP proceedings take longer than consumer class actions

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adjudicate). For successful petitioners, reported adjudication times (both the mean and median) include the time to calculate the compensation amount. *See id.* at 13.

More recently, since 2009, the average time to adjudication has dropped to about 1.6 years—a positive development that is presumably traceable to a rise in negotiated settlements and a reduction in the proportion of petitions involving a catastrophic injury. *Id.* at 9-13. (These days, a high proportion of petitions involve relatively minor injuries to adults, caused by the flu vaccine. *See infra* note 292.) Even so, drawing definite conclusions about acceleration would be premature; some post-2009 claims are still pending and gains may erode once those pending claims are resolved and factored in. *See* 2014 GAO REPORT, *supra* note 52, at 10-12; *see also* Telephone Interview with Curtis Webb, Attorney for VICP Petitioners and former Chair, Advisory Comm. on Childhood Vaccines (Oct. 27, 2014) ("The statistics suggest that cases are being resolved more quickly, but that is because the cases that are in the Program today are less likely to involve seriously injured children.").

When discussing time to adjudication, a final point to recognize is that many delays are caused by petitioners—as petitioners sometimes take time to compile medical records, submit expert reports, and finalize life-care plans. *See* Advisory Comm'n of Childhood Vaccines, Dep't of Health & Human Servs., Transcript of Meeting of June 1, 2005, at 21 [hereinafter June 1, 2005 ACCV Transcript] (on file with author) ("[I]t's problematic to measure the effectiveness of a program by how long it takes to process a petition when the . . . petitioner[] is the one requesting the delay, and that happens with significant frequency." (quoting Mark Rogers, Torts Branch, Civil Div., U.S. Dep't of Justice)). Still, even if petitioners are the ones "requesting the delay," it would be wrong to lay all the blame at petitioners' feet, for petitioners' *need* to take time to assemble detailed documentation is logically influenced by others' *demand* for detailed documentation. The GAO observed this interaction while compiling its 1999 report:

> Another factor significantly increasing processing times is that as the program received additional funding for staff and experts to defend claims, the government increasingly challenged claims in which the cause of injury was in doubt. As a result, petitioners needed more information and time to prepare cases, which resulted in processing times that were much longer than envisioned when the program began.

1999 GAO REPORT, *supra* note 52, at 3. Furthermore, the GAO found that, even after all the information was submitted, "in most cases, it took the court over another year to reach its decision." *Id.* at 11.

254 *See* THOMAS H. COHEN & STEVEN K. SMITH, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 202803, CIVIL TRIAL CASES AND VERDICTS IN LARGE COUNTIES, 2001, at 8 (2004); *see also* THOMAS H. COHEN, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 228129, TORT BENCH AND JURY TRIALS IN STATE COURTS, 2005, at 9 (2009) (reporting that, in 2005, the median tort case processing time, from the filing of the complaint to verdict or judgment was 22.3 months). Curiously, some writing about the VICP seem unconcerned about the VICP's adjudication times, while substantially overestimating the delays within the traditional tort system. *See, e.g.*, Evans, *supra* note 143, at S134 ("Adjudication times for VICP cases are much shorter than those for the civil system, averaging 3.0 years for vaccines administered after 1988.").

(which take roughly 32 months).[255] And, VICP petitions appear to take substantially more time to resolve than medical malpractice claims, which, in terms of injury severity and scientific complexity, probably offer the closest comparator.[256]

For some cases, the path through the system can be downright byzantine. One such case is *Kolakowski v. Secretary of Health and Human Services*.[257] Born "vigorous and alert" on December 17, 1998, Thomas Kolakowski was given a Hepatitis B vaccine on January 20, 1999.[258] He died five days later.[259] Believing there to be a link between the vaccine and what was listed on Thomas's death certificate as a "sudden unexplained death," Thomas's parents filed a VICP petition on August 4, 1999.[260] The petition was not finally decided until November 23, 2010—when it was denied in a 130-page ruling.[261] Baby Doe/90's claim went no speedier. Administered a DTP vaccine in 1995 that triggered a seizure disorder, Baby Doe/90 filed a petition for compensation on October 26, 1998.[262] Still, no entitlement decision was made until June 18, 2009, and no award was finalized until September 29, 2010—nearly twelve years after filing.[263] Ilya Dobrydnev encountered comparable difficulties. He filed a petition for injuries allegedly caused by a Hepatitis B vaccine on October 25, 2004.[264] After

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255 See Brian T. Fitzpatrick, *An Empirical Study of Class Action Settlements and Their Fee Awards*, 7 J. EMPIRICAL LEGAL STUD. 811, 820 tbl.2 (2010) (dividing 963 days by 30 to arrive at 32.1 months).

256 According to a recent study of closed medical malpractice claims, the average time from filing with the insurer to closure either with or without payment was 20.3 months, while claims involving pediatricians (arguably, the most analogous to VICP claims) averaged 24.1 months. *See* Seabury et al., *supra* note 72, at 113, 116 fig.3. Or, for medical malpractice cases resolved by an actual court verdict or judgment, the Bureau of Justice Statistics reports that the average adjudication time is roughly 33.2 months. *See* COHEN & SMITH, *supra* note 254, at 8; *see also* COHEN, *supra* note 254, at 9 tbl.8 (reporting that, in 2005, the median medical malpractice case processing time, from filing to resolution by verdict or judgment, was 30 months); VIDMAR, *supra* note 233, at 60 (reporting that, in a 1984–1987 sample of North Carolina medical malpractice claims, an average of 26 months elapsed between the filing of a lawsuit and trial); Studdert et al., *Claims, Errors, and Compensation Payments*, *supra* note 74, at 2025, 2027 tbl.1 (reporting that roughly three years elapsed (mean and median) between the opening and closing of a medical malpractice claim (with "claim" defined as a written demand for compensation)).

257 No. 99-0625V, 2010 WL 5672753 (Fed. Cl. Nov. 23, 2010).

258 *Id.* at *3, *97.

259 *See id.*

260 *See id.* at *1.

261 *See id.*

262 Doe/90 v. Sec'y of Dep't of Health & Human Servs., No.[Redacted]V, 2010 WL 3943641, at *1 (Fed. Cl. Sept. 29, 2010).

263 *See id.*

264 *See* Dobrydnev v. Sec'y of Dep't of Health & Human Servs., No. 04-1593V, 2013 WL 5631230, at *1 (Fed. Cl. Sept. 23, 2013).

ping-ponging around the system for nearly a decade, his entitlement to compensation was only recently rejected.[265] Here, I do not suggest that these cases are typical. They, fortunately, are not.[266] Instead, my point is to illustrate that, just as cases can get bogged down within the traditional tort system, cases can, and sometimes do, get bogged down within the supposedly "streamlined" process of the VICP.

2. Prospects for Health Courts?

The above shows that the VICP was sold to the public, in large measure, as a way to expedite compensation for vaccine-injured claimants. But in practice on this score, the VICP has failed to deliver. The relevant question now becomes whether health courts—which ascribe many problems that afflict the current medical malpractice environment to its slow time to decision—are apt to suffer the same setbacks.

There is an argument that the above delays are unique to the VICP. The best argument in favor of this VICP exceptionalism would be that the VICP has twice been hit by an onslaught of unanticipated filings. First, early in its lifecycle, the VICP anticipated receiving roughly 1000 "retrospective claims" (i.e., claims for vaccine injuries sustained prior to the Act's October 1988 effective date).[267] Instead, 4500 such claims were filed.[268] These filings created a backlog, which for many years strained resources, thereby slowing adjudications.[269] Then, just as the VICP dug itself out from that mountain of retrospective cases, the Program got hit a second time by a barrage of petitions (over 5500 in all) alleging a link between vaccines and autism.[270] If

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265 *See* Dobrydnev v. Sec'y of Health & Human Servs., 566 F. App'x 976 (Fed. Cir. 2014).

266 Nor are they total outliers. *See* Weiss et al., *supra* note 251 (concluding, after conducting a comprehensive study of VICP petitions and completing more than 100 interviews with relevant stakeholders, that "[h]undreds [of petitions] have surpassed the decade mark"); Telephone Interview with Curtis Webb, *supra* note 253 ("*Most* cases that involve catastrophic injury, if they are contested and successful, last between six or ten years, and cases with appeals can last even longer.").

267 *See* Louise Palmer, *Government Can't Meet Vaccine Injury Claims*, N.Y. TIMES, Apr. 25, 1993, at 6 (quoting Thomas Balbier, VICP Director, as stating, "We thought there would be maybe a thousand.").

268 *See id.*

269 *See* June 1, 2005 ACCV Transcript, supra note 53, at 27 ("There are many reasons why the program has been unable to meet [the 240-day deadline]. The first one came right at the inception of the program, and those were the retrospective cases. The program was besieged with thousands of them and it stressed the program and it took us 10 years to work through that backlog.").

270 The first autism spectrum disorder petition was filed in 1998. By 2003, 2437 petitions had been filed; by 2011, 5636 petitions had been logged. *See* Laura A. Binski, Note, *Balancing Policy*

health courts are not similarly overrun, one might argue, they might fulfill their promise of resolving claims quickly.

Yet while that conclusion is surely possible, there are important reasons why health court advocates should not write off the VICP experience. Most notably, the VICP's inundation problem fits squarely within the literature concerning specialized courts. When identifying concerns about specialized tribunals, that is, legal theorists have long argued that, *precisely because* specialized tribunals aren't diversified, they are susceptible to abrupt swings in the size of their dockets. As Judge Richard Posner has explained: "It is a mathematical law that the federal appellate caseload as a whole changes less from year to year than the components of that caseload. So if each component were assigned to a special court it would be harder to match supply to demand."[271]

Also worrying, other specialized tribunals exhibit this dynamic—occasionally encountering long delays when caseloads shift. For example, between 2009 and 2012, the average length of time to complete a claim for disability benefits within the Veterans Administration (VA) ballooned from 161 days to 260 days, while the VA's backlog of claims—defined as claims awaiting a decision for over 125 days—more than tripled.[272] Why? According to the GAO, the chief culprit was that, in 2010, a court decision forced the VA to re-adjudicate 260,000 claims initiated by Vietnam veterans for injuries allegedly sustained by exposure to the defoliant Agent Orange. These re-adjudications consumed 37% of the VA's adjudicatory resources, substantially impairing the systemwide pace of claims resolution.[273] The upshot of the above is that both theory and some evidence suggest that what happened in the VICP was not isolated or anomalous. Caseload volatility is, instead, an unfortunate but inevitable drawback of tribunal specialization.

Meanwhile, the VICP experience—initially underestimating the number of claims that would be filed, becoming inundated by claims, and then falling behind in adjudications—raises the related question of whether health courts would be able to accurately predict caseloads (and create

Tensions of the Vaccine Act in Light of the Omnibus Autism Proceeding: Are Petitioners Getting a Fair Shot at Compensation?, 39 HOFSTRA L. REV. 683, 701 (2011) (compiling these statistics).

