MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

1458

2003 HOUSE HUMAN SERVICES

HB 1458

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB1458

House Human Services Committee

☐ Conference Committee

Hearing Date 2-12-03

Tape Number	Side A	Side B	Meter #
1	XX	XX	Entire tape
2	XX		0.0--9.5
2	XX		26.0--31.7
Committee Clerk Signature	Pam Dever		

Minutes:**Rep. Devlin: Opened hearing on HB1458.**

Rep. Dosch, Dist. 32: In support. **(SEE ATTACHED TESTIMONY)**

Rep. Sandvig: Are there any instances you can sight where this has been a problem in ND?

Rep. Dosch: ND has been lucky due to previous work in tort reform. ND has not been effected like other parts of the country. This bill takes additional proactive approaches to certain areas.

Rep. Sandvig: Is it fair to compare ND with California?

Rep. Dosch: I believe it is. We know that CA is a very liberal state. They had to deal with these issues years ago as a result of the nature of CA. Their reforms have been time tested and used as models.

Rep. Potter: 6.8 If we start telling businesses what they can charge, like lawyers, then do we tell doctors. I am concerned with this.

Rep. Dosch: That has been one of the problems in the medical malpractice end of it; the litigation costs. The big huge awards are a problem. Sometimes the lawyers receive as much as

the injured person. Higher litigation costs trickles down to all of us. If you want meaningful reform, you have to look at the whole package. This model works in CA.

Rep. Weisz: 9.0 You make the point that $136,000 is unreasonable fee for a $500,000 claim. If they tried 6 cases and loss 5 and win 1 case, then is $136,000 unreasonable for a $6M settlement?

Rep. Dosch: This is not new. I figure they have many more cases out there then we do.

Bruce Levi, ND Medical Assoc.:10.1--20 In support **(SEE TESTIMONY & AMENDMENT)**

Rep. Amerman: On pg. 4, section 3, how does the court project life expectancy of the plaintiff?

Bruce: The court is given the discretion as to how periodic payments work and issues with projected value. The court would resolve the issue as to placing total value of payments.

Rep. Amerman: Your amendment under section 2, was this put in to cover all civil cases?

Bruce: Section 2 in the amendment is existing now. The amendment would require that in all cases where the future damages are in excess of $50,000, the court is required to set up periodic payments.

Shelly Peterson, ND Long Term Care Assoc.: In support. We have been working with the Health Care Assoc. And the Medical Assoc. On this issue. We feel this bill would assure a fair and balanced market in ND. One for the consumer and one for the attorneys and one for citizens of ND. We have not seen a lot of litigation in the area of long term care. Nationally, it is exploding. We have seem a great increase in our general liability insurance premiums. In 2002 in ND, we had any where from 0% increase to over 472% increase. Today, our average per bed cost is $300 per bed. Nationally, is $2360 per bed. Last year we had a 90% increase in general liability insurance. In ND, the Medicaid government controls 96% of a facility's rate. The federal

Medicare controls the other 4%. We see this legislation as positive. We are seeing that attorneys are getting 47% or of money settlement, so not much is left for the plaintiff.

Rep. Neimeier: 41.4 If this is rare in ND, then why are your rates so high?

Shelly: That is what is going on in other states. The southern states have had huge claims. We had one major carrier pull out of ND.

Rep. Maragos Dist. 3: 43.6 oppose bill. I will leave this letter for you and read it into testimony from Richard McGee II Minot, ND **(SEE ATTACHED TESTIMONY)**

Dan Ulmer, BC/BS: opposed to bill. **(SEE WRITTEN TESTIMONY)**

Christine Hogan, Ex. Dtr. State Bar Assoc.: opposed bill **(SEE WRITTEN TESTIMONY)**

End of side A, Tape 1

Side B: John Olson, ND Trial Lawyers Assoc.: oppose bill **(SEE TESTIMONY)** This bill will not handle the malpractice insurance premiums crisis in the US. There is enormous investment by lawyers in malpractice cases. Too many hours. Only a few in ND will handle it.

Rep. Porter: 9.8. Can you run through how the client-attorney relationship is from day one?. What is the fair and reasonable cut, etc?

John Olson: That's a good question. It is common that the standard fee is 1/3 recovery in all cases. Some may raise the % if they go to trial. In medical malpractice cases, the cases are so complex and expensive. Thus, the fees are higher. I don't see any great offense in the contracts from ND lawyers and injured clients. The fees are discussed upfront right away to client. They are written down. The client takes the contract and review for a time so he/she is clear about fees.

Rep. Wieland: I did not know that ND law discourages frivolous medical malpractice law suits and that it requires a plaintiff to obtain a medical expert.

John: That's right. There are experts out there in all area, not just medical malpractice. There is little success in these cases unless you get a medical expert who is believable, credible, and will be able to convince a ND jury or judge to win malpractice.

Rep. Neimeier: 18.1 Besides the insurance company and lawyer, who else can lay claim to the award?

John: May be a health insurance carrier, lean holder, other litigants.

Alvin Boucher, Atny, Grand Forks: 19.2 opposed to bill.**(SEE WRITTEN TESTIMONY)** I work with medical malpractice cases. This is what I do every day.

End of tape 1, side B This bill would put health care providers above others in the law. This is wrong and is not American justice. Do not pass this legislation Thank you..

(10 minute recess)

Paula Grosinger: ND Trial Lawyers Assoc.: oppose bill. Generally, ND has a good appeal to doctors coming in to ND. They are not afraid to practice here. **(SEE WRITTEN TESTIMONY)** I don't think there is a correlation between torte and malpractice premiums. It was brought up that CA has had success in keeping premiums low because of torte reform they passed in the 1980's. CA premiums still continued to rise until they passed Citizens Proposition 103. This was a mandated moratorium on increases in malpractice premiums. Nothing to do with torte reform legislation.

Vice-Chair Devlin: 9.5 Any further testimony. Seeing none, **HB 1458 is closed.**

(later today) **Chair Price:** Take out HB1458.

Rep. Porter: ND is ahead in the Torte reform game. **I move a DO NOT PASS.**

Rep. Potter: I second. VOTE: 13 YES, 0 NO, 0 AB. Rep. Pollert will carry.

Date: Feb 12
Roll Call Vote #: 1

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB [redacted] 1458

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken DNP

Motion Made By Rep Poeter Seconded By Rep Potter

Representatives	Yes	No	Representatives	Yes	No
Rep. Clara Sue Price - Chair	✓		Rep. Sally Sandvig	✓	
Rep. Bill Devlin, Vice-Chair	✓		Rep. Bill Amerman	✓	
Rep. Robin Weisz	✓		Rep. Carol Niemeier	✓	
Rep. Vonnie Pietsch	✓		Rep. Louise Potter	✓	
Rep. Gerald Uglem	✓				
Rep. Chet Pollert	✓				
Rep. Todd Porter	✓				
Rep. Gary Kreidt	✓				
Rep. Alon Wieland	✓				

Total (Yes) 13 No 0

Absent 0

Floor Assignment Rep Pollert

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
February 12, 2003 12:14 p.m.

Module No: HR-27-2389
Carrier: Pollert
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

HB 1458: Human Services Committee (Rep. Price, Chairman) recommends **DO NOT PASS** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1458 was placed on the Eleventh order on the calendar.

(2) DESK, (3) COMM

2003 TESTIMONY

HB 1458

TESTIMONY
HB 1458
Human Services
February 12, 2003

Chairwomen Price, members of the Human Services Committee, for the record my name is Mark Dosch Representative from District 32 south Bismarck.

I come before you to day to talk on the topic of medical professional liability reform. We all know the topic as it has become an issue that is being talked about across America. It is an issue that is effecting virtually every American, every family, every community. From the east cost to the west, from the middle class, to the poor, from the young to the very old. It is an issue that was once considered a "doctor or hospital" concern, is now an epidemic that is effecting us all.

Medical malpractice insurance rates have soared, causing major insurers to either drop coverage or raise premiums to astronomical levels. Doctors are being forced to abandon patients and practices, particularly in high-Risk specialties such as emergency medicine and OB/GYNs. Low-income neighborhoods and rural areas are particularly hard hit. The US Department of Health and Human Services concluded in a July report that awards in malpractice cases have risen 76% in the past few years.

So where does North Dakota stand? Together with our Legislative Council, we reviewed the California law entitled Medical Injury Compensation Reform Act, which was enacted many years ago to address their insurance crisis. It is time tested legislation and has been used as a model across the country. What you see before you in HB 1458 is a portion of that law. Although not in it's entirety, as ND has already addressed part of "tort reform" in previous legislative sessions, we owe much to our former colleges for their courage and foresight to address this issue. For it is their work that helped ND avert the "crisis" situation other states are now facing.

What is contained in HB 1458 is a few more steps in the reform process. As I mentioned in the beginning you will hear some opposition to this bill. No doubt from the trial lawyers who don't like the sliding fee schedule. I can understand why. According to my calculations, suppose a settlement of

$500,000, they would receive only a mere $136, 500.00. You will also hear from others, but I ask of you committee members only one thing, and that is to keep focused on the legislation before you, and the goal we are trying to achieve. Remember this legislation is time tested and does, and has worked for many years in California. Please remember this when the opponents start telling you just how bad this bill is.

Will these steps help curb the substantial increases in insurance rates one can't say for certain, but we believe it will help. We must do something, or face the same demise as many other states. Raising rates will result in many more people being unable to afford insurance, adding to the list of uninsured. Our state workers face the prospect of a $17 million premium increase erase their hopes for a raise, watching this money go to the insurance companies rather in to their own pockets. What will become of our small communities as they can no longer pay enough for a doctor to make a living and pay his medical malpractice insurance.

We all want those who are injured to receive just compensation. However Americans spend more per person on the costs of litigation that any other country in the world. This environment has caused doctors who fear getting sued to practice "defensive medicine," prescribing costly medical treatments for the sole purpose of avoiding litigation, thus raising costs of insurance even more. This hurts not only the insurance companies, but us as consumers, *as it is us who in the end ultimately will pay with higher and higher premiums,* and some day perhaps even with our life as the availability of doctors becomes a great concern.

Madam Chair, and members of the Human Services committee, please join with me, and our past courageous legislators in taking the next step in Tort reform. It's the right thing to do for ALL North Dakotans. Please support this bill with a DO PASS recommendation.

This concludes my testimony, I would be happy to answer any questions.

Thank you.
Rep. Mark Dosch

Testimony in Support of HB 1458
North Dakota Medical Association
House Human Services Committee
February 12, 2003

Chair Price and Members of the House Human Services Committee, I'm Bruce Levi of the North Dakota Medical Association. NDMA is the professional organization for physicians, residents, and medical students in North Dakota.

HB 1458 would provide an additional measure of stability in the medical liability insurance market

I understand that the intent of the sponsor of HB 1458 is to provide an additional measure of stability in the medical liability insurance market. There's a lot of talk about a nationwide "malpractice crisis." In his State of the Union Address, President Bush called for medical liability reform. The components of the problem are four-fold.

First, the availability of malpractice insurance is a major concern. In many parts of the country, availability of insurance has dropped dramatically and some large carriers are no longer in the market. The St. Paul Companies pulled out of the medical professional liability market worldwide. This impacted many physicians and other health care providers in North Dakota who were forced to find insurance with other carriers. Some companies, like the Pennsylvania-based PHICO, were liquidated by state regulators after devastating business results – PHICO's pullout also impacted North Dakota.

Second, the affordability of insurance is another major component of the problem. Even in states where there is adequate capacity, insurance rates are increasing – dramatically in some places. Information that the Association has obtained to date from surveys shows that many physicians in North Dakota have experienced significant challenges in obtaining affordable liability coverage, including significant premium increases. NDMA believes that significant challenges will become the norm due to capacity limits of those professional liability insurance carriers currently doing business in North Dakota and tougher underwriting standards that companies employ as they reach their capacity limits. Physicians with positive claims histories are being impacted as well as those with negative claims histories. Some physicians are indicating that they plan to limit their practice to lower risk patients and are less willing to perform high-risk procedures. There is also some concern about the future impact of these unsettling trends on patient access to medical care, and impacts on staffing and the ability to recruit and retain physicians.

Most physicians in North Dakota practice in groups. At least three of our larger multispecialty group practices have been forced to essentially "self insure," by raising their deductibles substantially while at the same time experiencing a substantial premium increase. The impacts are felt in both urban and rural areas. A rural multispecialty group saw a significant premium increase from the previous year, and is growing more concerned about their ability to recruit and retain physicians. Physicians and group practices forced to replace their carrier, particularly those previously insured by the St. Paul Companies and PHICO, were hit particularly hard in moving to new carriers, experiencing substantial premium increases and/or forced to accept higher deductibles and more stringent underwriting requirements. Independent physicians have also reported a wide range of premium adjustment this past year as well.

Since 2000, the Medical Association has been closely monitoring professional liability insurance trends, including working closely with the Insurance Department in an effort to stay ahead of the crisis that has emerged in many states. It is expected that hospitals will experience the largest liability insurance increases in 2003 [Medical Liability Monitor 1/10/03]. Our state insurance commissioner Jim Poolman has also formed a medical liability insurance task force which will bring together experts to stay ahead of these issues in our state.

The third component of the problem is access to health care, which has become one of the most significant concerns nationwide, as the lack of availability and affordability of malpractice insurance has impacted access to health care in many areas of the country. The situations in New Jersey, West Virginia, Nevada, Mississippi, and Pennsylvania are well known. If there's interest, I have an American Medical Association compilation of access issue nationally, including places where obstetricians have stopped delivering babies, where physicians have simply had to leave the state, and where physicians are refusing some high-risk procedures because of skyrocketing premiums.

And fourth, the cost of health care. Physician concerns about malpractice liability lead to increases in defensive medicine – performing procedures that may not be necessary, just to provide a defense in case the patient has an adverse outcome. A study at Stanford University found that tort reforms could lead to reductions in expenditures for defensive medicine in the billions of dollars. Medical liability insurance premiums are the third largest practice expense for physicians.

With medical liability crises in many states, medical liability reform has come in recent weeks to the forefront of public attention. In July, 2002, the Secretary of the US Department of Health and Human Services Tommy Thompson called for fixing our medical liability system, by curbing excessive litigation. Subsequent reports from HHS showed that the current crisis is not merely a reflection of an "insurance cycle," but a broken medical litigation system (Appendix A). HHS also reported that insurance premiums are lower in states that have reformed their litigation system (Appendix B).

North Dakota has undertaken some significant reforms since the 1970s (Appendix C). HB 1458 would initiate another step in our state's incremental approach to tort reform, and would strengthen North Dakota's ability to maintain stability in the medical liability insurance market.

The medical and hospital communities and their national organizations such as the American Medical Association, American Hospital Association, medical specialty societies and liability insurers have begun a campaign to enact tort reforms, possibly at the federal level and certainly at the state level to assure wider availability of medical services to the public. At both the national level and in many states, reforms are being sought that mirror California's MICRA [Medical Injury Compensation Reform Act] package, especially caps on noneconomic damages, as well as limits on punitive damages, a collateral source offset, periodic payment of large awards of future damages, and limitations on attorney contingent fees.

California's MICRA was passed in 1975 and its constitutionality was upheld in 1985. That was the first year that its impact could truly be felt. In 1984, insurance rates in California were higher than national averages. By 1995, they were significantly lower. California physician premiums have increased at a lower rate than the rest of the country. Since 1975, U.S. rates have increased 420%. California rates have increased only 168%.

What is obvious about MICRA is that it works and works well. Doctors and hospitals in California pay significantly less for liability protection today than their counterparts in states without MICRA-type reforms. MICRA has helped stabilize the liability insurance market. That is why MICRA is seen as a model.

HB 1458 as introduced would provide for these MICRA-style reforms, through establishment of a sliding-scale fee cap on attorney contingent fees; modification of what is called the "collateral source" rule to allow evidence of other sources of damage reimbursement, such as insurance, to be considered in determining economic damages; and a requirement that future damages over $50,000 be awarded as periodic payments rather than in a lump sum.

Amendments to HB 1458 would better address current concerns

After Representative Dosch introduced HB 1458, our Association reviewed the bill and began discussions with other organizations, defense attorneys, liability carriers, and health professionals about what steps could be taken in North Dakota to expand upon previous legislative reforms. The amendments being proposed address the placement of two of the proposed reforms into existing statutory provisions regarding collateral source payments and the periodic payment of future damages. The amendments would not change that part of the bill relating to attorney's contingent fees.

Collateral Source Rule

The collateral source rule is a rule of evidence that was developed by courts. It prohibits defendants in civil lawsuits from introducing evidence at trial that demonstrates that the plaintiff will receive payment for certain losses from a separate "collateral source," such as health, disability or workers compensation insurance. Under current law in North Dakota (NDCC 32-03.2-10), the jury in a civil action may not be informed of the potential for reducing economic damages because of payments from a "collateral source." However, the law does allow the party responsible for paying economic damages to apply to the court, after the award of damages has been made, for a reduction of the damage award to the extent that any of the economic losses presented to the jury were covered by payments from a collateral source. Under our current law, a "collateral source" is defined narrowly. Our Supreme Court has said that the intent of the statute was to eliminate double recovery from sources such as Workers Compensation and Social Security. However, the statute does not allow a reduction for life insurance, other death or retirement benefits, or any health insurance or other insurance or benefit purchased by the party recovering damages.

HB 1458 as introduced would change the collateral source rule in North Dakota only in medical liability cases. With the amendments being proposed, HB 1458 would revise our state's current "collateral source" rule in all civil actions to require the court to reduce economic damages that are awarded by amounts received from collateral sources and expand the definition of a "collateral source" to health insurance benefits.

Periodic Payments

The bill would also revise our current provision on periodic payments for future damages by requiring that future damages over $50,000 be awarded as periodic payments rather than in a lump sum.

Under this type of system, payments for damages that will occur in the future are compensated periodically, such as lost wages and future medical expenses that the plaintiff might incur. The

judge would determine the amount of payment for future damages, and order that this amount be paid to the plaintiff over a period of time.

Periodic payment contributes greatly to market stability by giving insurers a road map to plan for future expenditures over time. Excessive verdicts mean huge insurance payments, sometimes exceeding premium limits. Insurers are unable to plan and invest accordingly for these payouts. This can adversely affect reserves and contribute to market instability.

Periodic payment also ensures that plaintiffs will have the funds necessary to cover future expenses by protecting them from mismanaging their money. This is especially important in cases involving minors and other individuals, who might not otherwise be able to plan for future costs. Tax consequences of periodic payment are also more favorable to the plaintiff.

Attorney's Contingent Fees

The proposed amendments would not revise the provision in HB 1458 that would address attorney's fees in medical liability cases.

Medical liability plaintiffs' attorney fees are capped in several states. Currently in North Dakota, Rule 1.5 of the ND Rules of Professional Conduct for Attorneys requires that a lawyer's fee be reasonable. HB 1458 tracks language provided in HR 4600, the latest medical liability reform legislation passed by the US House of Representatives (and supported by Representative Earl Pomeroy). The bill would give the court in a health care malpractice action the ability to redirect attorney contingent fees to a plaintiff's damage award. The bill would also limit attorney contingent fees in any malpractice action to a sliding-fee scale – 40% of the first $50,000 recovered, 33-1/3 of the next $50,000, 25% of the next $500,000, and 15% of the amount exceeding $600,000.