271 RICHARD A. POSNER, THE FEDERAL COURTS: CHALLENGE AND REFORM 259-60 (1996); *accord* Ginsburg & Wright, *supra* note 33, at 805 ("[W]hen the docket of a specialized court is growing, it will not have an adequate number of judges, and getting new judges is difficult, time consuming, and imprudent in light of the probability that the caseload will soon turn down again.").

272 *See* U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 225, at 1.

273 *See id.* at 6-7; *see also id.* at 12 ("37% of its claim processing resources nationally were devoted to adjudicating Agent Orange claims.").

adequate adjudicatory capacity) ex ante. On that question, it is relevant that, in grossly underestimating initial claim filings, the VICP is not alone. To the contrary, a *number* of federal compensation programs (including the Radiation Exposure Compensation Program, the Energy Employees Occupational Illness Compensation Program, and the Black Lung Program) have done precisely the same thing—to precisely the same effect.[274] Furthermore, matching adjudicatory capacity with claimant demand may be particularly tough in the health court context. This is because "[a] primary goal of health court proposals is to expand the pool of injured patients who are eligible for compensation."[275] Currently, there are roughly 9000 successful medical malpractice claims lodged against physicians in the United States each year,[276] even while roughly 700,000 Americans sustain preventable medical injuries annually.[277] Just how many of those preventably injured patients would seek health court compensation—and thus, how much adjudicatory capacity health courts would need—would be anyone's guess.[278]

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274 When the Radiation Exposure Compensation Program was enacted, the DOJ estimated that 13,000 claims would be filed. *See* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-628T, FEDERAL COMPENSATION PROGRAMS: PERSPECTIVES ON FOUR PROGRAMS FOR INDIVIDUALS INJURED BY EXPOSURE TO HARMFUL SUBSTANCES 10 (2008) (statement of Anne-Marie Lasowski, Acting Director, Educ., Workforce, & Income Sec. Issues, Gov't Accountability Office). In fact, 20,600 claims were eventually lodged. *See id.* Or, when the Energy Employees Occupational Illness Compensation Program was created, the Congressional Budget Office estimated that 13,400 claims would be filed. *See id.* But in fact, 59,500 were filed. *See id.* Or, when the Black Lung Program was established, the Department of Labor anticipated the receipt of 520,000 claims; instead 960,800 were filed. *See id.* According to the GAO, these miscalculations "affected the length of time it took to finalize claims and compensate eligible claimants." *Id.* at i.

275 Mello et al., *"Health Courts," supra* note 85, at 465.

276 *See* Myungho Paik et al., *The Receding Tide of Medical Practice Litigation: Part 1—National Trends*, 10 J. EMPIRICAL LEGAL STUD. 612, 617 fig.1 (2013).

277 *See supra* note 61 and accompanying text (estimating that 700,000 patients are preventably injured each year).

278 Of course, not all 700,000 would be eligible for compensation because of health courts' injury-severity thresholds. A further concern is that, if health courts *do* become overwhelmed, speed may not be the only casualty. In other contexts, delays accompanying inundation have sometimes prompted policymakers to take controversial steps to expedite or streamline adjudications. *See, e.g.*, Richard E. Levy, *Social Security Disability Determinations: Recommendations for Reform*, 1990 BYU L. REV. 461, 499-501 (discussing how disposition "goals" imposed on ALJs when the SSA was "faced with large caseload backlogs" created "an atmosphere at SSA in which . . . ALJs felt pressure to process claims quickly and deny benefits whenever possible").

C. *Calculating Individualized Compensation Is Time Consuming and Challenging*

The next concrete lesson that the VICP offers for health courts concerns the difficulty of calculating individualized compensation. This insight is not new. Robert Keeton, a pioneer of the no-fault movement, cautioned back in 1973 that "[i]f a nonfault system undertakes to individualize compensation, it cannot escape the significant administrative cost of doing so."[279] The VICP illustrates Keeton's warning in vivid detail: It shows that, even when an act's architects bend over backwards to simplify damage calculations, projecting future losses can still be challenging. This fact, once again, has troubling implications for health courts, as well as certain other no-fault mechanisms.

As noted above, the VICP goes to great lengths to simplify damage determinations. Compensation in the event of a vaccine-related death is automatically set at $250,000,[280] while payment calculations for injuries are also standardized. Injured claimants, that is, are entitled to (1) lost wages, (2) compensation for pain and suffering, and (3) actual medical and rehabilitation expenses. But, of those three damage categories, only the third is consistently calculated on an individualized basis. Minors' lost wages are pegged to a national average,[281] while damages for pain and suffering are capped at $250,000.[282] Further, even within the third category, calculating *past* medical and rehabilitation expenses is typically easy and uncontroversial, leaving only *future* medical or remedial care as the locus of dispute.

1. The VICP Experience

Given these statutory shortcuts, soon after enactment, the VICP was praised for "provid[ing] a straightforward means of measuring damages."[283] Yet while the VICP does *formally* take numerous steps to simplify damage calculations, those efforts have, once again, fallen short of expectations. By May 1991, a commentator had dryly observed that "determining the amount of compensation payable to eligible petitioners has been more time-

279 Robert E. Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 611 (1973).

280 *See* 42 U.S.C. § 300aa-15(a)(2) (2012).

281 *See id.* § 300aa-15(a)(3)(B). Adults are entitled to their "actual and anticipated loss of earnings." *Id.* § 300aa-15(a)(3)(A).

282 *See id.* § 300aa-15(a)(4).

283 Robert L. Rabin, *Some Thoughts on the Efficacy of a Mass Toxics Administrative Compensation Scheme*, 52 MD. L. REV. 951, 959 (1993); *see also id.* (noting that, at least on paper, the VICP "assesses damages in a simple and administratively efficient manner").

consuming than might have been predicted."[284] That turned out to be an understatement. In 2002, for example, a median of 533 days elapsed between when a victim was found to be eligible for compensation and the time when damages were actually awarded; in 2003, a median of 564 days elapsed; in 2004, a median of 529 days elapsed; and in 2005, a median of 484 days elapsed.[285] This means that it often takes the VICP *twice as long* to calculate damages as Congress—which, recall, imposed a 240-day statutory deadline on vaccine adjudications—thought it would take to resolve cases from start-to-finish.

Worse, some damage disputes devolve into debates over minutiae. For example, one former special master has complained, "It's a game. I had people arguing over the cost of the thing you put in the bottom of the bathtub so people don't slip."[286] Similarly, the *Los Angeles Times* reported in 2004:

> Even when families do win compensation, officials have sometimes battled them over just a few dollars.
>
> In one case, government representatives argued that $150 a year was too much to spend on wheelchair maintenance. They have haggled over how much to allow for replacement shoes and braces for people with polio. Another time, they recommended rubber sheets for the bed of an incontinent person because they were cheaper, although less comfortable, than disposables costing $135 a year.[287]

In other cases, disputes have arisen concerning whether a fourteen-year-old girl with profound mental retardation and severe spastic quadriplegia is or is not entitled to a $40 pair of high-top tennis shoes;[288] whether a child, crippled at the age of ten years old by the Hepatitis B vaccination, is entitled to have the help of an assistant for either five or alternatively eight hours per day;[289] and whether the services of a licensed practical nurse can be obtained for $50 or $60, per hour.[290]

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284 MARINER, *supra* note 250, at 36.

285 *See* DVIC STRATEGIC PLAN, *supra* note 148, at 9.

286 Palmer, *supra* note 267 (quoting Denis Hauptly, Special Master, VICP).

287 Myron Levin, *Vaccine Injury Claims Face Grueling Fight: Victims Increasingly View U.S. Compensation Program as Adversarial and Tightfisted*, L.A. TIMES, Nov. 29, 2004, at A1.

288 *See* Wilkerson v. Sec'y of Dep't of Health & Human Servs., No. 90-0822V, 1998 WL 106132, at *12 (Fed. Cl. Feb. 24, 1998).

289 *See* I.D. v. Sec'y of Health & Human Servs., No. 04-1593V, 2013 WL 2448125, at *7 (Fed. Cl. Apr. 19, 2013).

290 *See* Ku v. Sec'y of Health & Human Servs., No. 04-1370V, 2012 WL 6879061, at *8-9 (Fed. Cl. Feb. 9, 2012).

2. Prospects for Health Courts?

Like the VICP, health courts are apt to encounter significant—yet heretofore unforeseen—difficulties in the course of damage calculations. Indeed, while there are relevant differences between the two systems, by the time these differences are tallied and their effects analyzed, it seems that, compared to the VICP, health courts are actually poised to have a harder time.

a. *Four Characteristics of Health Courts that Might Produce a Comparative Advantage*

There are four ways in which health courts differ from the VICP, where, when it comes to simplifying damage calculations, health courts might offer a comparative advantage. First, health courts would simplify all noneconomic damage awards, while the VICP requires an individualized assessment of such awards if the petitioner's damages fall below the $250,000 cap.[291]

Second, claimant characteristics probably cut in favor of health courts. Health courts probably have the edge because a non-trivial proportion of VICP petitioners are young, suffer permanent injuries, and yet have normal (or close-to-normal) life expectancies—a combination which compels special masters to estimate what care will be needed over the course of a long period.[292] In comparison, the health court claimant population is apt to be older and sicker, with shorter life expectancies demanding damage estimation.[293]

Third, health courts would have one ALJ-appointed life-care planner (i.e., an expert who obtains up-to-date information about the victim to project and quantify the victim's future needs) monetize the victim's past and future economic loss.[294] In comparison, in the VICP, it is "common practice" for each party (the petitioner and HHS) to retain its own life-care planner.[295] Then, once the dueling planners' reports are compiled, the

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[291] *Compare supra* note 101 (concerning health courts), *with supra* note 143 (concerning the VICP).

[292] This, however, is changing. With the Program's inclusion of the flu vaccine in 2005, adults have, in recent years, comprised the majority of petitioners seeking VICP compensation. *See* Advisory Comm'n on Childhood Vaccines, Health Res. & Servs. Admin., Transcript of Meeting of Dec. 6, 2012, at 13-14, 26-29, 50-51, 60, *available at* http://www.hrsa.gov/vaccinecompensation/accvtranscript1262012.pdf.

[293] *See infra* notes 300-01 (concerning the poor health of many medical malpractice victims).

[294] *See* Mello et al., *"Health Courts," supra* note 85, at 468.

[295] I.D. v. Sec'y of Health & Human Servs., No. 04-1593V, 2013 WL 2448125, at *2 (Fed. Cl. Apr. 19, 2013).

parties will either compromise their differences, or, in rare instances, they will call upon the special master to evaluate the competing plans and issue a judgment.[296] The effect of this one-planner versus two-planner difference is debatable. Limiting life-care planners eliminates certain conflicts (removing the need for a special master to weigh in, for instance, on a nurse's hourly wage). This could simplify calculations. On the other hand, health courts' one-planner requirement might just alter disputes' timing and character. If only one planner can be selected, that is, gone will be disagreements over the relative merit of dueling plans. But those disagreements could be replaced with new clashes over the planner's selection, the evidence the planner can consult, and the methodology he or she ought to utilize.