Reasonable limits on attorneys' fees benefit injured persons by helping to ensure that these parties receive their fair share of damages. Limits also help discourage frivolous lawsuits because they make it less lucrative to pursue meritless cases.

The North Dakota Medical Association urges a "do pass" on HB 1458 with the proposed amendments. The bill would provide an additional measure of stability in the medical liability insurance market.

PROPOSED AMENDMENTS TO HB 1458

Page 1, line 1, replace "three" with "one" and replace "sections" with "section"

Page 1, line 3, replace "section 32-42-01" with "sections 32-03.2-06 and 32-03.2-09" and replace "definitions" with "collateral source payments and periodic payments in civil actions"

Page 1, line 5, replace "32-42-01" with "32-03.2-06"

Page 1, replace lines 7 through 23 with:

"**32-03.2-06. Reduction for collateral source payments.** After an award of economic damages, the party responsible for the payment thereof is entitled to ~~and may apply to the court for~~ a reduction of the economic damages to the extent that the economic losses presented to the trier of fact are covered by payment from a collateral source. A "collateral source" payment is any sum from any other source paid or to be paid to cover an economic loss which need not be repaid by the party recovering economic damages including any contractual allowance, but does not include life insurance, other death or retirement benefits, or any ~~insurance or~~ benefit ~~purchased by the party recovering economic damages~~ from a federal program that by law must seek subrogation. The court may reduce the reduction for collateral source payments by an amount equal to the premiums to the collateral source paid directly by the party recovering economic damages for the one-year period immediately preceding the accrual of the action, as determined to be appropriate by the court.

SECTION 2. AMENDMENT. Section 32-03.2-09 of the North Dakota Century Code is amended and reenacted as follows:

32-03.2-09. Periodic payments ~~for continuing custodial care~~.

1. If an injured party ~~claims~~ is awarded future ~~economic~~ damages ~~for continuing institutional or custodial care that will be required for a period of more than two years, at the discretion of the court any party may request the trier of fact to make a special finding of the total amount awarded for this care, separate from other future economic damages, and if a separate award is made, any party may make periodic payments for this care in an amount approved by the court, provided payment of the total award for this care is adequately secured. The adequacy of the periodic~~

~~payments within the limit of the total award will be subject to review by the court from time to time, and upon the death of the injured person the obligation to provide for further continuing care shall terminate~~, the district court, at the request of either party, shall enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds fifty thousand dollars in future damages. As used in this section, "future damages" includes damages for future medical treatment, care or custody, loss of future earnings, loss of bodily function, or future pain and suffering of the judgment creditor. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages. As a condition to authorizing periodic payments of future damages, the court shall require the judgment debtor who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the judgment debtor.

2. The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments are to be made. The payments may only be subject to modification in the event of the death of the judgment creditor. If the court finds that the judgment debtor has exhibited a continuing pattern of failing to make the payments, the court shall find the judgment debtor in contempt of court and, in addition to the required periodic payments, shall order the judgment debtor to pay the judgment creditor all damages caused by the failure to make such periodic payments, including court costs and attorney's fees.

3. Periodic payments of future damages to the judgment creditor, other than damages for loss of future earnings, must cease when the judgment creditor dies. Money damages awarded for loss of future earnings may not be reduced or payments terminated by reason of the death of the judgment creditor, but must be paid to

persons to whom the judgment creditor owed a duty of support, as provided by law, immediately prior to the judgment creditor's death. If no duty of support existed immediately prior to death, all periodic payments of future damages shall cease upon death of the judgment creditor. In such cases the court which rendered the original judgment, upon petition of any party in interest, may modify the judgment to award and apportion the unpaid future damages in accordance with this subsection.

4. Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further payments ceases and any security given under subsection 1 reverts to the judgment debtor."

Page 2, remove lines 1 through 21

Page 2, line 22, replace "Three" with "A" and replace "sections" with "section"

Page 2, line 23, replace "are" with "is"

Page 2, remove lines 24 through 31

Page 3, remove lines 1 through 31

Page 4, remove lines 1 through 5

Renumber accordingly

APPENDIX A

U.S. Department of Health and Human Services

Update on the Medical Litigation Crisis: Not the Result of the "Insurance Cycle"

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation

September 25, 2002

This paper was prepared by the Office of Disability, Aging and Long-Term Care Policy within the U.S. Department of Health and Human Services. For additional information, you may visit the DALTCP home page at http://aspe.hhs.gov/daltcp/home.htm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201. The e-mail address is: webmaster.DALTCP@hhs.gov.

Interest groups supported by trial lawyers argue that the recent crisis in the medical litigation system is only a reflection of an "insurance cycle": they claim that the management practices of the insurance industry have caused the crisis. But their claims are not supported by facts. Comparisons of states with and without meaningful medical liability reforms provide clear evidence that the broken medical litigation system is responsible.

Fact 1: States With Liability Reforms Are Not Experiencing the Crisis

While it is true that high levels of investment income and competition kept premium rates lower in the 1990's, it is not true that the current crisis is caused by the insurance cycle. If that were so, then all states would be equally experiencing a crisis. In fact, some states that have enacted reforms have seen *decreases* in malpractice premiums.

The issues today are similar to those 15 years ago, and the many states that failed to heed the call to reform continue to suffer from higher litigation costs and reduced access to care. For example, in states such as Pennsylvania, Nevada, West Virginia and Mississippi, qualified physicians are retiring early or relocating to states that have reformed their litigation systems.

Fact 2: The Crisis is A Result Of Litigation Excess

Insurance premiums are largely determined by the expensive litigation system. Although most cases do not actually go to trial, it costs a significant amount of money to defend each claim--an average of $24,669. The most dramatic cost driver, however, is the effect of the few cases that result in huge jury awards. Even though very few cases result in these awards, they encourage lawyers and plaintiffs in the hope they can win at the litigation lottery, and they influence every settlement discussion as well.

According to the American Academy of Actuaries, insurers' costs began to increase in the late 1990's, fueled by increases in both the size and frequency of very large claims and in the costs of defending lawsuits. Case in point: the size of the median jury award more than doubled from $475,000 in 1996 to $1 million in 2000. This means that half of all jury awards are currently above $1 million.

In 2001, the average loss ratio (the ratio of claims paid to premiums collected by insurers) in states ***without*** caps was 100.86 compared to 68.98 in states with reasonable limits on non-economic damages. Simply put, claims have outstripped premiums in states without such reforms. With no limits on further increases in enormous jury awards and hence in future liability costs in sight, insurers in non-reform states are raising premiums dramatically, limiting coverage, or eliminating coverage altogether.

TABLE 1. Medical Malpractice Loss Ratios: States with $250,000 Caps on Non-economic Damages

State	2001 Loss Ratio
Indiana	41.34
Colorado	46.87
California	64.06
Nebraska	38.93
Utah	102.77
Montana	119.93
Average: 6 states with caps	68.98
Average: 44 States without caps	100.86
Source: Medical Malpractice Insurance Net Premium and Incurred Loss Summary,National Association of Insurance Commissioners, 2001 data.	

Fact 3: The Current Medical Litigation Crisis is Not Caused by Bad Investing

This crisis has not been "caused" by poor management practices by insurers or losses from investment income. In fact, investments by medical malpractice companies have been relatively conservative. Most states have laws that specifically limit the percentage of assets an insurance company can put in speculative or volatile investments. According to the NAIC, only 1/4 of the assets of property and casualty insurers were invested in stocks in 2001, compared to over 50% in bonds. Even with reductions in equity values, insurers' investments in equities, as a percentage of total assets, is in line with prior years (i.e. less than 10%).

5 Year Historical Asset Allocation Table

P&C - Size: All, Type: All, Line: Medical Malpractice, Weight: Market Value

TABLE 2. Asset Class

	Cash %	Corp %	Equity %	Govt %	Muni %	Other %	Pref %
1997	4.98	27.61	8.87	21.12	34.19	1.27	1.96
1998	5.83	26.51	8.93	18.77	36.44	1.89	1.64
1999	5.39	28.52	10.78	15.54	36.89	1.37	1.51
2000	6.48	30.89	9.72	14.90	35.03	1.40	1.57
2001	7.74	34.84	9.03	13.73	31.41	1.53	1.73
©2002 Brown Brothers Harriman & Co.							

Of course, premiums would have to be increased less if insurers were able to earn more investment income. Investment income helps pay claims.

It is significant, moreover, that the insurers are not leaving other markets. If the crisis were caused by lower investment returns, these companies would be exiting the property-casualty market, for example. But they are not. They are leaving the medical liability market because of the risk of unbounded payouts in that sector, particularly in non-reform states.

Fact 4: Reduced Competition Among Insurers is A Result of the Litigation Crisis

Doctors and patients benefited from the fact that a number of companies entered the malpractice insurance market in the 1990s. The increased competition and the efforts of the new companies to attract business kept premiums lower than they would otherwise have been. But the companies underestimated the extent to which the costs imposed by the litigation system would increase, particularly in non-reform states. Many lost money and exited the market.

The fact that companies entered and then left the market does not mean the litigation system has not caused the problem. On the contrary, the departure of insurers demonstrates how badly the litigation system is broken. Illustrating this fact, several major carriers have stopped selling malpractice insurance.

- St. Paul Companies, which was the largest malpractice carrier in the United States, covering 9% of doctors, announced in December of last year that it would no longer offer coverage to any doctor in the country.
- MIXX pulled out of every state; it will reorganize and sell only in New Jersey.
- PHICO and Frontier Insurance Group have also left the medical malpractice market.
- Doctors Insurance Reciprocal stopped writing group specialty coverage at the beginning of this year.

It should be noted that commercial insurance companies do not provide most medical liability insurance. Approximately 60% of doctors are covered by physician-owned companies, which were developed because commercial carriers had left the market or offered unaffordable policies. Physician-owned insurers are often the ones that fill the void left by exiting insurers.

The simple fact is that, because of the unprecedented size of jury awards in some states, malpractice insurance is too risky to be a profitable activity for many insurance companies. As a result, the number of insurers that have left or are contemplating leaving the medical malpractice market has reached crisis proportions in the last three years.

This directly affects patients' ability to get care not only because many doctors find the increased premiums unaffordable but also because insurance is increasingly difficult for doctors to obtain at any price, particularly in non-reform states. This forces them to give up their practices, restrict what patients they accept, or move to states that have reformed their system.

Fact 5: The Success of Litigation Reform Demonstrates That The Problem is Not Cyclical

Reform of medical liability systems in several states convincingly demonstrates that tort reform works. California's MICRA-Medical Injury Compensation Reform Act-is one such example. It reduces the cost of insurance premiums and provides that truly injured people get properly compensated for their injuries.

- The number of large jury awards has been declining in California, although ***the total number of claims has not***--Californians still have their day in court.
- The percentage of claims resolved through settlement and arbitration has increased in California, saving money for injured patients.
- Insurance premiums in California have risen by 167% in the 25 years since MICRA has been in effect while those in the rest of the country have increased 505%. MICRA included steps to protect the quality of medical care as well as procedures to help assure that medical malpractice insurance would be available at realistic and affordable prices. This bi-partisan reform has saved California residents billions of dollars in lower health care costs and saved federal taxpayers billions of dollars in the Medicare and Medicaid programs.
- For example, premiums for specialists in Los Angeles are substantially less than for specialists in metropolitan areas in states without reforms such as Florida, Illinois and Nevada.

TABLE 3. Malpractice Liability Rate Ranges by Specialty by Geography as of July 2001			
	Cap	**Low**	**High**
INTERNISTS			
California (Los Angeles area)	$250,000	7,900	13,000
Pennsylvania (Urban Philadelphia area)	No cap	10,700	11,800
Nevada (Las Vegas area)	No cap	11,600	15,800
Illinois (Chicago area)	No cap	16,500	28,100
Florida (Miami and Ft. Lauderdale areas)*	No cap	17,600	50,700
GENERAL SURGEONS			
California (Los Angeles area)	$250,000	23,700	42,200
Pennsylvania (Urban Philadelphia area)	No cap	31,500	35,800
Nevada (Las Vegas area)	No cap	40,300	56,900
Illinois (Chicago area)	No cap	50,000	70,200
Florida (Miami and Ft. Lauderdale areas)*	No cap	63,200	126,600
OBSTETRICIANS/GYNECOLOGISTS			
California (Los Angeles area)	$250,000	46,900	57,700
Pennsylvania (Urban Philadelphia area)	No cap	45,900	66,300
Nevada (Las Vegas area)	No cap	71,100	94,800

Illinois (Chicago area)	No cap	72,500	110,100
Florida (Miami and Ft. Lauderdale areas)*	No cap	108,000	208,900

Source: Medical Liability Monitor, Vol.26, No.10, October 2001: Shook, Hardy, Bacon, L.L.P., October 9, 2001.
* Florida reform legislation went into effect in 2001. It imposes caps of $250,000-350,000 unless neither party demands binding arbitration or the defendant refuses to arbitrate.

Malpractice reforms in the 1980s led to a 34% decline in malpractice premiums in those states that enacted reforms compared with states that did not enact reforms.

For more information on this subject, go to the Office of Disability, Aging and Long-Term Care website at http://aspe.hhs.gov/daltcp/reports.htm.

APPENDIX B

U.S. Department of Health and Human Services

Special Update on Medical Liability Crisis

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation

September 25, 2002

This paper was prepared by the Office of Disability, Aging and Long-Term Care Policy within the U.S. Department of Health and Human Services. For additional information, you may visit the DALTCP home page at http://aspe.hhs.gov/daltcp/home.htm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201. The e-mail address is: webmaster.DALTCP@hhs.gov.

On September 24, 2002, Medical Liability Monitor (MLM), an independent reporting service which tracks medical professional liability trends and issues, released preliminary results of the MLM's annual rate survey. This survey determined that the crisis in medical malpractice liability insurance identified in HHS's report entitled, "Confronting the New Health Care Crisis: Improving Health Care Quality by Fixing Our Medical Liability System," has worsened in 2002.

Insurance Premiums Have Risen More Rapidly in 2002

The cost of the excesses of the litigation system are reflected in the rapid increases in the cost of malpractice insurance coverage. Premiums are spiking across all specialties in 2002. When viewed alongside previous double-digit increases in 2000 and 2001, the new information further demonstrates that the litigation system is threatening health care quality for all Americans as well as raising the costs of health care for all Americans.

TABLE 1. Medical Malpractice Liability Average Premium Increases by Specialty (Date is When Survey Was Taken, Compared to Previous Rates)

Specialty	July 2000	July 2001	December 2001	Summer 2002
Internists	17%	10%	22%	26.3%*
General Surgeons	14%	10%	21%	23.7%*
Obstetricians/Gynecologists	12%	9%	19%	19.4%*

Source: Medical Liability Monitor
* preliminary data

The data in Table 1 reflect an average of specialties in all states. Averaging disguises the different experience in states that have reformed their litigation systems and those that have not.

Rates Are Rising Fastest In States Without Reasonable Limits on Non-Economic Damages

As reported in "Confronting the New Health Care Crisis: Improving Health Care Quality by Fixing Our Medical Liability System," 2001 premium increases in states without litigation reform ranged from 30%-75%. In 2002, the situation has deteriorated. States without reasonable limits on non-economic damages have experienced the largest increases by far, with increases of between 36%-113% in 2002. States with reasonable limits on non-economic damages have not experienced the same rate spiking.

TABLE 2. Premium Increases in Non-Reform States*

State	Premium Increase in 2002
Arkansas	112%
Connecticut	40%
Florida	75%
Georgia	40%
Maryland	37%
Mississippi	99%
Nebraska	36%
Nevada	50%
New Hampshire	50%
North Carolina	50%
Ohio	60%
Oregon	80%
Pennsylvania	40%
South Carolina	42%
Tennessee	65%
Texas	40%
Virginia	113%
Wyoming	38%

Source: Medical Liability Monitor, 2002.
*Highest increase among specialty physicians as reported in MLM Survey, 2002.

The July HHS report identified 10 non-reform states that had significant premium increases in 2001 for three key physician specialists. Here is how those states fared in 2002.

TABLE 3. Average Highest Premium Increases in Non- Reform States

State	2002 Average Highest Premium Increase

Arkansas	64%
Oregon	41%
Pennsylvania	40%
Ohio	35%
Georgia	29%
Nevada	26%
Connecticut	24%
New Jersey	15%
West Virginia	13%
Washington	7%
Source: Medical Liability Monitor 2002 Report. Average highest premium increase reported for internal medicine, general surgery and ob-gyn physicians.	

The most recent data from MLM indicate that physicians in additional states without reasonable limits on non-economic damages are now facing similarly substantial premium increases. These new states in crisis appear in the table below.

TABLE 4. New States in Crisis	
State	**2002 Average Highest Premium Increase**
Virginia	66%
Mississippi	54%
Florida	48%
New Hampshire	44%
Tennessee	40%
South Carolina	37%
North Carolina	32%
Colorado	23%
Nebraska	23%
Iowa	22%
Source: Medical Liability Monitor 2002 Report, September 24, 2002 (preliminary data). Average highest premium increase reported for internal medicine, general surgery and ob-gyn physicians.	

Physician Premiums Are Lower in States That Have Reformed Their Litigation System

A comparison of the range of physician premiums, by specialty, in states that have not reformed their litigation system, to California, which has implemented reasonable caps on non-economic damages, reveals how excessive awards for non-economic damages affect premiums.

TABLE 5. States with High Annual Premiums in 2002 by Specialty, Compared to California			

State	OB/GYNs	Surgeons	Internists
Florida	$211K-$78K	$124K-$36K	$56K-$15K
Nevada	$142K-$59K	$85K-$38K	$17K-$11K
Michigan	$141K-$50K	$107K-$43K	$46K-$14K
New York	$115K-$33K	$66K-$19K	$17K-$6K
Illinois	$102K-47K	$70K-$32K	$26K-9K
Texas	$98K-$42K	$71K-$31K	$26K-$10K
Maryland	$96K-$30K	$45K-$24K	$11K-$6K
West Virginia	$95K-$69K	$64K-$40K	$18K-$9K
Connecticut	$95K-$69K	$43K-$37K	$14K-$7K
District of Columbia	$90K-$84K	$43K-$38K	$13K-$11K
California	**$72K-$20K**	**$49K-$17K**	**$12K-$5K**

Source: Medical Liability Monitor 2002 Report, September 24, 2002 (preliminary data). Average highest premium increase reported for internal medicine, general surgery and ob-gyn physicians.

Impact of Year-After-Year Rate Increases in Select Crisis States

The recent data demonstrate the cumulative impact of year-after-year increases in premiums. In the 9 states which the American Medical Association deemed to be in a crisis, the Medical Liability Monitor compared the rate increases of 2001 and 2002. The results are clear:

TABLE 6. Highest Rate Increase for OB/GYNs in AMA Crisis States Compared to California 1998-2002

State	1998 Rate	2002	Rate Increase Since 1998
Washington	$38,882	$51,878	33.4%
Georgia	$39,732	$48,973	23.2%
Nevada (Clark Co.)	$94,824	$141,760	49.5%
Florida	$147,875	$210,576	42.4%
Mississippi	$37,296	$45,125	21%
Ohio	$61,364	$152,49	148.5%
Oregon	$21,680	$48,942	126%
Pennsylvania	$25,548	$64,314	125.3%
West Virginia	$84,551	$97,790	30.4%

Source: Medical Liability Monitor 2002 Report, September 24, 2002 (preliminary data). Average highest premium increase reported for internal medicine, general surgery and ob-gyn physicians.