Fourth, compared to the VICP, where damages are awarded once and in a lump sum—though often with an annuity—damages in health courts are to be paid periodically and remain open to modification.[297] Again, the effect of this difference is questionable. Permitting award modifications might expedite initial compensation calculations, effectively taking the pressure off getting it right the first time around. On the other hand, the cumulative effect of periodic review might be to complicate compensation determinations—essentially replacing one time-consuming and costly adjudication with several such skirmishes. On this score, it is worth noting that the Vaccine Act initially permitted damage revisions. Prevailing VICP petitioners, Congress initially explained, could seek additional damages if, for example, their medical costs rose or their condition deteriorated, while they had the duty to return to the Program if their costs fell or their condition improved.[298] Congress repealed those provisions in a 1987 amendment, however—prompted, at least in part, by parents' demands for greater certainty and finality.[299]

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296 *See* Toomey v. Sec'y of Health & Human Servs., No. 98-643V, 2007 WL 5173629, at *4 (Fed. Cl. Apr. 2, 2007) (describing the damages procedure); *cf.* Advisory Comm'n on Childhood Vaccines, Dep't of Health & Human Servs., Transcript of the Meeting of Dec. 8, 2011, at 17-18 ("[I]n the last few years . . . there has been a settlement in every single case on the issue of damages." (quoting Mark Rogers, Torts Branch, Civil Div., U.S. Dep't of Justice)).

297 *See* Mello et al., *"Health Courts," supra* note 85, at 465. Alongside the problems discussed above, this approach encourages malingering, sometimes called after-the-event moral hazard.

298 *See* National Childhood Vaccine Injury Act of 1986, Pub. L. No. 99-660, § 311(a), 100 Stat. 3755, 3762; *see also* H.R. REP. NO. 99-908, at 17 (1986) (explaining that "[a] petitioner awarded compensation shall notify the Program of any changes which significantly affect the compensation to be paid" while also advising that "if medical costs rise more quickly than expected or if the petitioner's injury becomes more serious, he or she may ask for increased and more frequent payment").

299 Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4303(d)(2)(A), 101 Stat. 1330-1, 1330-222 (1987). At the time of the 1987 amendment, Representative Henry Waxman (the Vaccine Act's main sponsor) explained: "We cannot expect these people to give up funda-

b. *Six Characteristics of Health Courts that Might Produce a Disadvantage*

Now, while the effect of the deviations above might cut in favor of health courts, there are six ways in which health courts' damage calculations are likely to be more complex and cumbersome than damage calculations within the VICP. First, as noted previously, the Vaccine Act simplifies damages in all death cases (imposing a hard limit of $250,000) and also streamlines the calculation of minors' lost wage. Leading health court plans do not contain these shortcuts.

Second, unlike the VICP, which adjudicates mostly claims of those who were well prior to vaccination, health courts will typically adjudicate claims of those who were sick.[300] Indeed, Paul Weiler's classic New York study reports: "[A] substantial proportion of patients were gravely ill, and many would have died from their underlying illnesses in months, days, perhaps hours, even absent the mishap in treatment." [301] This fact not only creates difficult causation questions (discussed below), it is also apt to raise, within health courts, vexing questions of damage aggravation and apportionment. Specifically, physicians are likely to argue that they are responsible for only the aggravation of the patient's underlying condition (which, itself, will require detailed evidence of the patient's pre-avoidable-injury prognosis). Patients, meanwhile, are likely to counter that, in at least some cases, the aggravation combines with the existing injury to create an indivisible injury for which the physician is wholly responsible. Creating tangled questions of fact and law, these damage aggravation issues are unlikely to be easily resolved.[302]

Third, unlike in the VICP context where there is just one respondent (HHS, represented by staff lawyers within the DOJ), many health court

mental rights if they cannot depend on the compensation payments." *1987 House Hearing*, *supra* note 119, at 11 (statement of Rep. Henry A. Waxman); *see id.* at 61 (statement of Jeffrey H. Schwartz, President, Dissatisfied Parents Together) (advocating lump-sum payments and maintaining that "[f]unding sources have to be reliable and adequate").

300 The CDC cautions against administering childhood vaccines to ill individuals. *See Chart of Contraindications and Precautions to Commonly Used Vaccines*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/vaccines/recs/vac-admin/contraindications-vacc.htm (last visited Apr. 24, 2015), *archived at* http://perma.cc/5VJD-MUHG.

301 WEILER ET AL., *supra* note 59, at 55. Similarly, a 2001 study found that "many deaths reportedly due to medical errors occur at the end of life or in critically ill patients in whom death was the most likely outcome, either during that hospitalization or in the coming months, regardless of the care received." Hayward & Hofer, *supra* note 234, at 418-19.

302 *See, e.g.*, Fosgate v. Corona, 330 A.2d 355, 358 (N.J. 1974) (explaining that the defendant physician typically bears "the burden of segregating recoverable damages from those solely incident to the preexisting disease"); *see also* DAN B. DOBBS, THE LAW OF TORTS § 177, at 433 (2000) (describing the "[e]specially difficult problems of causation [that] arise when the defendant is negligent toward a plaintiff who is already suffering from a disease or disability").

claims will implicate numerous defendants. Relevant here, Neil Vidmar's North Carolina study found that less than one-third of medical malpractice cases were brought against a single healthcare provider; 16% of claims involved five defendants or more.[303] This means that, in health courts (though not in the VICP), the liability of multiple defendants will need to be assessed, with the damages attributable to each quantified and monetized.

Fourth, because health courts evaluate the physician's conduct, they presumably will evaluate the *plaintiff's* conduct—most notably in considering whether the plaintiff reasonably mitigated her damages after sustaining a compensable medical injury.[304] Assuming this mitigation is fair game,[305] health courts will have to assess and quantify which portion of the plaintiff's injury would have been avoided if the plaintiff had utilized reasonable care and then determine how to subtract this from the plaintiff's compensable damages.[306]

Fifth, health courts will likely adjudicate claims involving a physician's failure to obtain informed consent prior to initiating treatment. These informed consent claims raise unique causation pitfalls. To prevail, the plaintiff must first establish "injury causation" (i.e., that the plaintiff would have been spared the particular harm if she had not undergone the challenged procedure). This inquiry requires conjecture about what alternate procedure the doctor may have performed and the foreseeable risks thereof. Then, a plaintiff must also show "decision causation." This requires showing both that the plaintiff, personally, would have withheld consent to the challenged course of treatment if she had been adequately informed, and also that a "prudent person in the patient's position" would

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303 *See* VIDMAR, *supra* note 233, at 33. For more on this study, involving medical malpractice cases filed in North Carolina federal and state courts from 1984–1987 and 1987–1989, see *id*. at 23-24. Likewise, a 2006 study of medical malpractice claims found that "the majority of injuries involved more than one health care provider: 60% involved two or more clinicians, and a quarter involved three or more." Mello & Studdert, *supra* note 163, at 605; *accord* Charles Silver, *Does Civil Justice Cost Too Much?*, 80 TEX. L. REV. 2073, 2102 (2002) (concluding that "increasing the number of defendants causes litigation costs per dollar transferred to rise").

304 *See* DOBBS, *supra* note 302, §§ 203–204, at 510-14 (describing the avoidable consequences doctrine).

305 Of course, health courts could ignore the plaintiff's failure to mitigate her injuries—but to do so would be contrary to health courts' broader aim of reducing the social cost of medical injury.

306 *Cf.* COMM'N ON MED. PROF'L LIAB., AM. BAR ASS'N, DESIGNATED COMPENSABLE EVENT SYSTEM: A FEASIBILITY STUDY 67-68 (1979) (recognizing that, "to invite inquiry on a case by cases basis into the effects of patients' conduct would generate the sorts of delays and transaction costs which the DCE approach [similar to the ACE approach] is designed to eliminate").

have likewise declined treatment.[307] Hypothesizing what *this* patient, and also what any reasonably prudent patient, would do in a given scenario is hardly straightforward—and, in fact, it is an inquiry that juries (comprised, of course, of current and future patients), not official "experts," might be better suited to conduct.

Sixth and finally, health courts, but not the VICP, must presumably wrestle with the "loss of chance" doctrine. Accepted now in over twenty states, this doctrine enables a plaintiff to obtain damages when the physician's medical malpractice reduced the patient's chance of recovery or survival—even if it cannot be said that the medical malpractice more-likely-than-not *caused* the patient's injury or death.[308] Again, lost chance cases raise complications for health courts as, assuming they accept the doctrine, health courts would not only need to pinpoint the "avoidable" misdiagnosis or error in treatment.[309] They would also, necessarily, have to quantify and then monetize the probability of the patient's survival or recovery both before and after the physician's misdiagnosis or mistake.

* * *

The upshot of the foregoing analysis is that, in the VICP context, it was assumed that damages would be relatively easy to quantify. In reality, however, VICP damages calculations are surprisingly difficult. Many take years. Health courts will also need to calculate a victim's future economic loss and, compared to the VICP, will have to do so (1) with arguably fewer statutory shortcuts; (2) often in the course of apportioning damages between various healthcare providers; (3) typically while quantifying the defendant's aggravation of a plaintiff's underlying medical condition; (4) while, at least sometimes, reducing the plaintiff's damages because of the plaintiff's negligent aggravation of her avoidably inflicted injury; (5) while, on some occasions, guessing what a hypothetical patient would have agreed to concerning medical treatment if adequately informed; and (6) in certain

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307 Canterbury v. Spence, 464 F.2d 772, 791 (D.C. Cir. 1972); *see also* DOBBS, *supra* note 302, § 250, at 657 (describing the rule and noting that it "does not reflect the [normal] causation requirement but imposes some additional and most unusual obstacle").

308 For more on this doctrine's application and acceptance, see *Herskovits v. Group Health Coop.*, 664 P.2d 474 (Wash. 1983) (en banc); Kenneth S. Abraham, *Stable Divisions of Authority*, 44 WAKE FOREST L. REV. 963, 975-77 (2009); Steven R. Koch, *Whose Loss Is It Anyway? Effects of the "Lost Chance" Doctrine on Civil Litigation and Medical Malpractice Insurance*, 88 N.C. L. REV. 595, 606 n.56 (2010).

309 If the doctrine is rejected, health courts' adoption would effect a major, though so far unacknowledged, change in substantive law.

cases, calculating compensation for a plaintiff's lost chance at recovery or survival. In light of these obstacles, damage calculations within health courts are almost certain to be more nettlesome than many now anticipate.