Continuing and accelerating increases in insurance means more doctors are confronted with premiums they cannot afford to pay. More doctors will retire early, reduce their practice to patients who present less risk of litigation, or move to states that have reformed their litigation system. This reduces Americans' access to quality care and increases the cost of care paid by all Americans. The litigation crisis is only getting worse.

With few exceptions, average premiums for states with reasonable limits on non-economic damages are lower than for the US as a whole. This holds true for all three specialties.

TABLE 8. Average Premiums for Internists, General Surgeons and Obstetrician/Gynecologists 2002

State	Internists	General Surgeons	Ob-Gyns
Indiana	$4,023	$14,574	$19,486
South Dakota	$4,150	$13,853	$18,633
North Dakota	$6,609	$16,238	$24,971
Hawaii	$7,156	$25,756	$42,928
Montana	$7,334	$26,775	$40,693
Utah	$9,244	$37,299	$45,588
New Mexico	$7,802	$35,915	$35,915
California	$10,098	$28,693	$48,704
Michigan	$26,146	$71,713	$88,945
Total US	$12,355	$36,564	$49,530
Source: Medical Liability Monitor 2002 Report, September 24, 2002 (preliminary data).			

For more information on this subject, go to the Office of Disability, Aging and Long-Term Care website at http://aspe.hhs.gov/daltcp/reports.htm.

APPENDIX C

Tort Reform in North Dakota

The following are statutes enacted in North Dakota relating to tort reform.

Statute of Limitations
In action without death, 2 yrs after injury known (reasonable diligence) but cannot be extended more than 6 yrs by nondiscovery unless discovery prevented by fraud of physician or hospital. In action with death, 2 yrs after discovery of malpractice, but not extended more than 6 yrs unless fraud; in cases involving minors, limitation can be extended up to 12 yrs for infancy (28-01-18; 28-01-25)

Economic Damages
Economic damages in excess of $250,000 subject to "reasonableness" review if requested (1987) (32-03.2-08)

Non-Economic Damages
In medical liability cases only, $500,000 limitation on noneconomic damages, regardless of number of people sued or actions brought for that injury (1995) (32-42-02)

Fair Share
No joint liability, unless joint tortious act (1987) (32-03.2-02)

Attorney Contingency Fee Caps
No contingency fee limits other than reasonableness (Prof. Conduct Rule 1.5)

Collateral Sources of Payments
Defendant may apply to court for reduction of economic damages to extent covered by collateral sources. Collateral source defined not to include insurance benefits (1987) (32-03.2-06)

Punitive Damages
"Clear and convincing standard," no claim in initial filing / must amend into pleadings; cap of greater of $250,000 or twice the amount of economic damages (32-03.2-11)

Permit Periodic Payments
Periodic payments permitted in court's discretion for future damages for continuing institutional or custodial care of over two years in duration (1987) (32-03.2-09)

Alternative Dispute Resolution – "Good faith effort" to consider alternative dispute resolution (1995) (32-42-03)

Expert Opinion Screen – Claimant must produce expert opinion supporting claim allegations within 3 months (1981, 97) (28-01-46)

Privilege Waiver – Claimant waives privilege for medical records, opinions, or other information / informal discussion allowed (1997) (28-01-46.1)

Frivolous Lawsuits
Court may require the plaintiff to pay attorney's fees and other costs of the defense in a "frivolous" claim (28-26-01)

1970s Reforms
The 1977 ND Legislative Assembly enacted medical liability reform legislation that included a $300,000 cap on all claims arising from any one occurrence, a prohibition on joining of causes of actions against health care providers, an elimination of the collateral source rule that required that damages be reduced by "any nonrefundable medical reimbursement insurance benefit, less premiums paid by or for the claimant over the immediate preceding five years," discretion in the court to award damages in regular intervals rather than in a lump sum if the damage award exceeds $100,000, a requirement that medical expert testimony be presented except under certain circumstances, a requirement that all health providers file proof of financial responsibility in the amount of $100,000 per occurrence as a condition of licensure, and other provisions. The legislation also provided that if the insurer under the basic policy of insurance pays its policy limit of $100,000 and the claimant is dissatisfied, the claimant was required to sue, naming a newly-created trust fund as defendant, and have the case tried without a jury.

The ND Supreme Court in Arneson v. Olson, 270 N.W.2d 125 (ND 1978), a suit brought by four physicians challenging the constitutionality of the legislation, declared the joinder of causes of action and expert witness provisions as unconstitutional as violating the Supreme Court's constitutional authority to establish rules of procedure. The Court also determined that the $300,000 cap on damages arising from any one occurrence violated the equal protection provision of the North Dakota Constitution and that the $100,000 policy payment provision subject to a further lawsuit without a jury trial violated the state constitution's guarantee of a jury trial. Upon making these declarations, the Court proceeded to declare the entire Act as unconstitutional on grounds all provisions of the legislation were so connected and dependent upon each other that it could not be presumed that the Legislature would have enacted the valid sections without the unconstitutional sections.

McGee, Hankla, Backes & Dobrovolny

A PROFESSIONAL CORPORATION

LAWYERS

1901 Over 100 Years 2003

GEORGE A. McGEE (1878-1963) RICHARD H. McGEE (1916-1992)

ORLIN W. BACKES
RICHARD H. McGEE II
BRIAN W. HANKLA
COLLIN P. DOBROVOLNY
JON W. BACKES
PETER S. HANKLA
JASON D. VENDSEL
BRYAN VAN GRINSVEN

Retired
WALFRID B. HANKLA
HERBERT A. WHITTIER

BYRON L. LINDSO, CPA
Business Manager

WELLS FARGO BANK CENTER
SUITE 306
1A SECOND AVENUE SW
P.O. BOX 908
MINOT, NORTH DAKOTA
58702-0908

TELEPHONE
701-852-2544

FACSIMILE
701-838-4724

February 4, 2003

Via Facsimile (701) 328-1271

Andrew G. Maragos
District 3 Representative
State Capitol
Bismarck, ND 58505

1280

Re: House Bill 1458

Dear Representative Maragos:

You and I have known each other for many years. I feel compelled to write to you and discuss what I believe to be a very troubling and unfair piece of proposed legislation. Your committee will address this proposed legislation on February 11, 2003. As you know, I have practiced law here in Minot for the past 25 years. I am a graduate of Bishop Ryan High School and Minot State College. I am a 1977 graduate of the University of North Dakota School of Law. I am the third generation of lawyers from the McGee family to practice law in Minot. My grandfather, George McGee came to Minot in 1901. My family has lived here ever since. This is the first time I have ever written a letter to a legislator to comment on proposed legislation. I feel I must do so at this time. I am concerned about HB 1458.

I would like to provide you with information regarding existing state law when considering this proposed legislation. I will be out of state on February 11, 2003 and would therefore ask that you consider my thoughts, share this letter with fellow legislators, and place this letter of record so my thoughts are known.

Before I discuss the content of this legislation I think it is important to give you an overview of applicable North Dakota statutes that regulate "frivolous" medical malpractice lawsuits and provide supervision over unreasonable awards.

The existing North Dakota laws are very protective of physicians and other health care providers. N.D.C.C. §28-01-46 requires that a Plaintiff in a medical malpractice case must provide to the court an affidavit from an expert within 3 months of the commencement of the action. This statement, under oath, must state that the expert physician has reviewed the medical records, and must, in sufficient detail, state why the medical care provided was below the appropriate standard of care. Failure to file such an affidavit results in mandatory dismissal of the lawsuit. This legislation clearly protects medical providers from "frivolous" lawsuits. N.D.C.C. Sections 32-42-01 and 04 require that an injured party consider alternative dispute resolution procedures (as opposed to lawsuits), before initiating a medical malpractice lawsuit. This section provides an added layer of protection

from purely frivolous lawsuits being started. Curiously, in every case that I have requested the healthcare professional and his/its insurance carrier to take advantage of this law, they have refused to do so.

N.D.C.C. §32-03.2-08 allows a health care provider, against whom a jury award for economic damages (future medical expenses, lost future wages, etc.) is rendered in excess of $250,000.00, to request that the court conduct a review of the reasonableness of such award. If the court should find that the award is unreasonable, the court is mandated to reduce the award to reasonable economic damages. N.D.C.C. §32-42-02 places a cap, or limit, on non-economic damages (pain and suffering and disability) in a medical malpractice case. An injured person or surviving family member cannot recover more than $500,000.00 for such a claim, no matter how badly they are harmed. N.D.C.C. §32-03.2-09 allows a party against whom a judgment is rendered for continuing institutional care to request that the court, in its discretion, allow periodic payments for such continuing care.

Finally, and importantly, N.D.C.C. §28-26-01 provides that if a court finds that a claim was "frivolous", the court is to award the healthcare provider reasonable and actual statutory costs, including reasonable attorney's fees, regardless of the "good faith" of the attorney for the party making the claim. In short, lawyers go out of their way to avoid frivolous lawsuits against the healthcare industry.

All of these laws presently "on the books" make it impossible to prosecute a frivolous medical malpractice lawsuit in North Dakota, without severe economic consequences in doing so. Furthermore, these laws place great discretion in the judge to monitor and, if necessary, modify unreasonable awards.

Having said all of the above, House Bill 1458 can only be intended to serve one purpose, which is to make it impossible for the average North Dakota citizen to hire a skilled attorney to represent him or her in a medical malpractice case. The attorneys' fees portion of the bill limits attorneys' fees according to a sliding scale. The title of this portion of the bill is "Maximizing Patient Recovery". This statement is a "feel good" heading, but is actually a red herring. The section begins with a provision authorizing the trial judge to change the attorney-client fee agreement and allow less attorney's fees at the conclusion based upon the "interests of justice and principles of equity". There exists no definition of these words, nor any guidance to the court. In practice, even though the client and the attorney are in agreement as to fair compensation, an attorney will never know what his or her fee will be, as it is subject to modification. The court can basically rewrite any contract between a client and his attorney. In every case the attorney faces the prospect of fighting with the client over fees even after the case is completed. It seems to me that judges have enough to do already without saddling them with decisions over fair compensation for legal services.

Maximum fees are also set on the sliding scale in the proposed legislation. Although attorneys handling auto accident cases and products liability cases are typically paid one-third for their services, attorneys who handle significantly more complicated medical malpractice claims would have their fees limited under the guise of "Maximizing Patient Recovery." Most auto accident attorneys are ill equipped to take on a medical malpractice claim. Currently, most experienced

medical malpractice attorneys have contingency agreements of 40% and many lawyers chose not to take such cases even at that rate, because the time, costs and risks involved are too great to provide a reasonable chance of recovery over the long term. As it is, it is very difficult to maintain a practice in this area. The medical malpractice attorney takes a fee only if the case prevails. The statistical evidence shows that of the cases that go to trial there is a 90% probability of no recovery to the client or lawyer.

Interestingly, the proposed legislation contains no comparable fee restrictions on attorneys who defend medical malpractice cases. While an attorney representing an injured party would be strictly limited under the propose legislation; hospitals, doctors and insurance companies can pay as much as they want for competent attorneys. Often, more than one attorney is hired to defend a case. It is not unusual for me to see two attorneys (from different law firms) and a nurse paralegal on the other side of the table in depositions and/or trials. The insurance companies also have direct and unlimited access to expert witnesses, since they already insure many of these experts. Obviously, insurance companies have extremely deep pockets, and can certainly afford to spend more on their cases than the typical North Dakota housewife or blue-collar worker who has been injured by medical negligence.

Representative Maragos, there is no doubt in my mind but that if HB 1458 passes, the net effect of this legislation will be that the citizens of North Dakota will be left with no access to the courts to redress injuries suffered due to medical negligence, because it will be impossible for them to find competent attorneys to represent them.

The periodic payments portion of the legislation must also be evaluated. First, as noted above, N.D.C.C. §32-03.2-09 already provides essentially the same strictures contained in HB 1458. Second, HB 1458 would allow the insurance company for the responsible medical provider to pay a small portion of the actual legally determined damages in a given case to the severe detriment of a North Dakota citizen injured by negligent medical care. The provision of HB 1458 applies to <u>all</u> future damages, whether economic or non-economic. Once the payments are set, they cannot be changed, regardless of changes in the circumstances of the victim, unexpected increases in medical costs, etc. The victim is "stuck" with interest rates at the time of the award. This, in spite of the fact that healthcare costs have been sustaining double digit increases for most of the last decade. One of the most troubling provisions of the proposed law is that once a judge determines the amount of periodic payments, the court moves out of the picture. The only way the injured party can later complain about missed payments, is if the injured party can prove that the "judgment debtor has exhibited a continuing pattern of failing to make payments." How many failed payments does it take to constitute a "continuing pattern?" Presumably, the insurance company will purchase an annuity to make the payments. To me, the term "continuing pattern" of failed payments is synonymous with insolvency. If the annuity company is insolvent, then it's tough luck for the injured party. In addition, this inflexible "annuity solution" for damage awards does not take into consideration changes in circumstances of the injured party, whether it be a change of medical condition, increased needs for therapy, transportation services, inflation, etc. If a negligent doctor has passed away, and the annuity company becomes insolvent, years later, when the injured party needs the compensation most, the injured party has no recourse. The courts cannot undo the situation. If the injured party

dies before the life expectancy determined by the jury, the insurance company simply petitions the court to end payment responsibilities. On the other hand, if the injured party lives beyond the annuity period, "too bad."

To sum things up, years ago the legislature passed laws to deal with frivolous lawsuits, periodic payment provisions, disclosure requirements and the like. Not once have I heard an insurance company or a health care professional state that these existing laws are somehow flawed or insufficient for their intended purpose. Comparing the laws presently "on the books" with the new law proposed, the only rational conclusion is that the sole purpose of the proposed law is to prevent injured citizens, through restriction of fees, from hiring competent counsel and thereby denying the common citizens access to justice through the courts.

I have over twenty years experience litigating these cases in North Dakota. I have never seen a frivolous case be successful. In my experience in representing patient's and their families, most of these cases are settled. The insurance companies making the settlement will generally do so subject to two provisions. First, the injured person must agree, in writing, that they will never discuss with a third person what happened. Secondly, the injured person must agree that the healthcare provider may ask the court to "seal" the public record (court file) so no one will ever find out the true facts of what occurred. I can state from first hand experience that these cases are always vigorously defended by the finest attorneys in North Dakota from very reputable insurance defense firms.

These cases are never easy. Without a doubt, they are the most difficult type of case a lawyer can handle. Presently, only a handful of attorneys in the state will consider such representation. To the best of my knowledge I know of no situation where a successful party in a medical malpractice action has complained that their attorneys fees were excessive. Removing all the jargon, this legislation serves no purpose other than to deny the citizens of North Dakota access to fair and competent representation. I urge the committee to carefully consider the repercussions of proposed HB 1458.

Respectfully,

McGEE, HANKLA, BACKES & DOBROVOLNY, P.C.

Richard H. McGee II

RHM:lmm:maragoslr

Testimony BCBSND-HB1458

It is with great reticence that we oppose HB 1458. We at BCBSND understand the recent medical malpractice insurance crisis and the ensuing costs of defensive medicine and truly believe that something needs to be done to curb those costs.

However HB1458 makes health insurance companies victims as well as the person who suffered the negligence of whatever act was committed. Our brief analysis of the amendments, and the original bill, indicate to us that insurance companies will NOT recover whatever expenses we incur as a result of a defendant being found guilty of being negligent. This solution to the collateral source rule makes victims of insurers, who have lived-up to their obligations. Thus, 1458 only creates more collateral damage by rearranging the collateral source statute.

For instance, if a doctor was found guilty of negligence in a childbirth case and we at BCBSND paid out $1,000,000 in health care costs. Under this act, unless the case was settled out of court, BCBSND would not be allowed to recover the cost it incurred as a direct result of the doctor's negligence. Thus BCBSND gets victimized, and the patient gets victimized twice as the $1,000,000 bill would exhaust his/her lifetime maximum as well as force them to live with whatever injuries the negligence caused.

Under existing law BCBSND is allowed to recover our expenses caused by the claim. As a result BCBSND recovers the $1,000,000 spent on the injury and then credits the recovery to the victim's account and allows them to continue being insured. If this act passes our costs will obviously increase and we will have to spread them across our entire membership.

In addition, it is our reading of the amendments that the only time our rights/subrogation/reimbursement/assignment contract clauses would apply would be if a settlement occurred. HB1458 states that if the case goes to trial we would be prohibited from recovering our costs (trier of fact). Adding the terms 'including any contractual allowance' disallows health and other insurance companies from recovering any expenses they incurred as a result of someone's negligence.

It's our thinking that the statute would encourage more trials since both the victim and the negligent person would not have to repay any entity for expenses incurred as a result of their negligence if they go to trial and they would have to do so under any out of court settlement type activity.

BCBSND doesn't believe that malpractice reform should create a statute that further victimizes injured parties or entities responsible for paying for the care and treatment of those who were neglected. Any reform needs to be fair to all parties in negligence actions rather than tipping the scales in favor

of the defendant. We need to remember that by the time awards are being deliberated the defendant has been found guilty. The jury has found that negligence has occurred and when that happens all party's involved need to be fairly remunerated for their efforts. We sincerely hope you will oppose HB1458.

Dan Ulmer

AVP Government Relations

Testimony on HB 1458

House Human Services Committee

Christine Hogan
Executive Director
State Bar Association of North Dakota

The State Bar Association of North Dakota represents the 1800 attorneys who are licensed to practice in North Dakota. The Association opposes House Bill 1348 for reasons of public policy. The Association is not taking a position on those parts of HB1458 that would change substantive aspects of the law of medical malpractice, but the Legislative Committee and the Board of Governors unanimously oppose the provision on page 4 of this bill that would fundamentally affect the ability of citizens of this state to make contracts with their own attorneys. This provision on page 4 of HB1458 would introduce a significant change in the law. It would authorize and would in fact *require* the judicial branch of government to interfere in private contracts between individuals and their attorneys. Aside from possible constitutional problems, this provision is unprecedented in North Dakota law. The judicial branch has not asked for and does not want this authority.

The integral, core value of the legal profession is the sanctity of the attorney–client relationship. Our system of justice casts the lawyer in the role of fighter for the person whom he or she represents. There is a strong tradition of loyalty that is attached to the

relationship between attorney and client. For generations, this tradition of loyalty, known as the attorney–client privilege, has been recognized in the law and has protected the public. The existence of the privilege provides all citizens, most especially injured citizens, a safe place to bring their problems, a place to bring their legal issues—a place where every individual's confidence will remain forever sacrosanct.

This tradition of attorney –client privilege would be fundamentally altered if judges would be given routine authority to examine and to revise the relationship—if judges were given the power to rewrite the contracts that people make with their own attorneys. Claimants in medical malpractice actions have trouble enough finding lawyers willing to take their cases. These are difficult cases, with no guarantees for anyone. The contingent fee agreement is one way that has developed over time that allows an injured claimant to have his or her day in court. To fundamentally change the current system of attorney – client privilege by requiring courts to step in and change fee arrangements between a client and an attorney after a recovery in court would cause unknowable damage to the traditional attorney –client relationship. There is no good reason to make such a drastic change in the law.

The State Bar Association of North Dakota strongly urges you to defeat this bill.

Thank you for this opportunity to appear before you.