V. LARGER LESSONS: WHY DID THE VICP STUMBLE, AND WHAT DOES IT MEAN FOR THE FUTURE OF ALTERNATIVE COMPENSATION MECHANISMS?

Many of the VICP's promises have gone unfulfilled. Despite expectations that the VICP would rationalize entitlement decisions, a lack of predictability continues to bedevil the program. Despite assurances that VICP petitions would be resolved quickly—within 240 days—most cases stretch on for years. And, despite valiant legislative efforts to streamline damages determinations, calculating individualized compensation remains time-consuming and challenging.

Part IV's exploration of the VICP's unfulfilled promises cast a shadow on certain of health courts' proponents' claims. It simultaneously revealed key insights that transcend health courts in their scope and applicability. Generalizable insights include: (1) some inconsistency in decisionmaking is, by all accounts, inevitable, particularly when cases are complex, politically charged, and dependent on findings concerning witness credibility; (2) because specialized tribunals are not diversified, they are susceptible to abrupt swings in the size of their dockets, which (as Richard Posner has theorized, and the VA Agent Orange experience illustrates) can stall or stymie case resolution; and (3) no matter how much policymakers strive to streamline compensation decisions, at least when injuries are serious, the individualized calculation of future economic loss remains difficult.

Now, Part V steps back from particular problems (such as inconsistency, delay, and damage difficulties) to ask two broader questions: Why did the VICP stumble? And: What larger lessons can be drawn from the VICP experience? This broader perspective reveals four additional insights, with implications, not only for health courts, but for our design and deployment of future specialized courts and tort replacement mechanisms in areas far beyond the medical malpractice arena. These include: (1) certain kinds of causation questions are insusceptible to easy resolution; (2) decision aids can be a double-edged sword; (3) boundary claims and segregability issues can pose a substantial burden—and the less self-contained a substantive area is, the more serious those problems will be; and (4) adversarialism is inescapable.

A. *Certain Kinds of Causation Questions Are Insusceptible to Easy Resolution*

It has long been known that, in order for a no-fault system to maintain low transaction costs, the system must be able to resolve causation questions quickly, reliably, and with minimal discovery. Given this, it is perhaps no surprise that workplace and automobile accidents have, so far, been most amenable to a no-fault solution. In both, determining whether an injury "arises out of" employment (in the case of workers' compensation) or the use of a motor vehicle (in the case of automobile no-fault) is generally straightforward, as injuries typically result from visible and undeniable trauma, as machines misfire or cars collide.[310] In contrast, there are other kinds of injuries that are not traumatic, visible, or otherwise uncontested. When confronting this constellation of injury, American no-fault regimes have consistently struggled.

Vaccine injuries fall into this latter, troublesome category. Unlike car wrecks or traditional workplace accidents, vaccine injuries are not traumatic or observable. Then, further confounding the causation inquiry, vaccines do not trigger "signature diseases," meaning that ailments caused by vaccines can also be caused by other mechanisms. And, many vaccines are administered to infants and young children, while neurological disorders often—just coincidentally—show up in the first years of life. This means that many neurological disorders become evident on the heels of a child's vaccination, creating a suspicious, though sometimes merely coincidental, temporal association.[311]

Not surprisingly, the above facts have complicated causation determinations within the VICP. And this complexity has, in turn, been a substantial, though unanticipated, drag on the system, contributing to many of the problems identified above, including the difficult judgment calls special masters must make (which leads to a lack of consistency and predictability) and the long times to decision. Thus, when assessing why the VICP has stumbled, some of the blame ought to be laid here: at the elemental scientific uncertainty at the root of the causal inquiry.

Importantly, too, in confronting—and becoming stymied by—elemental scientific uncertainty, the VICP is not alone. Comparable problems have plagued both state workers' compensation systems when adjudicating occupational disease claims and the neurological birth injury funds in Florida and Virginia. On the former, occupational disease claims compel adjudicators to determine whether this disease was caused by that workplace

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310 A notable exception is workplace occupational disease, discussed below.

311 *See* 1999 GAO REPORT, *supra* note 52, at 4.

contaminant, which is challenging, particularly when the disease is non-signature, latent (i.e., exposure and disease manifestation are separated in time), and can arise synergistically from the interaction of several substances.[312] Predictably, given these factual impediments, occupational disease cases have been insusceptible to easy resolution, generating long delays,[313] inconsistent outcomes,[314] high rates of attorney retention,[315] high levels of formal contestation,[316] and a high degree of undercompensation.[317] The experience of neurological birth injury funds in Florida and Virginia tells a similar story.[318] The crux of the problem there is that many neurological birth injury claims involve cerebral palsy, a general term for a group of permanent, non-progressive movement disorders that cause physical disability. Most cases of cerebral palsy (perhaps as many as 90%) are attributable to genetic or other conditions; relatively few are iatrogenic. But knowing which box to put a particular child's injury into is extraordinarily difficult—leading authors of one recent study to conclude regretfully "as long as determination of causal factors remains part of the compensation criteria, pivotal uncertainties persist."[319]

This yields a pair of crucial insights: (1) If particular conditions are met (namely, injuries are not traumatic, visible, or otherwise obvious), causation questions are unlikely to be easily resolved, and (2) in such cases, adjudications are unlikely to be predictable, simple, or swift. Indeed, many of a no-fault system's supposed benefits appear to dissipate the moment those systems confront causation questions steeped in scientific uncertainty.[320]

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312 *See* PETER S. BARTH WITH H. ALLAN HUNT, WORKERS' COMPENSATION & WORK-RELATED ILLNESSES AND DISEASES 5-10, 62-89 (1980) (cataloging factual challenges).

313 *See id.* at 163, 169.

314 *See id.* at 61-62.

315 *See id.* at 163 tbl.5.17 (reporting that, whereas lawyers are involved in only 14.6% of accident claims, lawyers are involved in 65.5% of claims asserting occupational disease).

316 *See id.* at 163 tbl.5.16 (reporting that, whereas 9.8% of accident claims proceed to a formal hearing, 62.7% of occupational disease claims do).

317 *See* J. Paul Leigh & John A. Robbins, *Occupational Disease and Workers' Compensation: Coverage, Costs, and Consequences*, 82 MILBANK Q. 689, 709 (2004) (estimating that, at most, workers' compensation covers 20% of the costs of occupational disease).

318 A recent review of the Florida and Virginia birth injury programs explains that "no one anticipated the reverberations that the causal complexities at the root of the inquiry would create." Siegal et al., *supra* note 22, at 506.

319 *Id.*

320 *Accord* O'CONNELL, *supra* note 42, at 72 ("[A]ny system of coverage or compensation for injury which moves beyond simple external traumatic impact is destined to encounter prodigious questions of causation.").

Applying those lessons, the ease and confidence with which causation questions can be resolved might inform our selection of accident types amenable to no-fault regimes going forward. Here, for example, it is much easier to assess whether an injury is caused by gun fire, a schoolyard accident, a railroad derailment, or an airline crash, on the one hand, than it is to determine whether an injury is caused by a prescription drug or a cigarette, on the other.[321] The former injuries are visible and traumatic; the latter injuries are not (and most illnesses caused by cigarettes and prescription drugs do not qualify as signature diseases). Thus, we might confidently say that (political barriers aside) a no-fault regime for handguns is far more promising than one for cigarettes.

Further applying the above lessons, those who seek to create a quasi-no-fault regime for medical injury face almost inevitable disappointment, as the causal questions health courts must address will often be suffused with scientific uncertainty. After all, most medical injuries are not traumatic or visible. Most patients seek care because they are sick, and sick people's health often deteriorates further. This means that most injuries stemming from medical malpractice will also, necessarily, have competing causes, wholly apart from a physician's error.[322] Like occupational disease claims, some medical injuries have long time lags between the physician's mistake (e.g., the missed or delayed diagnosis) and its effect (e.g., the cancer metastasized).[323] These delays create complications.[324] Then finally, the health court *project* adds an additional wrinkle: As noted above, the inquiry in a health court case will not be merely whether medical care caused the patient's injury. It will, instead, be whether "avoidable" or suboptimal medical care caused the patient's injury—a much harder determination.

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321 *See supra* notes, 40, 44, 49, and 50 (advocating no-fault regimes for railway accidents, prescription drugs, cigarettes, and firearm injuries, respectively).

322 *See* JEFFREY O'CONNELL & CHRISTOPHER J. ROBINETTE, A RECIPE FOR *BALANCED* TORT REFORM: EARLY OFFERS WITH SWIFT SETTLEMENTS 108 (2008) ("Under a medical no-fault scheme it would be therefore necessary to distinguish between the injuries caused by medical treatment, and those caused by, say, the 'presenting complaint.' Unfortunately, it is often impossible to determine whether a patient was injured by the treatment rendered or just by a normal extension of the condition that prompted treatment in the first place.").

323 Misdiagnoses account for a large proportion of medical malpractice lawsuits. *See* Tejal K. Gandhi et al., *Missed and Delayed Diagnoses in the Ambulatory Setting: A Study of Closed Malpractice Claims*, 145 ANNALS INTERNAL MED. 488, 488 (2006) ("Over the past decade, lawsuits alleging negligent misdiagnoses have become the most prevalent type of claim in the United States.").

324 *See* DANZON, *supra* note 59, at 175 (observing that "delay creates technological uncertainty in establishing the connection between the triggering event and the injury").

B. *Decision Aids Are a Double-Edged Sword*

When analyzing why the VICP has stumbled, the next culprit is surely the Vaccine Injury Table. The Table has not streamlined causation questions as substantially as many expected. It has, itself, become the subject of bitter controversy. And Table amendments have tarnished public perceptions of the Program. Again, this experience contains a sobering lesson for health courts, as well as other future specialized courts and replacement regimes that would rely on decision aids to streamline causation or compensation questions.

Recall that Congress created the Vaccine Injury Table to simplify and rationalize causation questions—essentially, to sidestep many of the issues above. Note, too, that at the time of the VICP's enactment, it was assumed that most petitioners would assert on-Table injuries—and, for a time, the assumption held. Early in the Program's lifecycle (prior to 1995), roughly 75% of petitioners proceeded down the on-Table track,[325] and, consistent with expectations, these petitioners' claims were, for the most part, easily and expeditiously resolved. In the words of the VICP's chief special master: "[L]itigating Table cases . . . met Congress's programmatic desire; that is, the special masters handle[d] the cases relatively quickly and render[ed] decisions with certainty."[326]

In the mid-1990s, however, there was a momentous shift. Exercising her statutory Table-modification authority—and relying, in large part, on findings of the IOM (the health arm of the National Academy of Sciences)—on March 10, 1995 and again on March 24, 1997, the Secretary of HHS amended the Table to add to and strike from the Table certain associated injuries.[327] At first glance, the amendments were a wash. In fact, more injuries were added than were subtracted. However, because HHS removed the injuries that had been the most frequently utilized by petitioners, the practical effect of these additions and subtractions was to shrink the Table's scope, and importance, dramatically. While 74% of

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325 *See* 1999 GAO REPORT, *supra* note 52, at 14.