February 12, 2003

Testimony before House Human Services Committee
Representative Clara Sue Price, Chairman

House Bill 1458

Madam Chairman Price and members of the House Human Services Committee. My name is John Olson of Olson Cichy Attorneys in Bismarck. I represent the North Dakota Trial Lawyers Association. Following are the important points we raise in opposition to House Bill 1458 relating to medical malpractice awards and attorneys fees.

1. Existing North Dakota law discourages frivolous medical malpractice lawsuits.

   a. N.D.C.C. § 28-01-46 requires a plaintiff to obtain a medical expert.
   b. N.D.C.C. § 32-42-01 requires a plaintiff to pursue alternative dispute resolution before initiating litigation.
   c. N.D.C.C. § 32-03.2-08 provides that the court review the reasonableness of a jury award in excess of $250,000.00.
   d. N.D.C.C. § 28-26-01 provides that the court can assess costs and attorneys fees against parties bringing frivolous lawsuits.

2. Limiting attorneys fees is contrary to good public policy.

   a. North Dakota Constitution prohibits any law relating to the "impairment of contracts" between private parties. (ND Constitution Art 1, Sec 18).
   b. Provisions in bill such as "interests of justice and principles of equity" are confusing and will result in unwarranted judicial review and interference.
   c. Inequity of sliding scale of attorneys fees will result in unavailable legal representation for injured plaintiffs seeking relief for medical negligence.

3. Structural periodic payments are grossly unfair and will perpetuate hardship and lack of protection for injured plaintiffs.

   a. Existing N.D.C.C. § 32-03.2-09 provides for periodic payments at the court's discretion.
   b. Severe limitations on damages to the injured plaintiff. Amount, interest accrual, change in circumstances and insolvency are all variables that are not protective of long term assurances for plaintiffs and needed recovery.

For the above reasons, I respectfully ask that you give House Bill 1458 a "do not pass" recommendation.

Thank you for your consideration of our concerns.

HOUSE HUMAN SERVICES COMMITTEE
HOUSE BILL 1458

Testimony
of
Alvin O. Boucher
February 12, 2003

My name is Al Boucher. I live at 1805 Chestnut Street in Grand Forks. I am here to testify in opposition to H.B. 1458.

I am one of three shareholders in the Robert Vogel Law Office, P.C., in Grand Forks. We are a small business which has been in existence for about 20 years. We employ six full time employees and four part-time employees. Only three of our employees are attorneys. All of our employees, including our part-time employees, earn well in excess of minimum wage. Although our law firm practices in a number of areas of law, our primary area of practice has been representing victims of health care malpractice. At the risk of sounding too melodramatic, it is our belief that if H.B. 1458 is passed, it will drastically change the nature of our practice. It will also dramatically limit our clients' ability to obtain legal counsel; and, it will put our clients' damage settlements at serious risk of loss.

The Bill, as best as I can glean, has three major provisions: (1) a periodic payment provision for future damages; (2) a collateral source provision which appears to eliminate subrogation in health care malpractice actions; and, (3) a limitation on attorneys' fees. I intend to address the attorneys' fees provision first, and then the periodic payments provision. I will let the insurance companies, Medical Assistance, and Medicare speak to the elimination of their subrogation interests by that section of the proposed legislation.

Our law office is a small business, not unlike other small businesses in this state. We often struggle to meet our payroll. In fact, we take substantial financial risks to do so. Besides paying our employees wages well above minimum wage, we provide health insurance, liberal amounts of annual and sick leave, maternity leave, paid holidays, retirement contributions, and other fringe benefits.

In other words, we substantially contribute to the economy of Grand Forks. To do this, we depend on contingency fees in our health care malpractice cases. However, unlike other small businesses, H.B. 1458 seeks to regulate what we can charge our clients in the name of medical liability reform. As far as I know, no other bill in this session limits or controls the fees or charges of other small businesses in this state in the name of liability reform, in the name of economic development, or in the name of any other so-called public good. Why is it right for government to interfere in the private business relations among the residents of this state? Since when did it become appropriate for the Legislature to tell a business what it can charge for its services. What's next? Will you tell restaurants what they can charge for pancakes and eggs? Will you tell a new high tech business what it must pay its employees? Will you tell real estate agents what fees they can charge? Will you tell a surgeon what he or she can charge for a knee surgery? Will you tell a medical malpractice insurance carrier what it can charge a hospital for insurance premiums? No, the Legislature will not because it does not want to interfere in private business. It lets the market economy determine the price. A law firm is no different from any other business. We all have costs of doing business, such as, meeting our payroll and keeping our doors open. What we charge for services is determined by our overhead. Frankly, if we charge too much for our services, market competition will cause our clients to go to other law firms.

To understand the impact this Bill will have on our business, and ultimately the ability of our clients to seek just compensation for their tragic injuries, it is important to understand what a contingency fee is and what it is not. But, prior to doing so it is also important to understand how difficult it is to represent victims of malpractice in North Dakota.

I don't know exactly how many thousands of people have contacted our office in the last twenty years about their sad stories, but it is in the thousands. The next case that comes to our office will be numbered 3047. This will be the 3047th file we have opened since our law firm was established in the mid 1980's. Almost all of these files are malpractice files. The vast majority of those cases did not result in a recovery for our clients, however. Besides these cases, we have rejected probably 3 to 4 times that many without even opening a file. Most of the people that have contacted us do not have a legitimate case; however, it takes significant attorney time and money to determine who has a good case and who does not. We must do our best to eliminate frivolous cases. When we spend 10's to 100's of hours investigating, but ultimately rejecting a case, we get paid nothing for our time. In other words, we aren't making money. This is similar to the work of a real estate agent or other persons earning money on a commission basis. What is different, however, is that most times we also lose the money we have advanced to investigate the case.

It is important to understand and accept that serious medical malpractice happens in North Dakota. According to the National Practitioners Data Bank, between September 1, 1990 and December 31, 2000, there were 191,938 payments (representing 100,241 physicians) to malpractice claimants in the United States. I do not have statistics for 2001 to the present. Of those payments, 244 were physician payments made in North Dakota

cases for the same period of time. (See www.npdb-hipdb.com) The mean payment in North Dakota was $167,869.00, and the median payment was $77,500.00. Some payments may be as low as $5,000.00, and some can be a million dollars. However, five hundred thousand dollar and greater settlements are extremely rare. For the same period of time, there were 3,202 nurse payments nationwide with only four payments attributed to North Dakota nurses. These numbers differ from the ND State Insurance Department numbers which may be discussed by the committee; but, the National Practitioners Data Bank numbers are the most accurate numbers because federal law requires the reporting and there are serious federal penalties for failing to do so. I know the reports to the Insurance Department are off because there are cases our office has settled that do not appear on the list. I believe this is because the settlements were within the deductible limits and not paid by an insurance company. The individual National Practitioners Data Bank information is protected from being discovered by consumers and their attorneys.

Over the years, we have been called to represent a client who had a breast removed unnecessarily because she was told she had breast cancer but she didn't; a client who had the wrong knee operated upon; a child client who was mistakenly given a medicine into the muscle instead of on top of the skin, causing brain damage and almost death; a number of clients operated on by the same Alzheimer's affected neurosurgeon who operated at the T1-2 level (around the shoulder blades) instead of the C5-6 level in the mid neck; clients who are victims of surgeons who still use antiquated surgical techniques that cause significant harm; clients whose cancer is missed because a positive x-ray report is not followed-up upon for over a year resulting in death. Other reported North Dakota cases include removal of the wrong kidney, fraudulent surgery, retained sponges and surgical

instruments, and sexual misconduct with patients. We have also sued physicians who were drug and/or alcohol addicted. I could go on and on. However, what is common to most of these cases is that the patients' injuries are often so devastating that they cannot work or the medical bills bankrupt them. With the exception of a few physicians, other professionals, or wealthier people that we have represented, our clients usually do not have the financial resources to pay hourly attorney fees or the costs to investigate and prosecute a malpractice action. The victims of malpractice must, therefore, find a lawyer willing to take the case on a contingency fee basis and willing to advance the costs of the case based on the hope of a substantial contingency fee.

Because state law requires expert opinion to eliminate frivolous actions, and almost no doctor in North Dakota testifies against another North Dakota doctor, we must go outside the state for expert opinion. Those experts charge from $200.00 to thousands of dollars per hour, depending on their specialty. The expert must review the medical records, x-rays, perform medical research, review depositions and give depositions. This takes a significant time committment.

I don't know if you have ever tried to get copies of your medical records, but it can cost over a dollar a page to get the records. I had one facility charge $30.00 for two pages of records. It is not rare in our more complex cases for the records from one facility to cost over one hundred dollars and the records from all the facilities that provided care to cost in excess of a thousand dollars. Our office often advances these costs because generally, the clients don't have the resources to obtain them and consequently won't get the justice they deserve.

After review of the records, an expert opinion may be negative (no malpractice). In

this situation, we do not pursue a case. Although we may have incurred $2-5,000 in costs, the client generally is unable to repay those costs to us. Therefore, our law firm must suffer the financial loss.

If there is a meritorious case, the costs to bring it to a successful resolution are astronomical. It is rare that I can settle a malpractice case in our office for less than $5,000.00 in costs advanced. Generally, our clients can't afford this expense and depend on us to advance it. In the more complex cases, our law firm has advanced over $50,000.00. I have heard of some law firms in North Dakota malpractice cases of advancing over $100,000.00 in costs to get the case through trial. We seldom have much control over the costs since most of it relates to expert opinion. Obviously, if the case is resolved successfully for the client, the costs are repaid by the proceeds. However, if the case is unsuccessful, and many are, despite very good expert opinion, our law firm, and others like ours, end up shouldering the financial costs. Although, we can and do often enter into an agreement with our clients that they must pay our costs, win or lose, the reality is that our clients do not have the money to pay us back, even if we were to sue them for the costs.

We must, therefore, rely on the possibility of a substantial contingency fee in another case to break even financially and meet our payroll. Currently, our office's standard contingency fee is ⅓ of the net proceeds after the costs of the case are deducted from the gross proceeds. Our fee goes up to 40% of the net recovery right before a trial because our office overhead and our attorney time increase greatly during this period of time. We have been doing this type of fee agreement for over 20 years. Some other law firms charge up to 40 to 60% of the gross recovery, plus costs advanced. It is true that in some cases

our fees may seem very high; however, overall our fees are not high because on average the high fees balance out the times when we earn nothing for thousands of hours of time and tens of thousands of dollars in case advances unpaid. While a $300,000.00 fee, in a million dollar recovery may seem large, it must be applied against the losses to our law firm that are suffered in other unsuccessful cases. When this is done, all of the lawyers and secretaries in our law firm make a modest living. If our ability to contract with our clients is restricted as proposed, our fees will be cut substantially. As a result, we and other attorneys will not be able to cost effectively pursue malpractice cases. It is important to realize that the defense bar and malpractice insurance claims agents go into settlement conferences bragging that there hasn't been a plaintiff malpractice trial verdict in Burleigh County for over 50 years; a plaintiff trial verdict in Cass County for about 20 years; and, a plaintiff trial verdict in Grand Forks County for over 60 years. Nationwide, plaintiffs win only one out of ten malpractice jury trials. In North Dakota, that number is significantly lower.

Quite simply put, if it is this Bill's intention to stop malpractice cases in North Dakota, it will probably do that because it will not be cost effective for attorneys to pursue the cases. (It may stop the cases, but unfortunately, it will not stop the malpractice.) If it is the Bill's intention to maximize patient recovery, it will not do that, because it will be difficult, if not impossible, for malpractice victims to find legal representation, let alone obtain any type of recovery. If the Legislature wants to truly maximize patient recovery, the Legislature should propose legislation that forces insurance companies and health care providers to settle meritorious claims much earlier. It often takes two to three years to bring a case to a final resolution, even when the malpractice is obvious.

To make matters even worse for the victims of malpractice, the Legislature wants to limit future damages to periodic payments. This is not a problem that needs fixing. Current law already requires the discounting of future damages to present value. But, what is most concerning about this provision is that it puts victims of malpractice at great financial risk. The proposed legislation does not make adequate provisions to ensure that future payments will be paid. Many insurance carriers go insolvent each year. A good example of this is Phico Insurance. This was one of the major medical malpractice insurance carriers in the United States, including North Dakota. The North Dakota Insurance Guarantee Fund is now left holding the liabilities of that company here in North Dakota. This default will have a great financial impact upon other insurance carriers in North Dakota.

The Bill further doesn't define precisely how future payments will be determined. Will the damages be discounted to present value? What interest rates, if any, will be used to compensate the victim for his or her loss of use of the money? Over what period of time will the payments be made? Who really will guarantee that the payments will be made? What affect will this have on the North Dakota Insurance Guarantee Fund? This will also add another layer of expense to the case because an economic or annuity specialist will have to be hired to determine the value of the future payments or to consult regarding the safety of the future payment. Frankly, this periodic payment provision is a mess and gives no direction to courts regarding how to proceed.

What is particularly disturbing about HB 1458, is that it singles out one particular kind of legal action. There is no evidence of a malpractice insurance crisis in this state. We have a very low malpractice claim rate compared to other states. There is no evidence that attorneys are charging too much for their services. Moreover, I see no evidence that this

legislation will lower the true cause of health care claims, which is the malpractice itself. If the Legislature truly believes that there are problems that must be addressed, shouldn't they be addressed in all legal actions and shouldn't they be addressed to the defense lawyers as well? But, in final the analysis, everyone in this country has a right to seek redress of their legal grievances in court. No one in this country, no matter their wealth and political muscle is above the law, including health care providers. This proposed legislation puts health care providers above others in the law. This is wrong and is not American justice.

Thank you.

Reach us
[illegible]dy Bradbury
Editor
[illegible]250-8251
[illegible]smarcktribune.com

In N.D., malpractice cases are public — even if public doesn't know it

■ Database run by Insurance Department

DEENA WINTER
For the Tribune

Wouldn't it be nice if, before going under the knife, you could find out whether your doctor has ever been successfully sued for malpractice?

Or whether he or she has been accused of removing the wrong kidney, failing to diagnose cancer, botching an operation, unnecessarily removing a breast, fusing the wrong discs together or leaving sponges, wires or forceps in their patients' bodies.

Consumers in other states are fighting for the right to that kind of information to help them choose physicians, but here in North Dakota such information already exists, and is open to the public's inspection. But very few North Dakotans use it.

"I don't even know if the public knows it's there," said Rolf Sletten, director of the state Board of Medical Examiners.

The little-used repository of public information has been compiled by the state Insurance Department since 1977, when lawmakers required it in response to escalating malpractice payouts and premiums and to "assure patients of receiving competent medical care."

They were ahead of their time: the databank is much older than the federal government's National Practitioner Data Bank, which has tracked malpractice payments and disciplinary actions nationwide since 1990. However, the federal databank is not open to the public — yet. Consumer advocates are pushing Congress to crack open the databank and let the public take a look at physicians' track records.

North Dakota is one of only a handful of states that already make a public record of physicians' malpractice histories. Malpractice insurance companies are required by North Dakota law to report every malpractice payment they make, along with the patient's complaint and physician's name, to the state Insurance Department.

The databank is unusual because it does not hide the names of the physicians, and reveals the amount of malpractice payments made, down to the penny. Even in cases that were settled before ever being filed in a courthouse (which is often the case), and lawsuits that were settled in a courthouse, but were sealed from the public by court order. Most malpractice settlements include a confidentiality agreement that prohibits both sides — and the court record — from revealing the terms of the settlement, including the amount of money paid out.

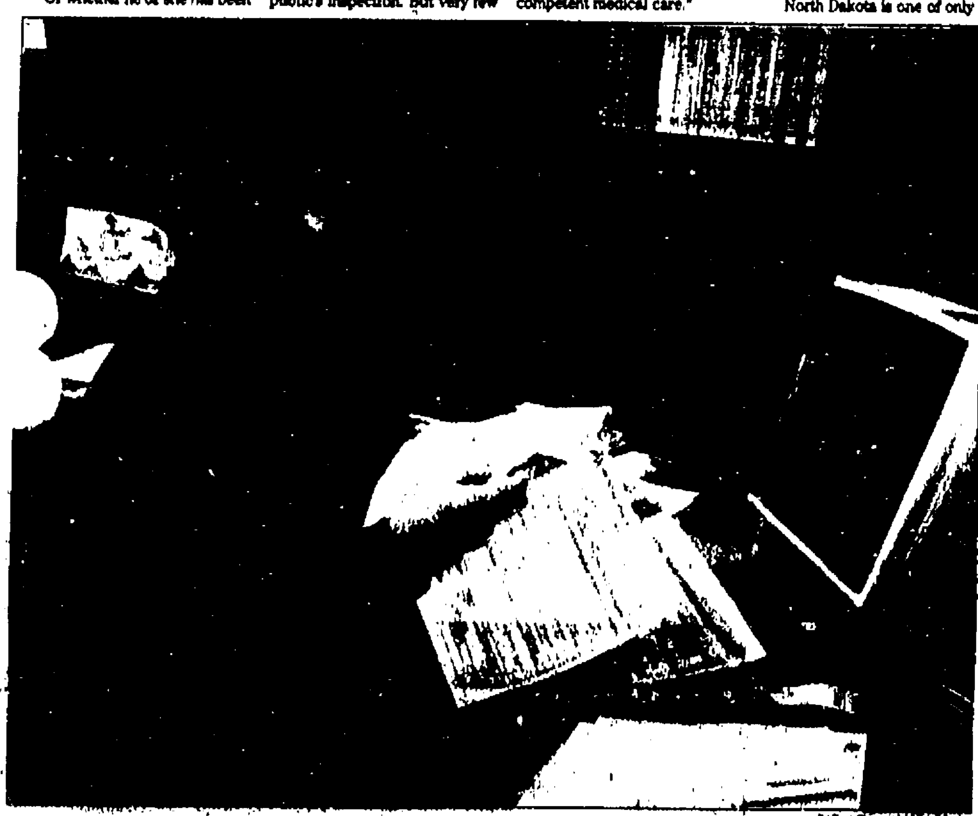
But that information is found in the Insurance Department, which was news to judges like Bruce Haskell.

"Oh really?" the district judge said. "That does kind of surprise me." He said that defeats "a lot of the goals" of confidentiality agreements.

Haskell said the vast majority of settlements are sealed to encourage settlements and protect the physician's reputation.

"The theory is that the doctor won't be subject to criticism," Haskell said.

He said malpractice lawsuits are expensive to pursue and defend, and sometimes it's more economical for the insurance company to settle cases — even groundless cases — than it is to fight to the bitter end. But he said there are pros and cons to sealing settlements: although keeping the information from the public might promote settlements, it also "allows certain things to be kept out of the public eye."



By Tom Stromme of the Tribune

Mike Andring of the North Dakota Insurance Department looks over medical malpractice claim reports before inputting them into the state's database. Andring says he processes an average of 15 claims per month.

Malpractice histories may soon be on Web

Realistically, physicians have little to fear in terms of public backlash, since the malpractice database is obscure and rarely used. Occasionally, a citizen will call the department and ask about a physician, and an Insurance Department employee will check the database for them.

But the data may soon become more accessible to the public, because the Insurance Department is considering putting the data on its Web site. That would inevitably lead more peo-

(More on DOCTORS, Page 14C)

Largest sums in malpractice

Top 10 malpractice payments by North Dakota physicians [illegible]

1. [illegible] Bismarck [illegible]

2. $1.5 [illegible] er care [illegible] plegia, (no [illegible] named), [illegible] emergency [illegible]

3. $1.[illegible] birth asphyxia suffered by C-section baby, Dr. Joel Haugen, Fargo, 199[illegible].