326 Stevens v. Sec'y of Dep't of Health & Human Servs., No. 99-594V, 2001 WL 387418, at *7 (Fed. Cl. Mar. 30, 2001); *see also* OFFICE OF SPECIAL MASTERS, *supra* note 150, at 42 ("When the Vaccine Program was created, the expectation was that most cases would involve Table injuries, and in the early days of the Program, that expectation was borne out. Most Table cases are quickly resolved, in keeping with the Congressional intent that vaccine injured persons be compensated quickly, easily, and with generosity."); Telephone Interview with Gary J. Golkiewicz, VICP Chief Special Master from 1988–2010 (Sept. 23, 2014) ("Under the Table, the system worked as closely to what Congress intended as you are going to get.").

327 *See* 1999 GAO REPORT, *supra* note 52, at 13-14. For more on the sources HHS consulted while amending the Table, see *id.* at 22.

petitions sought compensation for on-Table injuries prior to 1995, only 55% did by 1999, and now, only about 2% of VICP petitions proceed down the on-Table path.[328] Thus, the Table, which at enactment was viewed as the VICP's "most important feature,"[329] has, in the words of one lawyer for petitioners, morphed into "a meaningless thing."[330]

This migration away from the Table has had ripple effects, touching every corner of VICP administration. Compared to on-Table petitions, off-Table petitions (where causation is determined by reference to traditional tort principles) are more likely to be contested, rather than conceded, and once contested, "take longer to prepare, longer to present, and longer to decide."[331] Off-Table petitions are also, quite importantly, far less likely to result in compensation for the petitioner.[332] This means that much of the trouble identified above can be traced, directly, to the Table amendments.

What lessons can we draw from this experience? The most obvious takeaway is that decision aids' malleability is a double-edged sword. On the one hand, decision aids that attempt to crystallize scientific understanding *must* be susceptible to amendment, as scientific understanding evolves over time. If decision aids can't be updated, they will become antiquated and inaccurate. On the other hand, though, the need to amend a decision aid comes with the power to amend a decision aid. If a decision aid is *malleable*, in other words, it is also, by definition, *manipulable*. This means, by expanding or shrinking a decision aid, the modifying body has the power to dramatically alter a program's size, scope, and character.

Further, because these modifications will be so consequential, and because, too, the science supporting or refuting a modification is rarely clear-cut,[333] decision aid modification is apt to generate controversy. The

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328 *Compare id.* at 14 (offering the 74% and 55% figures), *with* 2014 GAO REPORT, *supra* note 52, at 20 (reporting that, since 2009, over 98% of petitions allege off-Table injuries). Further accelerating the shift toward off-Table adjudications, in recent years, six vaccines have been added to the Table without the addition of any associated injuries. *See id.* at 17-20.

329 1999 GAO REPORT, *supra* note 52, at 5.

330 Advisory Comm'n on Childhood Vaccines, Dep't of Health & Human Servs., Transcript of Meeting of Sept. 17, 2009, at 56 (statement of Clifford Shoemaker, Attorney); *see also* Telephone Interview with Gary J. Golkiewicz, *supra* note 326 ("The Table was the centerpiece of the Program, and now it's virtually irrelevant.").

331 *Stevens*, 2001 WL 387418, at *7.

332 *See* 1999 GAO REPORT, *supra* note 52, at 12 (reporting, as of 1999, that on-Table claims were nearly three times more likely to be compensated, as compared to their off-Table counterparts).

333 For example, in 1994, the IOM conducted a review of the relationship between vaccines and medical conditions. IOM's review found that there was insufficient evidence to prove or disprove a relationship between vaccines and *two-thirds* of the seventy-five medical conditions studied. *See id.* at 13 n.13.

VICP illustrates this point, as HHS's mid-1990s amendments ignited a firestorm of criticism. Parents and a parents' advocacy group challenged the amendments in court, contending that the Secretary of HHS had exceeded her statutory authority.[334] The GAO scolded HHS for "bas[ing] its decisions to add or remove table injuries on various factors" without "a clear and transparent methodology to demonstrate that these factors were consistently applied."[335] The VICP's chief special master chastised the government for "alter[ing] the game so that it's clearly in their favor."[336] The then-Chair of the Advisory Commission on Childhood Vaccines (a group created by Congress to oversee the VICP) called the amendments "a repudiation of the principles on which the compensation program" was enacted.[337] And Congress also expressed stern disapproval.[338] HHS, for its part, offered a somewhat tepid defense—highlighting that the amendments were necessary to ensure that the Table "conform[ed] with the scientific evidence"[339] and emphasizing how "difficult" and "not practical" it is "to try and fit causation science into very narrow boxes."[340]

This discussion of the Table's controversial status reveals a pair of additional insights. The first is that decision aids are easily politicized and, in fact, the more a decision aid helps to resolve close cases (and, thus, the more value it has from a procedural perspective), *the more controversial it will become*. Here's an illustration from the health court context: Today, it turns out, patients can catch and identify some errors, such as wrong-site surgeries, extreme drug overdoses, transfusions with mismatched blood, and complications caused by forgotten surgical instruments.[341] These cases are

334 *See* Terran v. Sec'y of Health & Human Servs., 195 F.3d 1302 (Fed. Cir. 1999); O'Connell v. Shalala, 79 F.3d 170 (1st Cir. 1996); *see also* ALLEN, *supra* note 113, at 293 (discussing the pervasive "bitterness" parents felt following these amendments); Advisory Comm'n on Childhood Vaccines, Transcript of Meeting of March 1, 1995, at 113 [hereinafter March 1, 1995 ACCV Transcript] (on file with author) ("We feel like we have been betrayed." (quoting Barbara Loe Fisher, Parents' Activist)).

335 1999 GAO REPORT, *supra* note 52, at 3; *see also id*. at 15 (observing that HHS's actions "do not always convey a sense of consistency").

336 ALLEN, *supra* note 113, at 293 (quoting Gary Golkiewicz, Chief Special Master, VICP).

337 March 1, 1995 ACCV Transcript, *supra* note 334, at 2 (statement of Curtis R. Webb, Chair, ACCV) (on file with author). For more on the ACCV, see *supra* note 53; *see also* Telephone Interview with Curtis Webb, *supra* note 253 ("The petitioner community understood that the Table modifications were a betrayal, a complete abrogation of the principles that underlie the Program. It was an attempt to neuter the Program.").

338 H.R. REP. NO. 106-977, at 2 (2000) (finding that HHS's actions had "undermin[ed] the remedial nature of the program as intended by the Congress").

339 Levin, *supra* note 287 (quoting Joyce G. Somsak, Acting Director, VICP).

340 1999 GAO REPORT, *supra* note 52, at 41.

341 *See* David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1113 (2006) (offering these, and other, examples).

easy. They are apt to result in payment, and they are unlikely to trigger prolonged contestation. Indeed, susceptible to resolution via the common knowledge exception or the ancient tort doctrine res ipsa loquitur, many of these cases do not even require the retention of costly medical experts.[342] As such, if all ACEs do is capture these unequivocal cases, their practical effect will be marginal. They will be picking only low-hanging fruit, simplifying only those cases that are already straightforward. On the other hand, if ACEs *do* take sides on contested questions—offering guidance at the frontier of medical injury where, for example, the standard of care is evolving or treatment guidelines are in flux—they will be truly helpful, streamlining litigation that would otherwise be hard-fought and spirited.[343] But the creation and subsequent amendment of the ACE list will spark significant criticism.[344]

The second insight that flows from the Table's controversial amendment is related, and concerns health courts'—and other specialized tribunals'—perceived legitimacy. It has long been said that in order to be effective, tribunals have to be perceived as legitimate. And in order to be perceived as legitimate, tribunals must be perceived as being fair.[345] If the public, or if litigants, lack confidence in a tribunal's fairness, that lack of confidence diminishes the public's faith in government, makes unfavorable decisions harder to accept, and potentially jeopardizes compliance with tribunal decisions.[346] Meanwhile, a drawback long identified with specialized courts is that, when it comes to being viewed as fair, these tribunals start at a deficit; they tend to lack generalist courts' widespread public acceptance and are "peculiarly susceptible to being thought partisan."[347] The broader lesson,

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342 *See* DANZON, *supra* note 59, at 38-39, 217 (noting that empirical examination tends to support "the conventional wisdom that cases involving obvious error tend to be settled out of court, with relatively low litigation costs").

343 *Cf.* Randall R. Bovbjerg et al., *Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System*, 265 J. AM. MED. ASS'N 2836, 2841-42 (1991) (concluding that ACEs can be used to resolve cases that would otherwise generate controversy).

344 *See* Clark C. Havighurst, *"Medical Adversity Insurance"—Has Its Time Come?*, 1975 DUKE L.J. 1233, 1270 (offering a similar analysis).

345 *See* Stempel, *supra* note 33, at 107 (stating that "tribunals must be perceived as fair in order to adjudicate effectively").

346 *Accord* Bruff, *supra* note 218, at 331 ("Part of a court's success in obtaining compliance with its mandates flows from the respect others have for it.").

347 Currie & Goodman, *supra* note 33, at 72; *see also* Stempel, *supra* note 33, at 89 (suggesting that a drawback of specialized courts is that they "lack the widespread public acceptance and perception of fairness that traditionally surround generalist courts"). Health courts' perceived legitimacy might be particularly fragile because the plaintiffs' bar is already opposed to these tribunals, partly owing to a suspicion that they would be "anti-patient" in orientation. *See supra* notes 23-27 (providing examples of arguments opposing health courts).

then, is the following: If specialized courts or no-fault compensation schemes rely heavily on decision aids, and if those decision aids must be initially created and then periodically amended, the decision aids' creation and amendment will be politically charged.[348] When it comes time first to create and then subsequently to update the decision aid, there will be winners and losers. And, among the losers, the public perception of fairness, already somewhat fragile in specialized courts, risks being tarnished, perhaps substantially.[349]

C. *Boundary Claims Impose a Substantial Burden*

A third broad lesson that flows from the VICP experience is the burden of boundary definition. Theorists have long identified "boundary problems" as a potential drawback to specialized courts' and replacement regimes' creation.[350] What theorists mean is that the creation of specialized schemes requires policymakers to draw lines to distinguish the cases that fall within the scheme from those that do not. Then, once lines are drawn, they must be policed, as litigants, with different incentives, will seek to push lines in different directions, either to make an end-run around the specialized tribunal and into the traditional court system, or vice versa.[351]

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348 These lessons also apply—and arguably, *especially* apply—to the noneconomic damage schedule that health court proponents plan to devise, as health court architects will need to decide how to classify injuries by severity, the dollar value to assign to each injury classification, how to adjust awards for inflation, and whether (or to what extent) ALJs can depart from the heartland in compelling circumstances. Moreover, health court proponents anticipate periodically amending this schedule based on "social judgments" concerning what is or is not appropriate injury compensation. Mello et al., *"Health Courts," supra* note 85, at 470. If Table revisions based on the IOM's findings created a "firestorm" in the VICP context, it is hard to comprehend the conflagration that would attend damage revisions based on amorphous "social judgments." *Cf.* Peters, *supra* note 13, at 269 (calling these damage revisions a "genuinely frightening idea").

349 *Accord* Telephone Interview with Jeffrey H. Schwartz, *supra* note 199 ("The action of the Secretary of Health in changing the Table without good science to back up that decision was simply the final straw."); Telephone Interview with Curtis Webb, *supra* note 253 ("[C]ertainly for people whose children suffered neurological injury shortly after vaccination, the Table changes badly damaged perceptions. The Program lost a great deal of legitimacy.").

350 *See, e.g.*, Oldfather, *supra* note 33, at 863 (noting that "boundary problems" can give rise to "administrative difficulties").

351 *See* Nora Freeman Engstrom, *Exit, Adversarialism, and the Stubborn Persistence of Tort*, 6 J. TORT L. 75, 75-80 (2015) (identifying the recurring problem of "exit" and explaining how exit, if left unchecked, can erode many of specialization's ostensible advantages); *see also* Peter H. Schuck, *Tort Reform, Kiwi-Style*, 27 YALE L. & POL'Y REV. 187, 198 (2008) ("So long as any categorical boundaries between no-fault and tort exist . . . claimants and their lawyers will always face strong incentives to prosecute claims in whatever remains of the tort system . . . .").

1. Traditional Boundary Claims

These boundary problems have been a significant and well-documented drag on workers' compensation—as, when the employer is not at fault, workers strive to fall within the system, and when the employers' misfeasance is obvious, workers are just as eager to hatch their escape.[352] Boundary problems have also dogged the Florida neurological birth injury program described above as, again, those with strong negligence claims have exited the program, seemingly at will.[353] Boundary problems have plagued automobile no-fault regimes, contributing to the high cost of no-fault automobile insurance and, ultimately, legislators' repeal of the legislation in several states.[354] And boundary problems (though of an unusual and unexpected character) have also bedeviled the VICP.[355]

Autism litigation offers a case in point. As noted, autism petitions—typically alleging that Thimerosal (a mercury-containing vaccine preservative) cause the affliction—have recently flooded the Program.[356] Complicating these cases is the jurisdictional question of whether Thimerosal claims have to be filed—or even *can* be filed—in the VICP since Thimerosal is not obviously a "vaccine" within the Vaccine Act's statutory definition.[357] That question, in turn, raises a tricky question of statutory interpretation: Is Thimerosal an "adulterant or contaminant," as petitioners claim, which would exclude these cases from the Vaccine Act's purview? Or is Thimerosal a "constituent material" of vaccines, as vaccine manufacturers and HHS insist, which would mean that the Vaccine Act preempts Thimerosal-related litigation? The question has generated a boatload of

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352 *See* Engstrom, *Exit, Adversarialism, and the Stubborn Persistence of Tort*, *supra* note 351, at 83-85 (cataloging ways in which workers bypass workers' compensation, in favor of recovery within the traditional tort system).

353 *See generally* Studdert et al., *The Jury Is Still In*, *supra* note 22 (describing claimants' successful "end run" around the Florida birth injury fund).

354 *See* Engstrom, *An Alternative Explanation*, *supra* note 21, at 344-47.

355 I say "unusual and unexpected" because, when the VICP was enacted, many fretted that vaccine-injured claimants would enter the tort system using the tort opt-out provision, described above in Section II.B. As noted, those worries were misplaced; few petitioners who receive an award within the VICP reject their award and proceed to file a civil action, and even petitioners whose claims are denied tend to acquiesce to the denial. However, vaccine-injured litigants have nonetheless entered the tort system via other unanticipated avenues.

356 *See supra* note 270 and accompanying text.

357 The provision defines the term "vaccine-related injury or death" to mean "an illness, injury, condition, or death associated with one or more of the vaccines set forth in the Vaccine Injury Table, except that the term does not include an illness, injury, condition, or death associated with an adulterant or contaminant intentionally added to such a vaccine." 42 U.S.C. § 300aa-33(5) (2012).

litigation, in both the VICP and beyond.[358] Further complicating matters, in 2002, Congress passed a statute to clarify that the Vaccine Act's "Definition of Vaccine" "includes all components and ingredients listed in the vaccine's product license application and product label."[359] This measure seemingly settled the controversy. But then, the following year, Congress repealed the amendment,[360] while noting that its action should not be interpreted to mean that *Leroy v. Secretary of Health and Human Services* (a case that held that the Vaccine Act encompassed Thimerosal claims) was incorrectly decided.[361] Then, in 2006, the Fifth Circuit held that, though Thimerosal is a vaccine, Thimerosal *manufacturers* are not vaccine "manufacturers" under the Act—and, thus, suits specifically targeting these defendants can proceed unencumbered.[362]

Thimerosal's murky status has thus been a substantial, but unexpected, site of controversy. It has not been the only one. In recent years, some autism plaintiffs have snuck out of the VICP and into court by seeking de minimis damages below the Vaccine Act's jurisdictional injury-severity threshold.[363] Recognizing that the Vaccine Act does not preempt claims for injunctive relief, other plaintiffs have sought court-ordered medical monitoring of all Thimerosal-exposed, but currently healthy, individuals.[364] Finally, seizing on the fact that the Vaccine Act applies only to those who have "*received a vaccine* set forth in the Vaccine Injury Table,"[365] still other

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358 *See, e.g.*, Laughter v. Aventis Pasteur, Inc., 291 F. Supp. 2d 406 (M.D.N.C. 2003); Benasco v. Am. Home Prods., No. 02-3577, 2003 WL 22174270 (E.D. La. Sept. 10, 2003); Wax v. Aventis Pasteur, Inc., 240 F. Supp. 2d 191 (E.D.N.Y. 2002); Bertrand v. Aventis Pasteur Labs., Inc., 226 F. Supp. 2d 1206 (D. Ariz. 2002); Liu v. Aventis Pasteur, Inc., 219 F. Supp. 2d 762 (W.D. Tex. 2002); Owens v. Am. Home Prods., 203 F. Supp. 2d 748 (S.D. Tex. 2002); Garcia v. Aventis Pasteur Inc., No. 02-0168, 2002 U.S. Dist. LEXIS 15122 (W.D. Wash. Apr. 22, 2002); Leroy v. Sec'y of Dep't of Health & Human Servs., No. 02-392V, 2002 WL 31730680 (Fed. Cl. Oct. 11, 2002).

359 Homeland Security Act of 2002, Pub. L. No. 107-296, § 1716, 116 Stat. 2135, 2321.

360 *See* Consolidated Appropriations Resolution, 2003, Pub. L. No. 108-7, div. L, § 102(a), 117 Stat. 11, 528.

361 *See id.* § 102(c), 117 Stat. at 528 (citing *Leroy*, 2002 WL 31730680). Congress's retraction was apparently precipitated by an outcry from parents' groups. *See* Beverly Jones Sill, Comment, Toussaint v. Merck & Co.*: Opening the Door to Thimerosal Vaccine Litigation in Civil Court?*, 21 GA. ST. U. L. REV. 773, 785 (2005).

362 *See* Holder v. Abbot Labs., Inc., 444 F.3d 383, 389 (5th Cir. 2006); *see also* Reilly *ex rel.* Reilly v. Wyeth, 876 N.E.2d 740, 751 (Ill. App. Ct. 2007).

363 *See* Advisory Comm'n on Childhood Vaccines, Div. of Vaccine Injury Comp., Transcript of Meeting of Mar. 16, 2004, at 79-80 (statement of Randy Moss, Partner, Wilmer, Cutler & Pickering) (on file with author).

364 *See id.*

365 42 U.S.C. § 300aa-11(c)(1)(a) (2012) (emphasis added).

plaintiffs have filed derivative suits, seeking damages for parents' loss of consortium when an autism-afflicted child fell ill.[366]

All told, the lesson from the autism saga, which involved over 5500 VICP petitions, at least 350 lawsuits, eleven putative class actions (including one brought on behalf of 175 million Americans), all three branches of government, years of litigation, and tens of millions of dollars in legal fees, is that, even when boundaries are carefully demarcated, gray areas persist. It is, of course, difficult to identify the fault lines in health courts' current jurisdictional definition. (Perhaps plaintiffs will take a page from VICP petitioners and enter the tort system seeking medical monitoring or by raising loss of consortium claims for a family member's impairment. Perhaps they will seize on health courts' carve-out for intentional torts and mixed coverage/treatment claims against managed health care organizations.[367] Perhaps they will invent entirely new arguments.) But the VICP experience, especially when considered alongside the experiences of workers' compensation regimes, neurological birth injury funds, and auto no-fault statutes, underscores that if the stakes are high, gaps will be found—and, when gaps *are* found, end-runs around the no-fault scheme can erode its administrative advantages.

2. Segregability

A closely related issue is what Professor Rochelle Cooper Dreyfuss calls "segregability," by which she means the extent to which claims in specialized courts are self-contained or instead spill over into courts of general jurisdiction. All things equal, the more self-contained an area of law is, the better suited it is to specialized treatment; the more "integrated" an area of law is, the less suited it is to such specialized treatment.[368] And of course, when considering whether to deploy a specialized court or no-fault regime, a policymaker ought to weigh the substantive area's factual and legal entanglements.

This insight is ominous for health courts because some medical malpractice claims *are not* self-contained.[369] Some such claims, for example,

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366 *See, e.g.*, Moss v. Merck & Co., 381 F.3d 501, 504-06 (5th Cir. 2004); Schafer v. Am. Cyanamid Co., 20 F.3d 1, 3 (1st Cir. 1994).

367 *See* Mello et al., *"Health Courts," supra* note 85, at 461 (explaining that such claims would remain under the jurisdiction of general tort law).

368 *See* Dreyfuss, *supra* note 33, at 409-12; *see also* Bruff, *supra* note 218, at 339 (suggesting that, when constructing specialized courts, policymakers should select areas that do not contain "integrated subject matter").

369 Problems identified herein would be exacerbated if health courts are initially rolled out in small pilot projects where "[p]atients would join the system through their choice of provider."

arise out of another tortious injury: A plaintiff might be tortiously injured in a car wreck and then negligently treated once in the hospital. It is black-letter law in most states that the at-fault motorist bears some liability for the actions of the errant physician; the two actions in this example are, thus, "integrated."[370] Meanwhile, some medical malpractice claims arise alongside product liability claims. So, for example, plaintiffs alleging pharmaceutical injury frequently sue both the drug manufacturer and the clinician who prescribed or administered the dangerous drug.[371] Again, the liability of the two actors is logically connected, and the current system sensibly adjudicates both at once. So, too, some medical malpractice claims give rise to civil rights actions, such as under 42 U.S.C. § 1983, the Federal Rehabilitation Act, or the Americans with Disabilities Act (ADA).[372] Here, a secondary defendant is not involved; however, the claim's resolution still requires consideration of decidedly non-medical matters.