4. $1.10 million, lack of oxygen supply, Dr. Ray Hoag, Fargo, 19[illegible].

5. $1.09 million, transected urecha-ureters during surgery, Dr. Richard Chillag, Minot, 1997.

6. $1 million, failed to diagnose acute myocardial infarction, Dr. Glen Wiens, Williston, 1991.

7. $1 million, wrongful death, Dr. Glenn Shafir, Fargo, 1991.

8. $999,675, perinatal asphyxia, Dr. Dawn Pankow, Wahpeton, 1990.

9. $950,000, failure to treat fractured vertebra, Dr. Roger Kennedy, Bismarck, 1989.

10. Several doctors had $900,000 payments.

Source: North Dakota Insurance Department malpractice databank

'You can't see hundreds of patients a week and not make a mistake'

DEENA WINTER
For the Tribune

Even though Alvin Boucher makes a living suing physicians, he wouldn't hesitate to seek out the healing hands of some of the very doctors he has hauled into court.

The Grand Forks attorney said it's not fair to conclude that a physician is incompetent just because he has made one or two malpractice payments in his career.

"You can't see hundreds of patients a week and not make a mistake," he said. "It's just impossible. No one's perfect."

He compares it to car accidents: Does one car accident make you a bad driver? Does it mean you should never drive again?

"You can't drive that many miles and not have a fender-bender," Boucher said.

But, he adds, medical mistakes can be catastrophic. They can be deadly.

While Boucher said it's not terribly troubling for a physician to have made a malpractice payment, when the number of payments begins to pile up, consumers should begin to ask questions. He said people should look at the amount of the payment, and what kind of malpractice cases they were. What did the patients claim went wrong?

> **"Medicine is an uncertain science and not every bad outcome is malpractice, and so the trick is trying to determine which ones are and which ones aren't."**
> Attorney Alvin Boucher

Some cases are settled for a nominal sum, $5,000 to $20,000, just to get rid of them, even though they are groundless, Boucher said. They're sometimes called "nuisance claims" or "cost-of-defense claims."

And even a million-dollar payment is not necessarily a red flag, he said. If a baby somehow ends up brain damaged, it doesn't take long for the dollars to add up.

On the other hand, he said, "There's a lot of horrible doctors out there who've never had a claim against them."

But when physicians have five or six payments on their record, that's cause for concern, he said, because it's not easy for patients to get insurance companies to compensate them.

"It's extremely difficult to get a payment," Boucher said.

The deck is stacked against them: First, they have to realize that malpractice occurred, and how does the average person know, for example, that the doctor left a surgical instrument in their chest?

"Some have found a sponge or surgical instrument five years later," Boucher said.

Boucher said the best malpractice cases probably never make it into his office, because no one knows the mistake was made. For example, a misplaced dot on a prescription could lead to a deadly overdose. But if the pharmacist catches the error, was there malpractice?

Conversely, healthy people can go in for surgery and die, but that doesn't mean there was any malpractice.

"Medicine is an uncertain science and not every bad outcome is malpractice, and so the trick is trying to determine which ones are and which ones aren't," Boucher said. "You can have horrendous results and no malpractice. ... It's difficult for people to know."

And expensive to find out.

First, they have to get an attorney to file suit within the two-year statute of limitations. Sound easy? Boucher's office takes on roughly 1 out of every 15 to 20 cases that come in the door. Most people don't get beyond the first phone call, and that's not because they don't have a case, but often it's not worth the expense.

"It may not be worth it; you can't afford to bring

(More on SUITS, Page 14C)

Doctors: Cautions raised on interpreting malpractice

FROM PAGE 1C

ple to discover, and use, the databank.

"It's good information," Insurance Commissioner Glenn Pomeroy said. "It's information that's out there that people may want to look at."

Such a move would put North Dakota in the company of only two other states — Massachusetts and Florida — according to Dr. Sidney Wolfe, director of health research for the national watchdog group called Public Citizen, which he and Ralph Nader founded 29 years ago.

Although Wolfe applauds the fact that North Dakota has such a databank, he is surprised that it also includes potential malpractice claims. If a physician knows a patient is unhappy about an outcome, he or she may report it as a potential claim. Those potential claims also end up in the databank, but Wolfe thinks they should be excluded. He said the databank should include only complaints that have gone through some type of due process.

Pomeroy said if his department does put the data on the Internet, it probably would make it clear that some of the cases have not been resolved.

"It's good information. It's information that's out there that people may want to look at."
Insurance Commissioner Glenn Pomeroy

As for the rest of the information contained in North Dakota's databank, Wolfe says it should be posted on the Internet, where more people can get to it.

"It's information that patients should know about (and) would find very, very useful," he said. "As a physician, I would too."

The American Medical Association opposes such public databanks, and has fought to keep the federal databank from the public's prying eyes, saying malpractice payments are not a fair way to judge a [illegible]n's competence.

The AMA has proposed disclosing only those physicians who have made more than one malpractice payment.

But Wolfe opposes that kind of filtering, saying that would eliminate about two-thirds of the physicians. He said one doctor might have several small, relatively insignificant payments, while another might have a whopper of a malpractice payment, for, say, operating on the wrong side of the brain, as a Florida physician did.

Wolfe said even one malpractice payment can say a lot about a physician, so list them all.

The North Dakota Medical Association would "adamantly oppose" such a move, said executive director Bruce Levi.

"Settling a lawsuit doesn't mean you're a bad physician," Levi said. "Anybody can get sued."

Levi said a 1996 New England Journal of Medicine study found that negligence occurred in only one out of five malpractice cases that had been settled. He said the medical community is committed to protecting patients from incompetent or unethical physicians, but scrutinizing malpractice histories is not the way to root them out. He said liability carriers often decide to settle because it's cheaper, so even if a physician has a number of malpractice settlements, like more than 10, that's not necessarily reason for concern.

"It would depend on the individual cases themselves," he said. "Some specialties involve more of a propensity to generate lawsuits."

He said a better way to evaluate physicians is to check to see whether they've ever been disciplined by the state.

The man who administers the national databank, Thomas Croft, said he supports North Dakota's public databank, even though his is sealed.

"The public ought to have as much information as we can give them," he said.

But when analyzing physicians' malpractice track records, people should be aware that high-risk specialties — such as obstetrics and neurosurgery — are more prone to malpractice lawsuits.

"Surgery in general tends to attract more claims — anything that involves invasive procedures," Croft said.

However, he said people should also bear in mind the fact that relatively few malpractice cases end up being settled or adjudicated in favor of the patient.

Croft said a pattern of small payments can mean more than one large payment. He said experts have concluded that a pattern of malpractice claims or payments is a better indication of incompetence than the size of the payment. Hospitals confirmed that in a 1995 survey conducted by his department.

Who uses the list?

Currently, the Board of Medical Examiners is the only state entity that uses information from the malpractice databank. The board reviews all of the malpractice payments and investigates some, depending upon the nature of the claim, dollar amount and number of cases the physician has had in the past.

The board has no set-in-stone trigger for launching an investigation of a physician, but a series of malpractice payments does "raise some concern," the board's director said.

"That would be a reason to look carefully," Sletten said.

He said the databank is a useful tool for consumers, but people should not place undue emphasis on the information in it.

"A doctor can certainly have a number of malpractice cases and still be a good doctor," Sletten said. "I think that they need to be very, very careful in interpreting malpractice."

However, the vast majority of physicians nationwide have never made a malpractice payment.

Croft said about 10 percent of the nation's practicing physicians have made a malpractice payment in the past decade. And more than two-thirds of those physicians made only one payment. Only 1 percent of the nation's physicians have made more than three payments, according to statistics from the national databank.

There are 238 physicians listed in North Dakota's malpractice databank, which dates back to 1983. That's about 15 percent of the state's 1,600 physicians. Of those, most made only one payment. Only nine physicians made three malpractice payments, which is less than 1 percent of the total.

Only one doctor made more than three payments: Dr. Lee Christoferson of Fargo. During a five-year period ending in 1996, his insurance company made 12 malpractice payments totaling $1.4 million.

"A doctor can certainly have a number of malpractice cases and still be a good doctor. I think that they need to be very, very careful in interpreting malpractice."
Rolf Sletten, director of the state Board of Medical Examiners

Most of his patients claimed he botched knee, hip and shoulder surgeries or performed excessive or improper surgeries. One person was paid $35,000 after a drill bit broke inside the person's knee. Another seven cases were reported as potential claims — including one who died after surgery.

Cass County court records indicate Christoferson was sued prior to 1990, too. But Christoferson is no longer practicing medicine in North Dakota. The state Board of Medical Examiners yanked his license in 1996 and restored it in 1998, under several conditions, which he has not met, Sletten said. Even if Christoferson did meet the board's requirements, he would be barred from performing surgical procedures.

Christoferson did not respond to a Tribune request for comment.

Some physicians have reported a pile of potential claims, even though they may not have made many, if any, malpractice payments.

So[illegible] the case for one Bismar[illegible] Kenneth Mattheis has only one malpractice payment listed in the databank. His insurance company paid $160,000 to settle a case in which he was accused of removing the wrong disc during surgery.

Only one payment, but the insurance company also reported eight potential claims, including negligent and unnecessary surgeries.

Only one payment, but the state's disciplinary board still found reason to suspend Mattheis' license in January 1999, saying he "engaged in a continued pattern of inappropriate care involving inappropriate treatment/diagnosis."

Sletten said proving that is extremely difficult, akin to trying, and winning, several malpractice cases at once.

A Minot doctor has only two malpractice payments listed, but seven other potential claims reported, including two in which patients died and another whose lung cancer was not diagnosed promptly.

Another doctor reported performing an arthroscopy on the wrong knee, another removed a breast and then discovered no malignancy. One Fargo physician has paid out $250,000 because two newborns died allegedly because he failed to diagnose fetal distress and a breech baby.

Bismarck neurosurgeon George England was successfully sued for removing a portion of the wrong disc and fusing the wrong two neck bones together in 1995. The patient was awarded $50,000 in damages.

And an elderly Dickinson man was paid $300,000 after Dr. B.K. Sinha of Bismarck removed the wrong kidney, leaving the cancerous one behind, in 1987. The patient claimed Sinha did not tell him of the mistake, and tried to conceal his mistake by altering medical reports. The case was settled before trial.

Certainly, patients would be interested in reading about those types of cases when looking for a doctor. But once armed with such information, what's a consumer to do with it?

"I'm a great believer in asking your doctor questions," Croft said. "My advice — particularly in North Dakota where there may not be so many options — (is) ask the physician, 'What was this all about?' "

Suits: Few filed, few won within state

FROM PAGE 1C

it," Boucher said. "The return may not justify the expenses."

Within three months of bringing the lawsuit, the attorney must hire an expert to review the medical file and "set forth the cause of action."

It's almost impossible to find North Dakota physicians who will testify against their fellow physicians, because the pool is so small that a lot of them know each other. Out-of-state physicians charge anywhere from $300 to $1,000 for each hour of their time.

Not only are malpractice lawsuits extremely expensive to bring, they're also "very, very tough" to win, Boucher said, except in clear-cut cases, like if a doctor were to amputate the wrong leg.

"I think people should know. I think similar things should be done about lawyers."
Alvin Boucher, attorney

Very few cases ever get filed in a courthouse, and of those that do, very few go to trial, and of those, very few end up in the patient's favor.

Nationwide, the patient wins only 1 out of 10 jury verdicts, Boucher said.

According to data from the North Dakota Trial Lawyers Association, of the 54 medical malpractice cases tried in North Dakota from 1975 to 1992, only 10 patients were successful.

In light of all that, Boucher believes North Dakotans have a right to access to the state's malpractice databank.

"I think people should know," he said. "I think similar things should be done about lawyers."

But if people begin to really use the databank, he believes the state Medical Association will get lawmakers to slam the books shut.

"I guarantee it," he said.

Testimony by Paula J. Grosinger Lobbyist #193, North Dakota Trial Lawyers Association
To: House Human Services Committee, The Honorable Clara Sue Price Chairperson
Re: HB 1458
Date: 12 February 2003

"Well – Something has to be done."

Chairman Price, members of the Committee, "Well, something has to be done because Doctors can't afford malpractice insurance and some people are getting rich."

My name is Paula Crain Grosinger, RN. I am a former insurance agent. I am a Baccalaureate Degreed Registered Nurse who has worked in autonomous nursing practice, and the acute care setting, as well as the intensive long term acute care setting. In the latter I had primary nursing responsibility for the development of documentation forms including incident reports, policy and procedure manuals, and helped a new hospital successfully complete its first state survey in the patient care setting.

I carry professional liability insurance for my small business and I carry malpractice insurance as a nurse.

I am also the executive director of the North Dakota Trial Lawyers Association and a lobbyist for the North Dakota Trial Lawyers Association. The association has over 150 attorneys who provide representation to those who have been wrongfully harmed or injured.

Some of you may be wondering, "Why did she go over to the dark side?"

"Well – Something has to be done."

When 1,500 medical instruments are left inside patients each year[1]; **when one in 50 hospitalized patients is injured due to negligence[2] (American Academy of Family Physicians); when 98,000 Americans die due to hospital mistakes each year** (National Academy of Sciences and National Institutes of Medicine)[3] … Well, something has to be done.

Think about those ninety-eight thousand Americans who die from things as simple as infections caused by health care providers' failure to wash their hands, to preventable medication errors, to complex cascades of events. That's the equivalent of a DC-10 loaded with people taking off from the Bismarck airport, crashing, and killing everybody on board every day for a year.

Don't you think we'd all be saying, "Something has to be done"?

We are fortunate. We live in a community and state where most doctors have high competencies and are deeply concerned about the welfare of their patients. Bismarck has one of the top 100 Heart Hospitals in the United States and enjoys a level of health care envied by both patients and practitioners around the country. Medical malpractice premiums are about 40% lower than the national average.[19]

Testimony by Paula J. Grosinger Lobbyist #193, North Dakota Trial Lawyers Association
To: House Human Services Committee, The Honorable Clara Sue Price Chairperson
Re: HB 1458
Date: 12 February 2003

I recently completed over ten years of service on the St. Alexius Advisory Board. I am aware of the issues involved with physician recruitment and retention. The cost of medical malpractice insurance and the fear of lawsuits and plaintiff judgments are not deterrents in North Dakota. Again, we are the envy of other states. So what exactly is House Bill 1458 trying to fix?

Doctors in other states have seen malpractice insurance premiums skyrocket. But is this because of a tort crisis?

That is not supported by the facts, and certainly in North Dakota it's not supported by the facts. What the facts do show is that medical malpractice insurers, who profited from double-digit returns on their stock market investments during the 1990s, let underwriting standards slide as they bid for more customers while keeping premiums artificially low. When the market dropped, or became what is called a "hard market," insurance companies jacked up premiums to make up for their own mistakes.

Rather than blame their Enron-like accounting practices (as in the case of St. Paul Companies which released $1.1 billion in reserves between 1992 and 1997 to boost its bottom line while trying to avoid paying taxes on those reserves)[4], and rather than admit they brought problems upon themselves with their underwriting and investment practices they said, "Well, something's got to be done."

So, insurance companies, and those interested in insurance companies -- some of them at high government levels, created a crisis complete with manufactured press events and headlines that played on the public's fears:

- "Doctors are leaving practice because of frivolous lawsuits and runaway jury verdicts."
- "Health care crisis caused by greedy plaintiffs and attorneys."
- "Doctors protest high malpractice premiums: Tort reform needed."

For every problem there is a solution that is neat, simple, and wrong -- especially when the solution hasn't made the right causal connection.

What about those runaway jury awards and the explosion of medical malpractice lawsuits?

First, there is no explosion. The National Center for State Courts confirms that overall claims rates continue to decline.[5] (North Dakota Insurance Department records indicate less than 2000 reported incidents of medical malpractice claims since they started keeping records in 1983)[6]. Second, juries and medical malpractice awards aren't a significant cause of premium increases. The national jury payout average is $125,000 with the average projected payout for all claims expected to settle between now and 2010 being less than $45,000. North Dakota by the way is 49th in medmal payouts.[7] (Most tort cases result from automobile accident injuries and most civil case filings are contract disputes.[5])

Even the **Chairman of the Board of the American Academy of Family Physicians Dr. Richard G. Roberts** says it's not about the money:

"The size of the awards is driven primarily by the medical care costs of the successful plaintiff. Pain and suffering along with other noneconomic damages, can be factors in the increase in awards, but the rising cost of medical care appears to be the most significant." [8]

Roberts also notes that of the one in 50 hospitalized patients injured due to negligence, only 10% of those injured file lawsuits. That "there is more malpractice committed than is recognized, litigated or compensated... and injured patients are much more likely to sue when they believe their physicians failed to address their concerns." [8]

Former Texas Insurance Commissioner J. Robert Hunter and former state legislator now current Washington State Insurance Commissioner Mike Kreidler agree that the medmal premiums charged by insurance companies and do not correspond to jury awards but rather according to Hunter, "rise and fall in concert with the state of the economy." [9]

Even the CEO of one of California's leading malpractice insurers, Donald Zuk says "I don't like to hear insurance company executives say it's the tort system – it's self-inflicted." [4] By the way, successes in halting the rise in California malpractice premiums were not the result of tort reform. They were the result of legislated moratorium (Citizens' Proposition 103) on malpractice insurance premium increases.

House Bill 1458 and its Federal cousin H.R. 4600 are the wrong solution for this so-called "crisis."

This Bill will not reduce insurance premiums. Instead, it mandates structured settlements that will ensure malpractice victims remain vulnerable and in poverty while large insurance companies reap the interest benefits of a plaintiff's jury award. And what happens if an insurer becomes insolvent? There is no protection for the injured victim who faces a lifetime of ongoing medical expenses. Taxpayers like you and I will then be responsible for someone else's mistakes. Besides, North Dakota law already has provisions for periodic payments for those who are medically harmed and require custodial or institutional care.

Think about the cost to a family of a child with malpractice-induced cerebral palsy over the life of that child.

And what if you are a middle income or economically disadvantaged person who loses both breasts unnecessarily due to medical negligence? The contingency fee provisions of this bill would ensure that victims like Linda McDougal won't find an attorney.[10] (Fargo Forum article provided.)

If we really want to do something about malpractice premiums, we should be looking at solutions that reduce medical mistakes.

There is no open reporting of medical mistakes or even medical malpractice. [11] Most peer review systems keep the public and injured patients in the dark about which doctors cause the most harm. Performance Improvement programs and Risk Management initiatives tend to stymie reporting of actual incidents. In fact, nursing staff who file incident reports related to errors may find they are now in a hostile and retaliatory work environment. [12]

There is a national databank which is supposed to contain reports of malpractice claims paid by insurers on behalf of named practitioners, but it's of no use to medical consumers. The public is denied access. In fact, the American Medical Association provides information on their website under the **heading "How to evade a report to the NPDB** (National Practitioners Data Bank)".[13]

Well, something has to be done – but HB 1458 fixes nothing and only further harms those who have already been harmed.

Why should negligent defendants who are doctors be treated much more favorably in the eyes of the law than negligent accountants, lawyers, engineers, or even blue collar workers? A basic principle of our legal system is that all are treated equal under the eyes of the law. 1458 clearly violates this principle.