It remains to be seen how these "integrated" claims would be adjudicated within a health court system, as there are four obvious adjudicatory possibilities, but each has serious drawbacks. The first option would be to give plaintiffs with integrated claims the freedom to select their tribunal. Yet arming plaintiffs with this freedom would, in some cases, run up against certain defendants' right of removal[373] and, even when it is

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Mello et al., "*Health Courts*," *supra* note 85, at 461; *see also id*. (advocating these roll-outs). It is not *at all* clear where a patient who sustains a single tortiously inflicted, indivisible injury at the hands of doctor *x* (enrolled in a health court) and doctor *y* (not enrolled in a health court) would be able to initiate a claim for compensation.

370 *See* V. Woerner, Annotation, *Civil Liability of One Causing Personal Injury for Consequences of Negligence, Mistake, or Lack of Skill of Physician or Surgeon*, 100 A.L.R.2d 808 § 2 (1965) ("[M]ost of the courts which have considered the question have taken the view that the original tortfeasor is liable for the consequences of negligence, mistake, or lack of skill on the part of the physician or surgeon who treats the original injury.").

371 The landmark *Wyeth v. Levine*, 555 U.S. 555 (2009), is just such a case, as Diana Levine initially sued Wyeth and the clinician (and the clinician's employer) who improperly administered the Phenergan at issue.

372 *See, e.g.*, Howe v. Hull, 873 F. Supp. 72, 74 (N.D. Ohio 1994) (evaluating a claim that the HIV-positive patient's treatment violated, inter alia, the ADA and the Federal Rehabilitation Act); Morgan v. City of New York, 32 A.D.3d 912, 914 (N.Y. App. Div. 2006) (considering whether the plaintiff's allegedly unlawful detention at a New York mental health facility constituted medical malpractice and violated the Fourth Amendment, 42 U.S.C. § 1983, and 42 U.S.C. § 1981); *see also* William Landess, *Medical Malpractice—New Malpractice Twist: Civil Rights Claims*, OUTPATIENT SURGERY (Aug. 2012), http://www.outpatientsurgery.net/issues/2012/08/medical-malpractice-new-malpractice-twist-civil-rights-claims, *archived at* http://perma.cc/4ZWZ-Z9GC (noting that "we're now seeing more and more patients claim civil rights violations that essentially allege malpractice").

373 As it is, 28 U.S.C. § 1441(a) gives defendants a right of removal, stating:

> Except as otherwise expressly provided by Act of Congress, any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may

possible, would promote forum shopping, perhaps to the point of tempting plaintiffs to tack on frivolous claims (against non-physician secondary defendants, for example) since the inclusion of such claims would trigger the forum selection choice.[374] Second, policymakers might return integrated medical malpractice claims to the traditional judicial system en masse. That, however, would erode many of the physician-side benefits that health courts seek to confer, while (still) encouraging frivolous claiming. Third, policymakers might divert integrated claims to health courts en masse. But this seems wholly infeasible. This action would again (in some instances) raise federal jurisdictional problems, and it also would task ALJs with deciding matters totally outside their sphere of expertise (car wreck and product liability cases, for example). A final—and apparently the favored—option is to conduct two separate adjudications.[375] However, those separate, often overlapping, adjudications would impose a heavy administrative burden on litigants (eroding efficiencies health courts might otherwise confer), tax public resources (forced to fund parallel adjudications), and create a risk of inconsistent judgments. Moreover, when physician and non-physician defendants are both involved, policymakers would still need to resolve the vexing question of how to allocate damages among defendants inside and outside the traditional tort system. Or, if there is no damage allocation, that would effect a significant, and potentially ill-considered, alteration of substantive law.

D. *Adversarialism Is Inescapable*

The final broad insight is that adversarialism is inescapable. Both the VICP and health courts aim to quell the adversarialism of dispute resolution.[376] But, when assessing why the VICP has struggled, it seems obvious that one final reason is that adversarialism has crept back in. Adversarialism's persistence within the VICP, once again, has implications,

> be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending.

28 U.S.C. § 1441(a) (2012).

374 *See* Bruff, *supra* note 218, at 339 (discussing the forum shopping risk).

375 *Cf.* Mello et al., *"Health Courts," supra* note 85, at 461 (stating that "medical product liability claims . . . would remain under the jurisdiction of the tort system").

376 *See* 42 U.S.C. § 300aa-12(d)(2)(A) (2012) (charging VICP special masters with crafting rules to "provide for a less-adversarial, expeditious, and informal proceeding for the resolution of [VICP] petitions"); Mello et al., *Policy Experimentation*, *supra* note 16, at 103 tbl.6 (predicting that health courts are "less likely to provoke defensiveness and adversarialism among physicians" and identifying a "[l]ess adversarial process" as one of eight benefits health courts would confer on claimants).

not only for health courts, but for our creation and consideration of other no-fault mechanisms.

By statute, Congress directs special masters "to provide for a less-adversarial, expeditious, and informal proceeding."[377] Yet as early as 1989, Congress expressed regret that, despite this statutory directive, "all participants ha[d], to some degree, maintained their traditional adversarial litigation postures," and Congress implored VICP participants to "re-dedicat[e]" themselves "to the creation of an expeditious, less adversarial, and fair system."[378] Notwithstanding Congress's urging, however, many report that, over the years, the system's adversarial nature has endured—and even grown more pronounced. When the Federal Judicial Center conducted a survey of VICP special masters in the mid-1990s, the special masters' chief complaint was that the DOJ lawyers were "behaving like . . . adversar[ies]" and "over-litigating" various claims.[379] Congressional leaders, who have held numerous hearings to examine the VICP's operation, have concluded that the Program engenders "avoidable, protracted and adversarial litigation."[380] A medical expert, who has long participated in the Program, has observed: "What should be a quiet, civil, deliberative discussion of facts and medicine too frequently degenerates into a contentious, vituperative, decibel-escalating exchange."[381] Most academics concur. For example, Professor Peter Meyers, who has written extensively about the Program and directs George Washington University Law School's Vaccine Injury Clinic concluded in 2011 that the VICP "is no longer the quick, informal, and less adversarial program that Congress intended it to be."[382]

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377 42 U.S.C. § 300aa-12(d)(2)(A).

378 H.R. REP. NO. 101-247, at 512 (1989).

379 JOHNSON ET AL., *supra* note 138, at 44.

380 H.R. REP. NO. 106-977, at 2 (2000); *see id.* at 13 (describing "questionable practices" by DOJ lawyers).

381 *Compensating Vaccine Injuries: Are Reforms Needed?: Hearing Before the Subcomm. on Criminal Justice, Drug Policy, & Human Res. of the H. Comm. on Gov't Reform*, 106th Cong. 63 (1999) [hereinafter *1999 House Hearing*] (statement of Dr. Arnold Gale, Medical Expert, Stanford Univ.); *see also id.* at 63 ("Ad hominem attacks on physicians by all attorneys are common.").

382 Peter H. Meyers, *Fixing the Flaws in the Federal Vaccine Injury Compensation Program*, 63 ADMIN. L. REV. 785, 851 (2011); *see also* BURKE, *supra* note 36, at 161 (noting that, "over time the amount of lawyering and adversarialism in the [VICP] has grown," as "medical experts and HHS officials regularly square off against parents, their lawyers, and opposing medical researchers"); Boxler, *supra* note 191, at 2 (observing that the VICP is "mimicking the adversarial nature of traditional tort litigation"); Elizabeth C. Scott, Comment, *The National Childhood Vaccine Injury Act Turns Fifteen*, 56 FOOD & DRUG L.J. 351, 362 (2001) ("While causation, timing problems, and the cost burden of the system all make recovery more difficult for petitioners . . . , the adversarial nature of the system is perhaps the most difficult hurdle for the inured plaintiffs."). Even health court proponents concede that the VICP "has become quite adversarial." Paul J. Barringer et al.,

Further, though it is hard to know whether this is the cause or the consequence, the VICP has also exhibited an unexpectedly heavy reliance on lawyers.[383] Early on, some apparently anticipated that VICP procedures would be straightforward enough to render counsel superfluous. Representative Patsy Mink explained in a 1999 hearing, "when we established this program, we envisioned a system in which citizens would be able to file claims without assistance from attorneys."[384] Contrary to those expectations, however, over time, it has become clear that claimants need counsel—and typically specialized counsel—to successfully navigate the Program.[385]

Surprisingly, the adjudication of VICP petitions has been marred by combativeness, even though three of the Program's structural features should logically deter this behavior: (1) The ostensibly culpable party (the maker of the errant vaccine or at-fault physician) is shielded from liability and is not a party to VICP proceedings; (2) petitioners' counsel is paid win or lose; and (3) the Fund now touts a bulging surplus (some $3.5 billion), which suggests that a few extra payments (or the provision of $40 sneakers) should not arouse particular controversy. (Indeed, the surplus is so large

Administrative Compensation of Medical Injuries: A Hardy Perennial Blooms Again, 33 J. HEALTH POL. POL'Y & L. 725, 737 (2008).

383 Addressing this chicken-and-egg question, some would suggest that the introduction of lawyers precipitated the Program's adversarial nature. *See* Walters v. Nat'l Ass'n of Radiation Survivors, 473 U.S. 305, 324-26 (1985) (observing that "[t]he regular introduction of lawyers" into proceedings is unlikely to contribute to the proceedings' informality or expedience); Robert A. Kagan, *Do Lawyers Cause Adversarial Legalism? A Preliminary Inquiry*, 19 LAW & SOC. INQUIRY 1, 2, 6-7 (1994) (contending that the legal profession "promot[es] and perpetuat[es] adversarial legal contestation").

384 *1999 House Hearing*, *supra* note 381, at 13 (statement of Rep. Patsy T. Mink); *see also* Telephone Interview with Gary J. Golkiewicz, *supra* note 326 (noting that, when the Program was created, "it was expected that pro se's could handle their cases"); Advisory Comm'n on Childhood Vaccines, Div. of Vaccine Injury Comp., Transcript of Meeting of Dec. 5, 2001, at 43-44 (statement of Timothy Westmoreland, H. Comm. on Gov't Reform) (on file with author) (suggesting that, at the time of enactment, congressional leaders anticipated that at least on-Table claimants would be able to navigate the Program without attorney assistance). *But cf.* MARINER, *supra* note 250, at 43 (observing that the Act "contemplates" that petitioners will be represented by counsel).