Talking Points:

- Medical errors are the 8th leading cause of death in this country. November 1999 report of the Institute of Medicine (IOM), entitled *To Err Is Human: Building A Safer Health System* http://books.nap.edu/books/0309068371/html/index.html [14]

- "More Americans die at the hands of incompetent or dangerous doctors than are killed by car crashes, homicides, suicides, illegal drug use and AIDS combined... anyone can become a victim of malpractice." [15] *National Center for Patient Rights*

- Patients are often harmed by inadequate care and outright medical mistakes in the days after they are sent home from the hospital. Nearly one in five patients have adverse events after they go home – new or worsening symptoms resulting from treatment they received, not from their underlying disease. [16]

- One out of four debtors in 1999 identified illness or injury as a reason for filing for bankruptcy. A significant number of these debtors identified tort injuries as the basis for their incapacity. As other research indicates that women receive a significantly larger proportion of their compensatory damages as noneconomic, it is notable that the study found that households headed by women, and single women, were nearly twice as likely to file for bankruptcy for medical reasons as households with a male present. For other especially affected categories, debtors over 65 years of age, 47.6% listed medical costs as a reason for filing, compared to 7.5% of debtors under 25. [17] *Elizabeth Warren, Harvard Economics Study*

- Talk about "greedy attorneys and clients." Attorneys have to bear the up front expense of hiring experts for the discovery phase of a malpractice lawsuit. This involves hiring medical doctors whose fees typically start at $400 - $500 per hour.

- HB 1458 treats malpractice victims unfairly by creating more obstacles to financial recovery, limiting their ability to obtain legal counsel, and limiting payment for counsel who must carry the burden of proof. At the same time it places no restrictions on payment for the defense.

- If those responsible for causing harm do not pay for their wrongdoing, taxpayers will have to pay instead.

- **American College of Obstetricians** and Gynecologists says a typical OB-GYN can expect to be sued 2.5 times in a career. Dr. Denise Baker, the Sarasota, FL OB-GYN referred to by President Bush in his 2003 State of the Union address has been sued four times in four years. Her practice problems cannot be said to be typical or indicative of a need for tort reform. [18]

- Attorneys face legal sanctions for frivolous cases. If **Uniform Civil Code Rule 11** is violated, attorneys fees and costs are imposed on the plaintiff.

Sources

1. New England Journal of Medicine, ***Risk Factors for Retained Instruments and Sponges after Surgery*** (http://content.nejm.org/cgi/content/full/348/3/229 Jan. 16).

2. American Academy of Family Physicians News Department, ***Tort Reform Only Part of solution for Liability Crisis*** (Leawood, KS: American Academy of Family Physicians, 17 May 2002).

3. National Academies Press, ***Priority Areas for National Action: Transforming Health Care Quality*** (Washington, DC: The National Academy of Science - Institute of Medicine 2002).

4. Zimmerman, R. and Oster C., ***Insurers' Price Wars Contributed to Doctors Facing Soaring Costs; Lawsuits Aone Didn't Inflate Malpractice Premiums; Reserves at St. Paul Distorted Pricing Picture in 1990s***, (New York, NY; Wall Street Journal, 24 June 2002).

5. The National Center for State Courts, **Examining the Work of State Courts** (Williamsburg, VA, 2001, NCSC Court Statistics Project) http://www.ncsconline.org/D_Research/csp/2001_Files/2001_Tort&Contract.pdf

6. North Dakota Department of Insurance (Bismarck, ND)

7. Doroshow, J., ***An Accident and a Nightmare*** (New York, NY, Citizens for Corporate Accountability and Individual Rights November 1998).

8. Roberts, R., ***Understanding the Physician Liability Insurance Crisis*** (Family Practice Management, October 2002); pp. 47-51.

9. Hunter, R., ***Medical Malpractice Costs a Small Fraction of Total Health Care Costs*** (New York, NY, Citizens for Corporate Accountability and Individual Rights, 14 November 2001).

10. Aamot, G., ***Woman Scarred by Medical Error Fights Bush Plan*** (Fargo, ND; Fargo Forum, 3 February 2003) p. A8.

11. United States Congress, Office of Technology Assessment, ***Defensive Medicine and Medical Malpractice***, OTA-H-602 (Washington, DC: U.S. Government Printing Office, July 1994).

12. American Nurses Association (ANA), **ANA Files Amicus Brief in Support of Six Nurse Whistleblowers** (Washington, DC, ANA Press Release, 19 June 2001).

13. American Medical Association (AMA), ***How to Avoid a Report to the NPDB (National Practicioners Data Bank)***, (AMA Web Page)

14. National Academies Press, ***To Err is Human: Building a Safer Health Care System*** (Washington, DC: The National Academy of Science - Institute of Medicine, November 1999) pp. 26-48.

15. Wittkin, Laura; National Center for Patients' Rights

16. Rubinkam, M., ***Medical Errors Follow Patients After Hospital Stays*** (Philadelphia, PA; Report on Harvard Study by Associated Press, 4 February 2003).

17. Warren, E.; Sullivan, T. & Jacoby M., (Norton's Bankruptcy Advisor, May 2000; also published in World Health Advisor – Harvard School of Public Health, May 2000).

18. Unger, H., ***Doctor Has Had Her Share of Lawsuits*** (Sarasota, FL; Sarasota Herald-Tribune, 30 January 2003) p. A1.

19. **Medical Liability Monitor**, Volume 26, Number 10 (Chicago Illinois, October 2001).

Medical errors follow patients after hospital stays, study says

Michael Rubinkam
Associated Press

Published Feb. 4, 2003 MEDS05

PHILADELPHIA -- Patients are often harmed by inadequate care and outright medical mistakes in the days after they are sent home from the hospital, according to new research.

The study, conducted at one large hospital, found that nearly one in five patients had ``adverse events'' after they go home - new or worsening symptoms resulting from the treatment they received, not from their underlying disease. Most problems could have been prevented or eased with better care.

The researchers said the problems often occur because hospitals fail to communicate effectively with patients and their primary care physicians after discharge, and neglect to follow up to identify symptoms and complications before they become more serious.

Many studies have looked at patient safety inside hospitals, including a review by the Institute of Medicine that blamed medical mistakes for the deaths of 44,000 to 98,000 hospitalized Americans each year. The latest report, in Tuesday's Annals of Internal Medicine, is the first to assess how often discharged patients become sick as a result of their treatment.

Researchers at the University of Ottawa and Harvard Medical School contacted 400 patients who were hospitalized at an unidentified urban teaching hospital.

They found 76 patients had adverse events after they were sent home. Of those, 23 were deemed preventable and 24 would have been less severe with better care.

Two-thirds of the problems resulted from drug side effects. In one case, an asthmatic patient who had a heart attack was prescribed a beta blocker, a drug that slows the heart rate but can cause asthma attacks. The patient developed wheezing and a cough.

In another case, a patient with an inflamed pancreas was sent home after his X-ray was misread. He was readmitted four days later with worsening symptoms.

Study co-author Dr. David Bates said the results demonstrate a need for

Index
ap health | science
your health
mpls.st.paul health
disease index
talk about your health
contact us

Utilities
Email this
Print this
Make us yo homepage
Search
News
More search optic

better follow up.

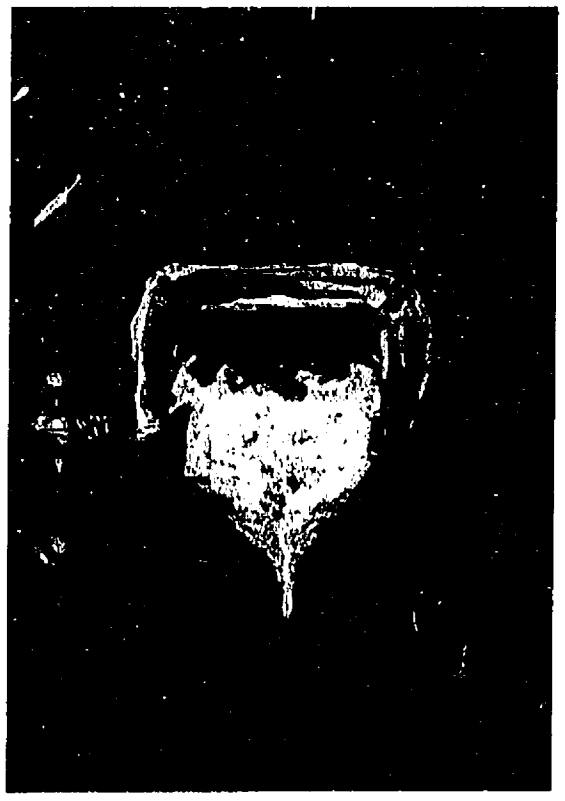
``The current reimbursement structure does not reward providers for giving post-discharge care," but ``hospitals ought to support having someone get in touch with (discharged patients)," said Bates, of Harvard's Brigham and Women's Hospital.

The study's results are not surprising because patients are discharged from the hospital more quickly than in the past - and in worse shape, said Dr. Kenneth Kizer, president of the National Quality Forum, which is working to develop better ways of measuring medical care. ``They are still vulnerable, their needs still have to be looked after and they need to be tended to."

Return to top

Understanding the Physician Liability Insurance Crisis

Just when you thought declining reimbursement and rising expenses had squeezed your practice dry, liability insurance premiums began to climb dramatically. Here's what's behind the increases.



Richard G. Roberts, MD, JD, FAAFP

In certain areas of the country, skyrocketing medical liability insurance premiums are pushing physicians out of practice and denying patients access to needed services. In eight states, premiums increased an average of 30 percent or more last year. Another 12 states saw average premiums increase 25 percent during the same period, and problems are emerging in several other states as well. (See the map on page 49.) The hot spots are states where insurers have either left the market or gone bankrupt, where awards are particularly high or where there is very active litigation in certain areas (e.g., pregnancy-related cases). Premium increases as high as 80 percent have been reported in some areas.[1]

The premium differences between these areas and those in other parts of the country are dramatic. In Wisconsin, a family doctor who delivers babies and performs cesarean sections pays about $14,000 a year for coverage that extends to infinity. Family physicians with far less coverage pay three to five times as much in some other states. Physicians in other specialties are suffering, too. In southern Florida, obstetricians spend $209,000 for $250,000 in coverage and, in effect, are essentially self-insured.

The size of the awards is driven primarily by the medical care costs of the successful plaintiff.

ILLUSTRATION BY C.M. SCHNEIDER

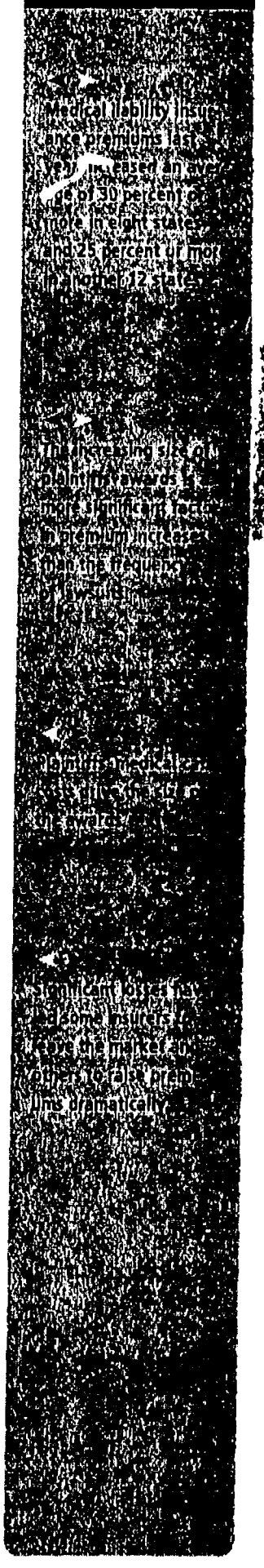
Dimensions of the problem

The most important factor in rising medical liability premiums appears to be the size of the awards, rather than the frequency of lawsuits. In Wisconsin, the number of claims filed actually decreased from 348 in 1990 to 249 in 2001.[2] In 1995, the national median for jury awards was $500,000 and the median pretrial settlement amount was about $350,000. By 2000, the median jury award had risen to $1 million, with the median pretrial settlement award at $500,000. In 2000, defendant doctors prevailed in 60 percent of all the cases that

Dr. Roberts is past president of the AAFP. He served for six years on the Board of Governors of the Wisconsin Patient Compensation Fund and for the past eight years has served on the Board of Directors of the Physician Insurance Company of Wisconsin. He is a professor of family medicine at the University of Wisconsin Medical School and practices in Belleville, Wis. Conflicts of interest: none reported.

CME
Covered in FPM Quiz

SPEEDBAR



KEY POINTS

went to a jury.[3]

The size of the awards is driven primarily by the medical care costs of the successful plaintiff. Pain and suffering, along with other noneconomic damages, can be factors in the increase in awards, but the rising cost of medical care appears to be the most significant factor.

Other important data describing the medical liability insurance crisis come from the Physician Insurers Association of America (PIAA), which represents 51 companies, many of which are doctor owned or doctor directed. In 2001, the companies' loss ratio, the amount of money they paid out for malpractice claims compared to the amount they took in, was about 116 percent. In other words, for every dollar that they received in premiums, they paid out $1.16.[4] Malpractice insurers can be profitable with a loss ratio as high as 105 percent because the difference between the amount received in premiums and the amount paid out in losses may be more than made up for by investment income earned on the premiums that are held in reserves for future pay-outs.

Malpractice carriers faced the "perfect storm" in 2001.

What happened? A robust economy in the 1990s meant more visits to doctors and excess capital. More patients going to their doctors meant a greater chance for more lawsuits in the future with higher liability costs. Excess capital meant that there was more money to invest, and the companies invested their funds in the industry they knew best – their own – by discounting their premiums below actuarial risk in order to obtain or preserve market share. The increased suits, and awards, that began to roll in toward the end of the 1990s coincided with a drop in the investment economy. Suddenly, malpractice carriers faced the "perfect storm" in 2001: Higher loss ratios (116 percent) occurred at the very time investment income plummeted (–8 percent yield), resulting in significant losses. Consequently, major carriers decided to leave the market. Among them was the second largest carrier, The St. Paul Companies, which reported nearly $1 billion in losses for medical liability in 2001.

Costs of medical liability

Several factors are crucial in understanding the true costs of medical liability: insurance premiums, defensive medicine, physician time and medical care costs.

Insurance premiums. The dramatic premium increases experienced recently by many physicians have much to do with stable or even decreasing premiums paid during the mid-to-late 1990s. At that time, insurers were looking for ways to avoid paying taxes on their reserves, which were growing rapidly as a result of significant gains in their investment portfolios. Rather than maintain excess capital on the books and pay taxes on that capital's investment income, the companies bought or preserved market share by selling policies for less than their actuarially predicted risk. The market was "soft." In other words, they sold $10,000 of risk for $5,000 in premiums to sell twice as many policies. At the time, doctors were pleased with stable or declining premiums; insurance company shareholders were happy with their rising share prices and dividends. Eventually, when the under-reserved losses finally came due and the investment economy cooled, a correction was bound to occur. That day has arrived, and the medical liability insurance market has "hardened" dramatically in the past two years.

Defensive medicine. Doing additional tests or procedures more for liability protection than patient benefit costs an estimated $40 billion to $100 billion a year.

Physician time in litigation. Physicians who are sued for malpractice spend on average about one week of their professional life dealing with the claim.

Medical care costs. Rising liability insurance premiums are part of the reason for increasing medical care costs, as doctors attempt to pass on the additional costs of

liability coverage in the form of higher patient fees. Similarly, rising medical care costs affect liability premiums as insurance companies have to pay out more for the medical care of successful plaintiffs.

Even more distressing are the indirect costs of the medical liability system, represented by changes in physician practices and relationships with their patients.

Practice changes. Without question, being sued for malpractice represents a very profound experience for physicians. According to one study of about 150 doctors who were sued for malpractice, 95 percent reported significant physical or emotional symptoms during the litigation process, 42 percent stopped seeing certain kinds of patients and 28 percent stopped doing certain kinds of procedures.[5]

Public and legislative interest in tort reform appears to increase when medical care access is restricted.

Extensive media coverage of trauma centers closing in Nevada and women driving long distances to find maternity care in Mississippi spotlight the impact that the liability insurance crisis has had on access to medical care. Public and legislative interest in tort reform appears to increase when medical care access is restricted.

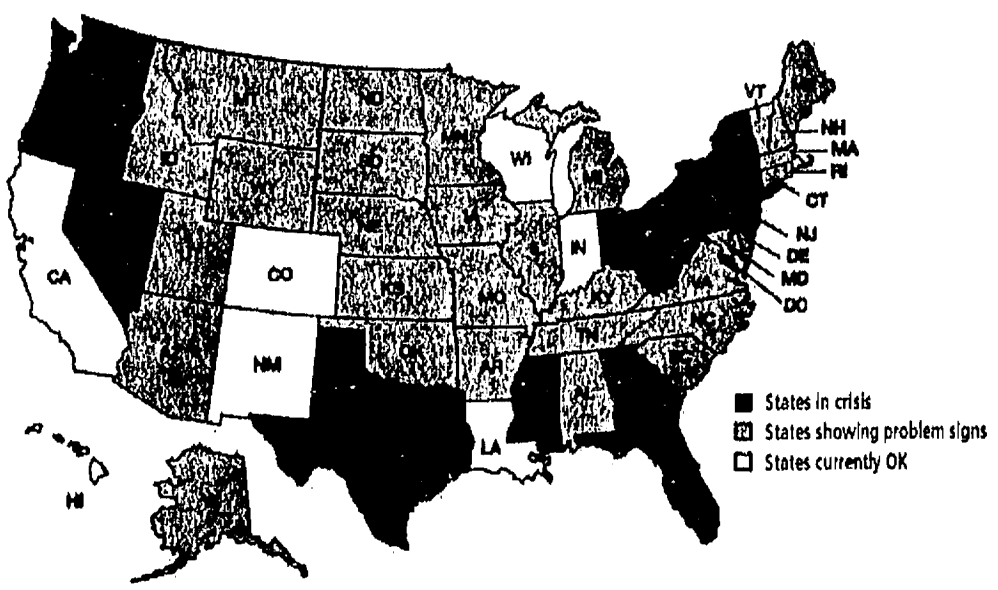
Changed relationships. Being sued can permanently change how doctors regard themselves and their patients. Some may contend that the risk of malpractice litigation is simply an inevitable cost of doing business for physicians. That point of view fails to recognize that doctoring is by its very nature an intensely personal endeavor, not one that can be treated as an arms-length commercial transaction.

Perspectives on malpractice

Doctors often assert that if there were fewer lawyers, there would be fewer medical malpractice lawsuits. While the U.S. has one-sixth of the world's lawyers, studies have shown that it is the number of doctors, not lawyers, in an area that predicts the number of malpractice lawsuits.[6] The explanation for this finding lies in the fact that more doctors in an area means more doctor-patient encounters. More encounters means a greater chance for more unwanted or unexpected outcomes, with more lawsuits as the result.

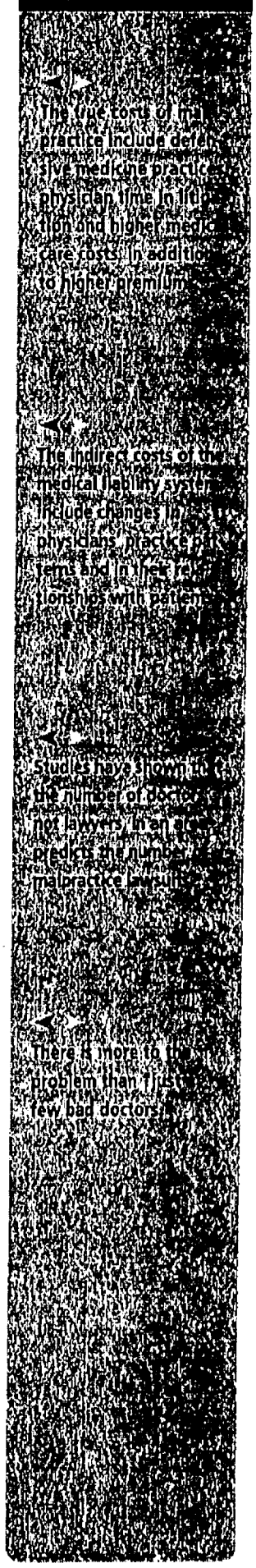
Plaintiffs' lawyers commonly attribute the problem to "just a few bad doctors" and point to studies such as one in Southern California that reported that 0.6 percent of Los Angeles County's doctors resulted in 10 percent of the lawsuits and 30 percent of the

A NATIONAL PERSPECTIVE

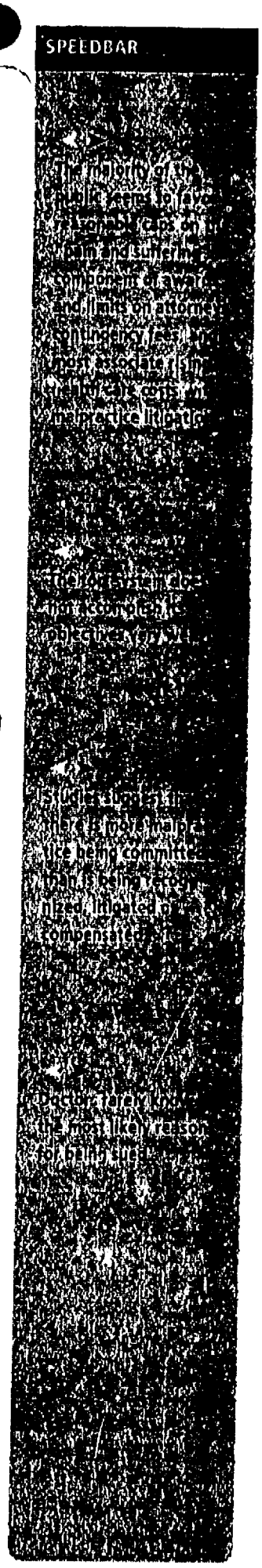


Source: American Medical Association analysis, June 2002. Available at: www.ama-assn.org/ama/pub/article/1616-6373.html. Accessed Sept. 20, 2002.

SPEEDBAR



SPEEDBAR



pay-outs in one year.[7] The problem with this study and others like it is that they look at limited periods of time during which only a small number of doctors are likely to be named in suits, while virtually every doctor is likely to be named in at least one suit over the course of a career.

Insurance companies contend that the current crisis is about matching premiums to liability: Insurance policies were sold in the 1990s for less than their projected risk and now the piper has to be paid.

The public ends up confused in the media battle for their support. Consider the combatants: the poor underpaid doctors, the lowly downtrodden lawyers and the small struggling insurance industry. All look like villains to members of the public. At this time, however, the public appears to have heard the message about premiums rising too high and creating havoc in the availability and practice of medicine. If recent surveys are to be believed, the public is sympathetic on this point.

> **One of the great dilemmas of American health care is that even as doctors are able to do more and better, patients expect more and better.**

A poll conducted in April for the Health Care Liability Alliance by Wirthlin Worldwide showed that 73 percent of respondents favor reasonable caps on the "pain and suffering" component of malpractice awards, and 76 percent favor limiting attorney contingency fees. Some 78 percent of respondents were concerned that increases in medical liability costs could limit their access to care, and 71 percent felt that malpractice litigation is one of the main reasons that health care costs are rising. Almost half (48 percent) thought there are too many lawsuits filed against doctors, although about 17 percent thought there are too few.[8]

One reason for these different perspectives is that people are not in agreement on the goals of the tort system and whether it accomplishes those objectives. Most would argue that the tort system is supposed to accomplish three goals: make the injured party whole again, punish the individual who committed the harm and put others on notice that they should avoid the behavior that caused the injury. In fact, the system does not do any of these very well.

As to making the patient whole, the Harvard study in New York State showed that fewer than two percent of patients injured as a result of negligence sued for malpractice. And the researchers estimate that "perhaps half the claimants will eventually receive compensation."[9] Several other large, important studies have found similar results. These studies suggest that there is more malpractice being committed than is being recognized, litigated or compensated. The system is not very efficient at making patients whole when fewer than 1 percent of those with injuries due to medical error ever get any money.

When it comes to punishing the individual who committed the harm, the tort system certainly exacts an emotional punishment on individual doctors, but insurance softens the financial blow.

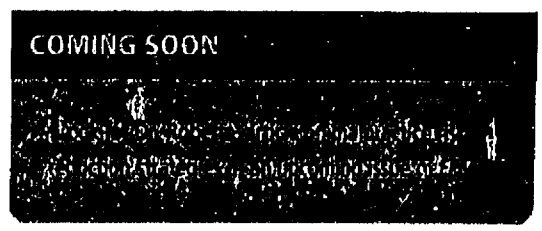
The system also falls short at putting others on notice. Doctors rarely know the most likely reasons for being sued. Therefore, they do not know what they should be doing or not doing to avoid a particular harm.

Potential solutions

There are only two ways to go through a medical career and never be named in a suit. The first is to never see a patient. The second is to keep all patients deliriously happy, because happy patients do not sue. Of course neither approach is very realistic. Another "solution" doctors may contemplate is practicing without liability coverage. As tempting as this strategy may be, many states mandate coverage by making it a prerequisite to maintaining a medical license. The following are more practical strategies for improving the current malpractice climate:

Public education. One of the great dilemmas of American health care is that even as doctors are able to do more and better, patients expect more and better. It seems difficult, if not impossible, to meet public expectations. The media contribute to this

COMING SOON



problem by sensationalizing medical advances. Physicians and the media share a responsibility to provide realistic portrayals of medical care so people have more reasonable expectations of what physicians can do.

Improved legal defense. Emerging science has made some types of malpractice cases easier to successfully defend. For example, studies show that the cause of neonatal seizures, mental retardation or cerebral palsy in more than 90 percent of affected children is unknown, but it is not due to the birth process.

Tort reform. Adopted in the 1970s in California, the Medical Injury Compensation Reform Act (MICRA) has served as a model for many tort reform efforts. Experience with MICRA-type reforms has shown that a cap on noneconomic damages (pain and suffering, loss of consortium, etc.) is the single most effective way to moderate premiums – it lowers premiums by about 15 to 18 percent.

Reducing the statute of limitations to three years for an adult also reduces premiums by about 8 to 9 percent. Restraining attorneys' contingency fees to a sliding scale that limits them to no more than a third of the overall award will bring premiums down by about 5 to 7 percent.[6] Two other reforms that can help to moderate premiums are the collateral source rule, which allows the jury to hear that there are other sources of money for the patient, and periodic payment, which allows for payments to be paid over time as they are needed (e.g., future medical costs), rather than in a single lump sum.

Alternative dispute-resolution systems such as binding arbitration or mediation, though appealing in some respects, are not necessarily more cost-effective than more traditional approaches. Loser pay systems are popular, especially in Europe, but are not generally favored by Americans.

The Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act, introduced by Rep. James C. Greenwood, R-Pa., would apply MICRA reforms to all states through federal law. Political pundits give the HEALTH Act a low chance for passage at this time. Many believe that the better strategy is to push for MICRA reforms at the state level in those states with the biggest problems.

Conclusion

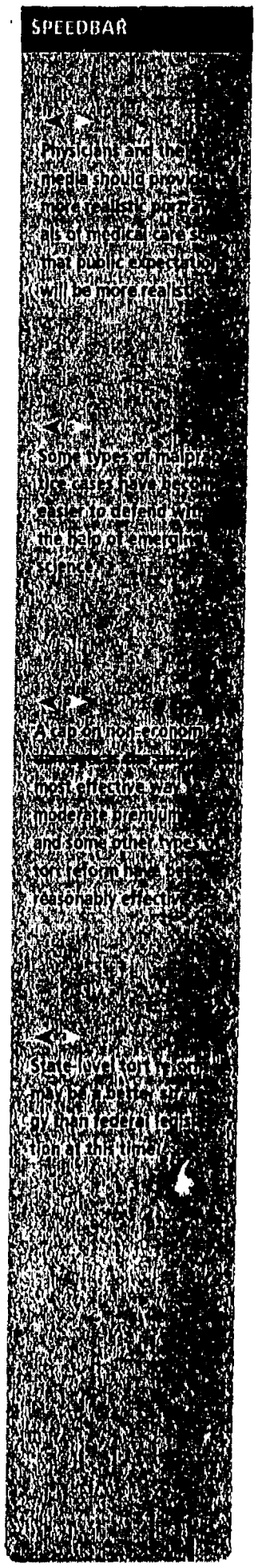
Lawsuits alleging medical negligence date back as early as the founding of the Republic. The direct and indirect costs of malpractice litigation are considerable. Liability insurance premiums fluctuate based on patterns of medical care utilization and on returns from the investment economy. The key actors in the liability system all have different perspectives on the reasons and solutions for the current crisis. While the initial temptation is to push for any and all types of tort reform, experience has shown that some reforms are more effective than others and that some may actually make matters worse. FM

> **Some tort reforms are more effective than others and some may actually make matters worse.**

Send comments to fpmedit@aafp.org.

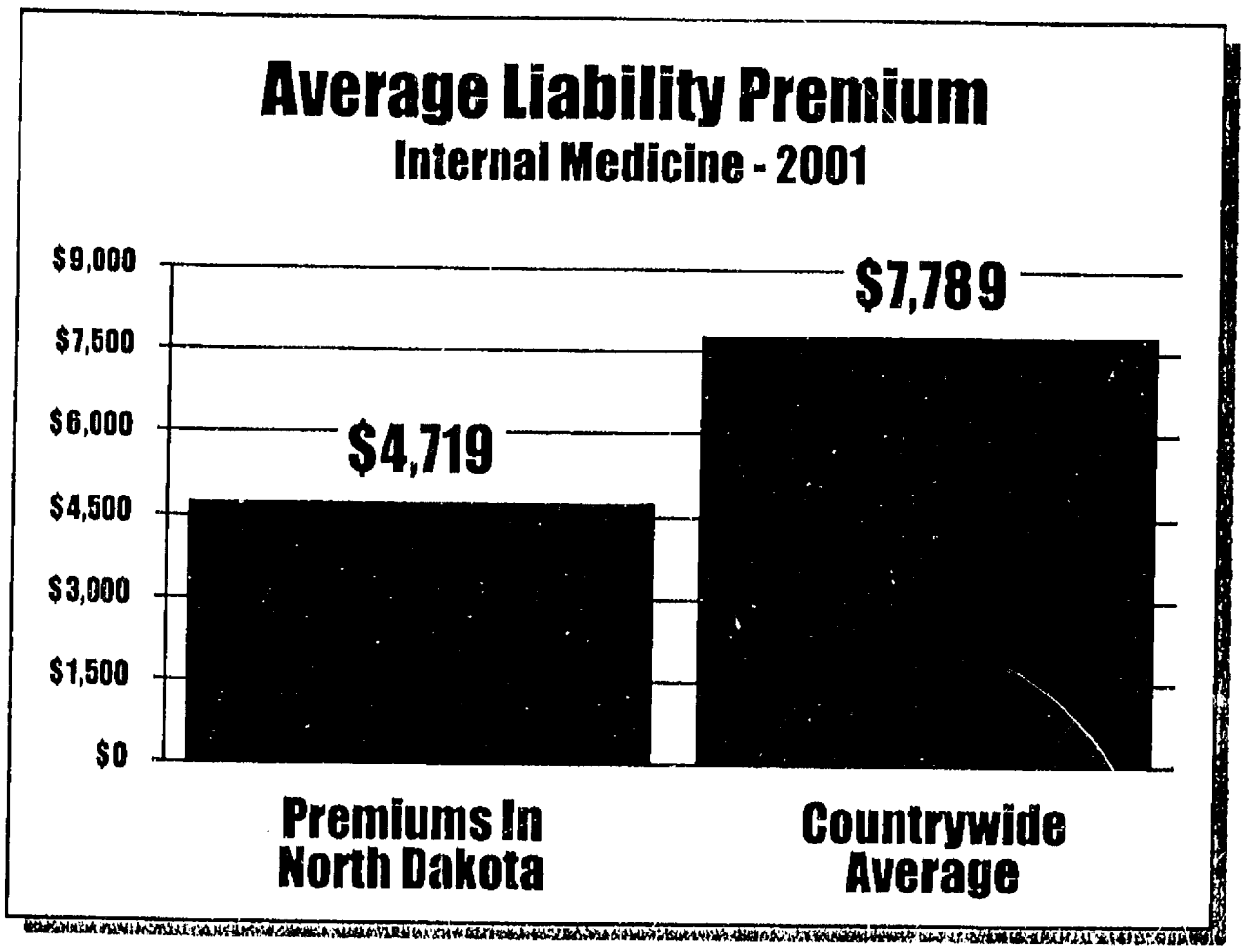
1. Albert T, Adams D. Professional liability insurance rates go up, up; doctors go away. *AMNews.* Jan. 7, 2002.
2. *Wisconsin Medical Mediation Panel Annual Report 2001.* Madison, Wis: State of Wisconsin; 2001.
3. *Medical Malpractice: Verdicts, Settlements and Statistical Analysis.* Horsham, Pa: Jury Verdict Research; 2002.
4. Smarr LE. Statement of the Physician Insurers Association of America before the Subcommittee on Commercial and Administrative Law, Committee on the Judiciary, U.S. House of Representatives; June 12, 2002.
5. Charles SC, Wilbert JR, Kennedy EC. Physicians' self-reports of reactions to malpractice litigation. *Am J Psychiatry.* 1984;141:563-565.
6. Danzon PM. The frequency and severity of medical malpractice claims: new evidence. *Law Contemp Probl.* 1986;49(2):57-84.
7. Phelps CE. *Experience Rating in Medical Malpractice Insurance.* Santa Monica, Calif: Rand Corporation; 1978.
8. Wirthlin Worldwide poll conducted for the Health Care Liability Alliance; April 2002. Available at: www.hcla.org/html/hcla0423 2002POLL.htm. Accessed Sept. 19, 2002.
9. Localio AR, Lawthers AG, Brennan TA, et al. Relation between malpractice claims and adverse events due to negligence. Results of the Harvard Medical Practice Study III. *N Engl J Med.* 1991; 325:245-251.

SPEEDBAR



Medical Malpractice Insurance

Are North Dakota Premiums Out Of Control?

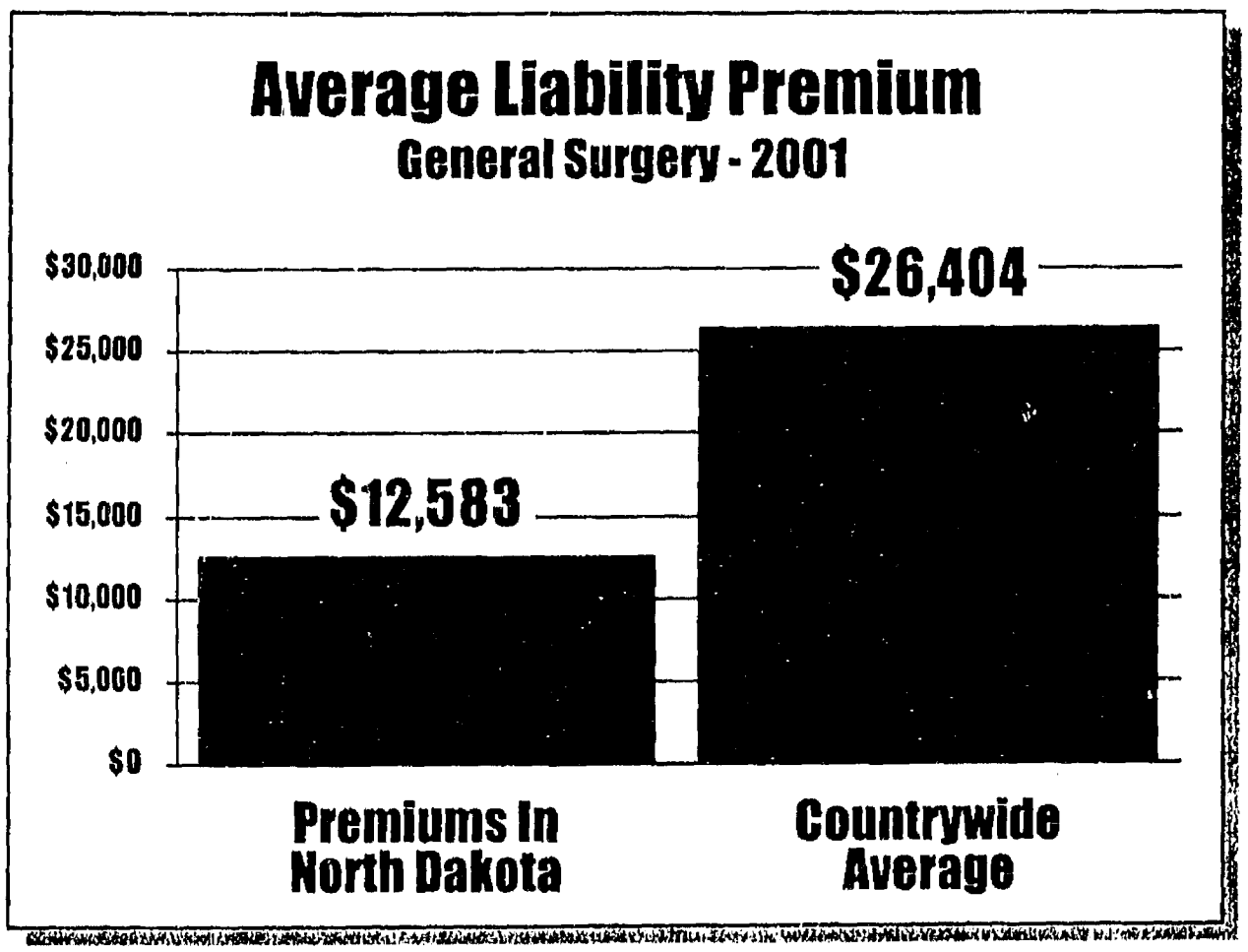


- **Internal Medicine Premiums Countrywide Are 65% Higher Than They Are In North Dakota**
- **Caps Do Not Bring Down Malpractice Premiums**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

•Derived from data provided by Medical Liability Monitor (vol 26, #10 – Oct 2001) A state's average premium is calculate as the unweighted mean value of premiums for all companies for which data is provided across all regions. A state is classified as having a "cap" when there exists a general noneconomic damage cap that affect medical malpractice or a broad medical malpractice specific cap on noneconomic damages. Caps that affect one area of medical malpractice (e.g. just wrongful death cases) or punitive damage caps are not counted since these represent a small number of cases.