385 In 1992, HHS's Inspector General reported that 20% of all claimants who had filed petitions as of August 1991 proceeded without the assistance of counsel. But the same report found that "all of [pro se petitioners'] cases have been dismissed for lack of evidence." OFFICE OF INSPECTOR GEN., *supra* note 149, at 16 & app. B; *accord* Telephone Interview with Gary J. Golkiewicz, *supra* note 326 (noting that, these days, some cases require technical briefing and generate legal fees on the claimants' side of $700,000 to $800,000, calculated on an hourly basis).

that if payments continue at the current clip, the Program could last another quarter century with no new revenue.[386])

Nor can the VICP experience be written off as idiosyncratic, as in facing unexpectedly high levels of attorney involvement and a rising tide of adversarialism, the VICP is not alone.[387] Studies of workers' compensation systems reveal a similar story—especially in (seemingly analogous) cases of occupational disease.[388] Studies of Florida's and Virginia's neurological birth injury programs surfaced near-identical complaints.[389] And a review of auto no-fault systems reveals a similar rising lawyer-retention tide.[390]

This discussion reveals two final insights. The first and more concrete observation is this: Notwithstanding health court proponents' confident

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386 *See* Jeryl Bier, *House to Consider Tax on New Flu Vaccines*, WKLY. STANDARD (June 18, 2013, 10:52 AM), https://www.weeklystandard.com/blogs/house-consider-tax-new-flu-vaccines_736725.html, *archived at* https://perma.cc/G8QP-AZKY. On the other hand, it is possible that the VICP's unusual attorney payment mechanism (whereby lawyers are paid win or lose) encourages prolonged contestation. *See* Boxler, *supra* note 191, at 24-36 (contending that the VICP's payment mechanism creates perverse incentives). Similarly, it may be that careerist lawyers within the DOJ are uniquely inclined to litigate aggressively—and that lawyers hired by liability insurers or physicians would face resource or reputational constraints to dampen their adversarial impulses. *Cf.* Telephone Interview with Curtis Webb, *supra* note 253 ("My experience is that the DOJ is at *least* as bad as a typical litigant, as, say, a drug company. The typical defendant risks a *huge* award if they're unfeeling about what a seriously injured child needs. But here, the DOJ doesn't face repercussions when they take extreme positions.").

387 *See generally* Engstrom, *Exit, Adversarialism, and the Stubborn Persistence of Tort*, *supra* note 351 (discussing how adversarialism has stymied various no-fault compensation mechanisms within the United States).

388 *See supra* note 315 (noting that the majority of occupational disease cases are contested and involve counsel); *see also* BURKE, *supra* note 36, at 39 ("Over time, workers' compensation systems have come to look more litigation-like, with lawyers playing a larger role . . . ."); Elinor P. Schroeder, *Legislative and Judicial Responses to the Inadequacy of Compensation for Occupational Disease*, 49 LAW & CONTEMP. PROBS. 151, 157-58 (1987) ("[T]he system that was supposed to provide speedy compensation as the workers' quid pro quo to relinquishing tort actions has taken on many of the trappings of common law litigation—retention of lawyers, delays, cost, and compromise." (footnotes omitted)).

389 At the time of enactment, many assumed that claimants would be able to obtain compensation for birth-related injury "without the hassle and expense of obtaining legal representation." Siegal et al., *supra* note 22, at 528-30; *see* VIRGINIA AUDIT, *supra* note 52, at 6 ("The expectation was that the family would not need to hire a lawyer to gain entry into the program."). In reality, however, rates of lawyer retention run high, and both the Florida and Virginia programs have, in time, become surprisingly adversarial. *See* Engstrom, *Exit, Adversarialism, and the Stubborn Persistence of Tort*, *supra* note 351, at 110-13 (compiling various evidence).

390 Auto no-fault was dubbed "no-lawyer" insurance at enactment because it was assumed that the claims process would be straightforward enough to render counsel superfluous. *See* O'CONNELL, *supra* note 42, at 10. In fact, however, a significant and growing proportion of injury victims retain counsel, even to process first-party claims. *See* Press Release, Ins. Research Council, Study Finds More Auto Injury Claimaints Are Hiring Attorneys (July 8, 2014) (on file with author) (reporting that 36% of personal injury protection claimants retained counsel in 2012, up from 17% in 1977).

claims to the contrary,[391] claimants in health court claimants will need lawyers. Health courts may confer many benefits on injury victims, but the ability to obtain adequate compensation without the assistance of counsel will not be one of them.

The second and broader insight is that tort replacement regimes, if around long enough, seem *destined* to become adversarial. They seem to reach some kind of "adversarial equilibrium"—becoming, over time, ever more similar to the tort system that they were designed to supplant.[392] Adversarialism's durability within the VICP—a system that, from an institutional design perspective, did so many things right—contains a sobering lesson for the future construction of no-fault mechanisms and also points the way toward future research on the generalizability and genesis of this phenomenon.[393]

CONCLUSION

The above paints a gloomy portrait of the VICP and identifies lessons that ought to inform the health court debate, as well as our creation and utilization of future specialized courts and alternative compensation mechanisms. Still, it is important to keep the above critique in proper perspective.

First, it is important to recognize that, for all its trouble, the VICP has not been an unmitigated failure. Successfully shielding manufacturers from liability, the Program has revitalized the vaccine marketplace. Since the VICP's creation, vaccine research has flourished, several new vaccines have been approved for use, and vaccine prices have (partly) stabilized.[394]

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391 *See, e.g.*, Mello et al., *Policy Experimentation*, *supra* note 16, at 103 tbl.6 (identifying "[e]nhanced ability to file a claim without assistance of attorney" as one of the eight benefits health courts would confer on claimants); *see also* Mello et al., *"Health Courts," supra* note 85, at 465 ("[C]laimants could easily proceed without the assistance of counsel in most cases."); *Q&A*, *Health Courts Seen as Remedy to Rising Health Care Costs*, HARTFORDBUSINESS.COM (Oct. 21, 2013), http://www.hartfordbusiness.com/article/20131021/PRINTEDITION/310189963/health-courts-seen-as-remedy-to-rising-health-care-costs, *archived at* http://perma.cc/UKS4-WHKJ (quoting Philip K. Howard as stating that "health courts will eliminate the need to even hire a lawyer for most plaintiffs, shaving considerable time and expense off of the current process"); *cf.* Peters, *supra* note 13, at 267 (characterizing the assumption that lawyers could be jettisoned as "breathtakingly naïve").

392 *See* Engstrom, *An Alternative Explanation*, *supra* note 21, at 371-79 (coining the term "adversarial equilibrium" and studying these dynamics in the auto no-fault context).

393 I intend to explore these questions in future work. *See* NORA FREEMAN ENGSTROM, WHY NO-FAULT FAILS (forthcoming).

394 *See* Cook & Evans, *supra* note 187, at 877 ("The vaccine marketplace remains healthy; liability-related vaccine shortages are a distant memory, new vaccines are being licensed, and many are in various stages of development."); Avery Johnson, *Vaccine Makers Enjoy Immunity:*

Transaction costs are another success story. Mostly owing to strict limits on payments to petitioners' counsel, transaction costs within the VICP hover at around 14% of benefits paid; some 86% of Program funds go directly to claimants.[395] At roughly 50%, the tort liability system's transaction costs are substantially higher.[396] Finally, as noted above, with a balance of roughly $3.5 billion, the VICP is certainly on a firm financial footing.[397] The VICP, it bears emphasis, has done certain things well.

Second, this Article's limits, and ambition, must be clear. Though this Article casts doubt on proponents' claims that health courts will eliminate inconsistencies, resolve cases within a year, and quell adversarialism, there are still *plenty* of reasons to support health courts.[398] There are also, of course, *plenty* of reasons to oppose health courts.[399] Indeed, much can be (and has been) said about health courts, both pro and con, that this Article leaves unaddressed. Rather than re-litigate the health court case, this Article attempts to reorient, and conceptually ground, the health court debate.

Third, in identifying problems within the VICP, this Article does not definitively *prove* that health courts will fail to provide prompt and predictable compensation to victims of medical injury. After all, though the VICP and health courts are alike in many respects, they are not clones. As with all case studies, it is conceivable that the experience of the VICP cannot be generalized. And, perhaps most importantly, though this Article raises numerous concerns about the VICP, only occasionally can it show that

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Drug Firms Defend Legal Shield but Others Say Special Court Limits Recourse, WALL ST. J., Feb. 23, 2009, at B2 (reporting that the Act "is an important reason why the vaccine business has been transformed from a risky, low-profit venture in the 1970s to one of the pharmaceutical industry's most attractive product lines today"). That said, following the VICP's creation, vaccine prices did not drop nearly as sharply as anticipated. *See* Elisabeth Rosenthal, *The Price of Prevention: Vaccine Costs are Soaring*, N.Y. TIMES, July 3, 2014, at A1 (showing that, in 1986, five recommended vaccines were $215, while in 2014, the same vaccines cost $937 in inflation-adjusted dollars).

395 *See Detailed Information on the Vaccine Injury Compensation Program Assessment*, EXPECTMORE.GOV, http://georgewbush-whitehouse.archives.gov/omb/expectmore/detail/10003807.2005.html (last visited Apr. 24, 2015), *archived at* http://perma.cc/XWK3-NMSK (reporting that, "between FY 2001 and FY 2004," 86% of compensation within the Fund went directly to claimants "rather than attorneys or administrative entities").

396 *See* DEBORAH R. HENSLER ET AL., RAND INST. FOR CIVIL JUSTICE, TRENDS IN TORT LITIGATION: THE STORY BEHIND THE STATISTICS 29 tbl.4.1 (1987) (reporting that, in auto cases, defendant and plaintiff legal fees consumed forty-five cents of every dollar expended); Studdert et al., *Claims, Errors, and Compensation Payments*, *supra* note 74, at 2031 (calculating medical malpractice claims' transaction costs).

397 *See supra* note 386 and accompanying text.

398 For example, the VICP experience does nothing to undermine—and in fact, supports—assertions that health courts would reduce transaction costs.

399 For a summary of arguments against health courts, see generally Mehlman & Nance, *supra* note 5.

the VICP underperforms vis-à-vis the tort system when it comes to adjudicating analogous claims.

Yet it has been said, "Before the traditional tort system is abandoned . . . there must be substantial grounds to ensure confidence in an alternative institutional mechanism that would serve as its replacement."[400] When it comes to resolving claims for medical injury, health court proponents seek to replace common law courts, in place for centuries, with a new and untested alternative. They have, in large measure, advocated their reform idea based on health courts' ability to offer a few concrete administrative advantages. The VICP experience casts significant doubt on health courts' ability to offer those advantages. That experience ought to shake public confidence in this new alternative mechanism—and inform future analysis.

400 Rabin, *supra* note 283, at 962; *accord* BAUM, *supra* note 33, at 227 ("Proponents of specialized courts are often assigned a burden of proof. That burden seems appropriate.").