Medical Malpractice Insurance

Are North Dakota Premiums Out Of Control?

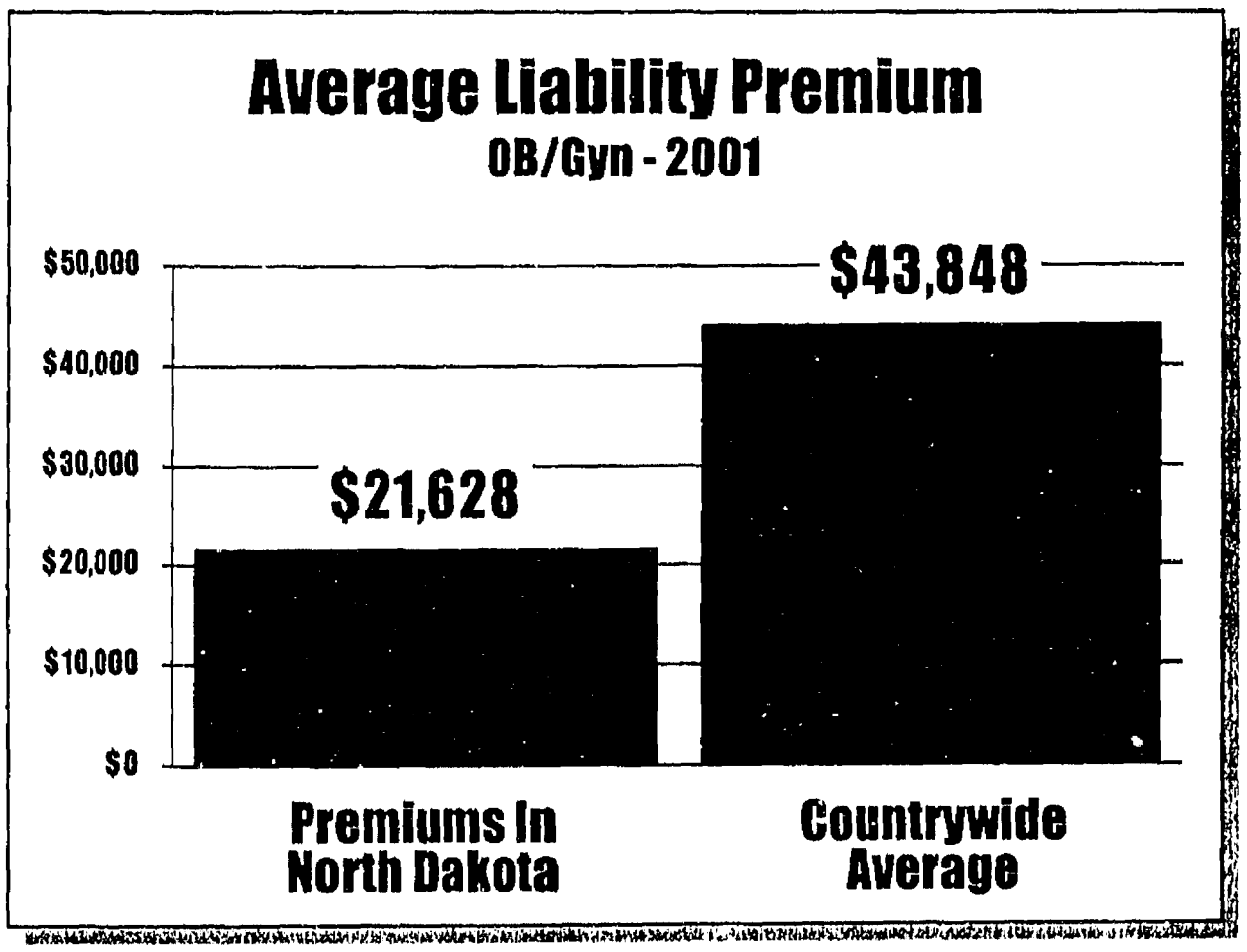


- **General Surgery Premiums Countrywide Are 109% Higher Than They Are In North Dakota**
- **Caps Do Not Bring Down Malpractice Premiums**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

Derived from data provided by Medical Liability Monitor (vol 26, #10 – Oct 2001) A state's average premium is calculate as the unweighted mean value of premiums for all companies for which data is provided across all regions. A state is classified as having a "cap" when there exists a general noneconomic damage cap that affect medical malpractice or a broad medical malpractice specific cap on noneconomic damages. Caps that affect one area of medical malpractice (e.g. just wrongful death cases) or punitive damage caps are not counted since these represent a small number of cases.

Medical Malpractice Insurance

Are North Dakota Premiums Out Of Control?

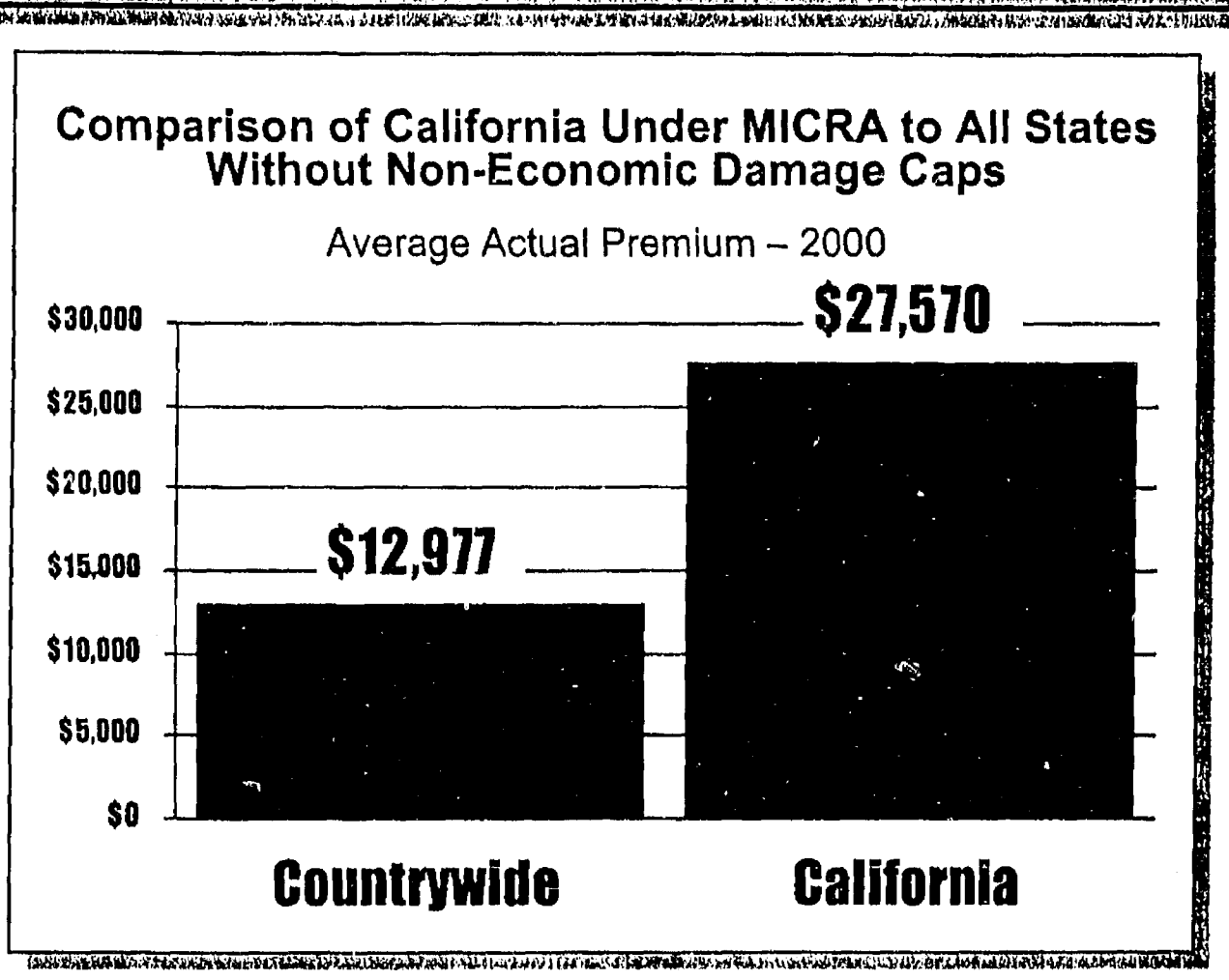


- **OB/Gyn Malpractice Premiums Countrywide Are 102% Higher Than They Are In North Dakota**
- **Caps Do Not Bring Down Malpractice Premiums**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

•Derived from data provided by Medical Liability Monitor (vol 26, #10 – Oct 2001) A state's average premium is calculate as the unweighted mean value of premiums for all companies for which data is provided across all regions. A state is classified as having a "cap" when there exists a general noneconomic damage cap that affect medical malpractice or a broad medical malpractice specific cap on noneconomic damages. Caps that affect one area of medical malpractice (e.g. just wrongful death cases) or punitive damage caps are not counted since these represent a small number of cases.

Medical Malpractice Caps

California Rates Are Higher Than States Without Caps

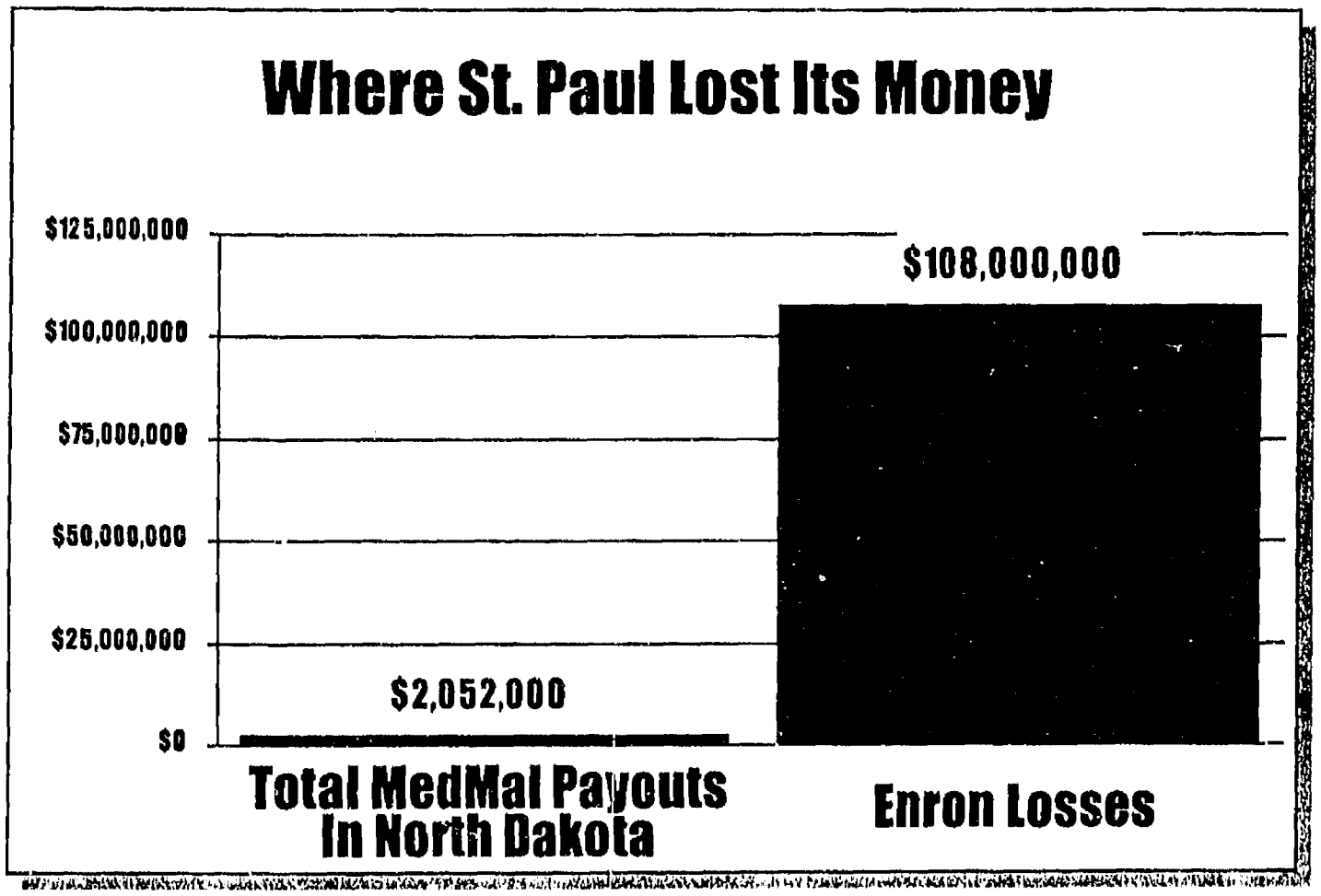


- **California Has The Most Restrictive And Severe Medical Malpractice Caps In The Country**
- **The Source Used By The Bush Administration Indicates That Premiums Are 112% Higher**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

SOURCE: Medical Liability Monitor, 2001. Dollar values represent the combined average of all premiums presented for OB/GYNs, Internists, and General Surgeons among the selected states, 2000-2001.

Medical Malpractice Caps

Is Medical Malpractice Really St. Paul's Problem?



- **St. Paul Lost 53 Times More In The Enron Fiasco Than In North Dakota Malpractice Claims**
- **Bad Investments Are St. Paul's Real Problem**
- **Deterring Malpractice Is The Best Way To Bring Down Costs & Protect Our Families**

Source: North Dakota Medmal payments for 2000 as reported in the AM Best State/Line Report, Format A3. St. Paul announced on December 4, 2001, an exposure of $85 million after taxes due to the Enron bankruptcy. Additionally, they have reported that they hold $23 million par value on Enron Corporate Senior Unsecured debt.

McDougal Transcript

My name is Linda McDougal. I am 46 years old. I am from a small Norwegian community in north western Wisconsin, about 35 miles east of the twin cities, called Woodville, Wisconsin. The population of my town is a little over one thousand, we are small town USA.

I am a veteran of the United States, and my husband is too. We both served in the Navy, and 8 months ago... In preparation for an annual physical, I went to the hospital in the twin cities, for a routine mammogram. I was called back, ah... for additional testing and they proceeded with a needle carbiopsy, and within a day I was told that I had breast cancer.

The following week, I met with a surgeon, and the surgeon laid out my options. I could go for a lumpectomy or a single mastectomy or a double mastectomy. With the lumpectomy and single mastectomy, I was quoted statistics on, umm.... Chances of reoccurrence within five to six years.

I was told that I would have to go on chemotherapy and radiation, possibly followed by a drug called tomoxifin. I went in and discussed this with my husband at length. We—my world was shattered at this point, but we discussed it and decided on the most aggressive form of treatment to us. And that was the double mastectomy.

Surgery was set up and I had the procedure done at United Hospital in St. Paul, Minnesota. Forty-Eight hours after my surgery, the surgeon walked in my room and told me 'I have bad news for you,' you don't have cancer.

Not—being in shock...my husband was with me, uh...we were reduced to tears, and we couldn't get out of the hospital fast enough. I dealt with shock for many days. To some extent I am still suffering from a deal of shock. Uh... my... its difficult when its easier to accept the fact that you have cancer, than to accept the fact that you don't have cancer.

Its difficult to accept the fact that I don't have cancer because my—the trust I have in the medical profession was betrayed. The pathologist apparently had switched slides with the paper work, and made a...very big mistake.

Its been very difficult for me to deal with this....uh... several weeks after my—the removal of my breasts, I had infection. Uh... I had to undergo an emergency surgery to remove...part of the reconstruction materials that had caused an—there was an infection raging through my body.

I am still fighting infection it's been seven and a half months. And I am still fighting infection and cannot continue with the reconstruction process. I don't at this time, I don't know how long it's going to take me, but it could be a year, maybe two before I have anything that...I can't see how its even going to resemble anything like a breast. Uh... they assure my that it will, but I can't see it.

What the future holds for me, I—I don't know. I know...that...limits on....limits on the ability to sue doctors is not the answer. In my particular case I was told when I came public with this, that the pathologist involved had a ten year period of exemptlamentry performance, and that they don't reprimand or punish this doctor until a second reoccurrence—or second occurrence. I don't understand that if somebody has to die, but to limit—put limits on what I need in the future is not fair.

I feel like I have to speak out for all the victims out there that can't speak for themselves, uh because there are victims. You could be a victim tomorrow. Umm... I think everybody needs to ask....they need to speak from there heart and their conscious, instead of to corporate America and the insurance agencies. Rather than deal with ...umm... putting limits on my recovery over the future years, you need to address why this happened. The need to get to the root of the problem and stop—stop the medical mistakes from happening.

Doctors aren't held accountable, and they need to be. That is all I have to say.

February 12, 2003

HOUSE HUMAN SERVICES COMMITTEE
HB 1458

CHAIRMAN PRICE AND COMMITTEE MEMBERS:

My name is Jack McDonald. I'm appearing here today on behalf of The Arc of North Dakota. The Arc is an open membership organization made up of people with mental retardation and other related developmental disabilities, their families, friends, interested citizens, and professionals in the disability field.

The Arc of North Dakota has over 1,200 committed members and friends...your neighbors and constituents...in chapters in **Grand Forks, Fargo, Valley City, Jamestown, Bismarck, Dickinson** and **Bowman.**

The Arc has a number of legislative priorities for the 58th Legislative Assembly. One of them is to do everything it can during this session to assist those we serve who suffer from mental retardation.

The Arc is concerned about the impact this bill will have upon victims of medical malpractice, and particularly about malpractice that happens during childbirth that might result in mental retardation or other developmental disabilities. This, unfortunately, is not an uncommon occurrence.

Statistics indicate that up to 98,000 people are killed each year by medical mistakes. Most people do not pursue legal action. Those who do pursue legal remedies most often lose. Doctors win about 75-80% of all malpractice cases.

HB 1458 addresses the small number of malpractice victims who may actually win a case, and penalizes them for winning by: (1) having their damages reduced by collateral sources; (2) having their damages reduced to a periodic payment schedule; and (3) having their attorney fees capped. The net result of 1 & 2 is that injured victims of malpractice will recover far less than they deserve. The net result of 3 is that victims of malpractice will not be able to find attorneys to take their cases. This will be particularly hard on those who will suffer mental retardation for the rest of their lives.

North Dakota has malpractice insurance premiums that are among the lowest in the nation. The problem the bill is designed to address does not exist here. There aren't many malpractice verdicts in the history of the state, but one of them out of Minot is a malpractice case which resulted in a verdict for the family of a baby who was negligently delivered and has multiple lifelong disabilities (including profound mental retardation) as a result of the doctor's lack of care. Under HB 1458, the family's recovery would have been greatly reduced, and there would be no guarantee that the recovery would even cover the care costs caused by the malpractice. If the doctor who caused the injury isn't going to pay for the care costs, then the costs fall back on the family and then to all of us through the Department of Human Services, as this committee knows full well.

There is ample evidence that the increase in malpractice costs is more closely related the management and investment practices of the insurers than to lawsuits. As indicated above few people pursue lawsuits, and those who are awarded large verdicts are usually awarded those verdicts because of the cost of future care.

We urge a do not pass. If you have any questions, I will be happy to try to answer them. THANK YOU FOR YOUR TIME AND CONSIDERATION.