



STATE LIABILITY REFORM TRENDS:

Caps up, alternatives abound

by

JON H. SUTTON,

*Manager, State Affairs,
Division of Advocacy and Health Policy*

Over the past few years, many state legislatures have made medical liability reform a key issue. Spurring this renewed interest are the annual double-digit increases in medical liability insurance premiums that have forced some surgeons and other high-risk specialists to close their practices or discontinue certain procedures, leading, in turn, to decreased access to care. Other driving factors include the fact that trauma centers have had difficulty meeting coverage requirements for surgical and specialty care, and, in some parts of the country, women report having to travel far from home for obstetrical services.

To respond to these problems, states have typically sought to enact medical liability reforms modeled on California's Medical Injury Compensation Reform Act (MICRA). Passed in 1975, MICRA includes a \$250,000 cap on noneconomic damages, modifications to the collateral source rule, mandatory periodic payments of future damages, and a sliding scale for plaintiff attorneys' contingency fees. MICRA is considered the "gold standard" in reform, and the College, the American Medical Association, and national specialty societies believe legislation of its type best addresses the problems with our current tort system at both the state and federal levels (see page 18).

State experience with caps

Perhaps the most critical, and most controversial, component of MICRA is the cap on noneconomic damages. These damages are generally defined as compensation for physical and emotional pain, suffering, inconvenience, mental anguish, loss of enjoyment of life, and other intangible nonmonetary losses. The personal injury bar and many consumer groups fiercely oppose caps on noneconomic damages, making it difficult to pass them as part of a broader medical liability reform package.

Those states that have passed caps have often gone with a dollar amount that is higher than MICRA's \$250,000 limit. In many cases, an annual inflation adjustment has been incorporated, because one of the criticisms of MICRA is that the amount of the cap has stayed the same for almost 30 years. The chart on page 18 listing states with caps shows that most of them exceed the \$250,000 limit.

During the 2004 legislative session, almost every state that considered legislation containing a cap on noneconomic damages as part of medical liability re-

form placed that cap above the MICRA level of \$250,000. Only the District of Columbia, Iowa, and Georgia held true to the MICRA cap, but their bills were either still under consideration (DC), vetoed (Iowa), or defeated in the legislature (Georgia). This trend is likely to continue, especially in those state legislatures where medical liability reform is an extremely contentious issue and the cap level is seen as a negotiating tool.

Trends and alternatives

Even though the College and other medical organizations consider MICRA to be the ideal method of medical liability reform, political realities in some states have impeded the enactment of these reforms. Instead, some elements of MICRA may be adopted, or other viable options, such as medical review panels or alternative dispute resolution mechanisms, may be considered. Some alternative reforms are as follows.

1. *"I'm Sorry."* Some states have recently enacted legislation loosely referred to as "I'm Sorry" laws. Since 2003, five states have adopted this approach, with four doing so this year. Colorado was the first state to adopt this reasonable reform, with Ohio, Oklahoma, Wyoming, and North Carolina following suit.

What exactly does an "I'm Sorry" law do, and why should it interest physicians? For years, physicians have found frustrating their lawyers' advice that they not talk to a patient or family member when an adverse incident or outcome occurs. Physicians generally are compassionate, caring, and honorable individuals. It goes against a physician's natural inclination to withhold an expression of sadness or an apology for a procedure that failed to turn out as anticipated, regardless of whether a mistake was made. Defense attorneys warn that such conversations could be construed as admissions of guilt in medical liability lawsuits. Yet, in many cases, patients or families have indicated that if the physician had just sat down with them, explained what happened, and apologized for the mistake, they might not have filed a lawsuit.

North Carolina recently passed an "I'm Sorry" law. Under this statute, "Statements by a health care provider apologizing for an adverse outcome in medical treatment, offers to undertake corrective or remedial treatment or actions, and grati-

MEDICAL LIABILITY REFORMS SUPPORTED BY THE ACS

- Cap noneconomic damages at \$250,000 with no limits on economic damages.
- Eliminate the collateral source rule to allow introduction into evidence any collateral source payments and allow offsets for those payments.
- Modify joint and several liability so that defendants are only liable for their own portion of noneconomic and punitive damages.
- Allow periodic payment of damages for future damages over \$50,000.
- Establish a sliding scale for attorney contingency fees of up to 40 percent of the first \$50,000; 33-1/3 percent of the next \$50,000; 25 percent of the next \$50,000; and 15 percent of any amount over \$600,000.

STATE CAPS ON NONECONOMIC DAMAGES

Alaska	\$400,000*
California	250,000
Colorado	300,000
Florida	500,000*
Hawaii	375,000*
Idaho	250,000*
Indiana	250,000
Kansas	250,000
Louisiana	500,000 (total damages)
Maryland	635,000
Michigan	349,700*
Mississippi	500,000
Missouri	565,000
Montana	250,000
Nebraska	1,750,000 (total damages)
Nevada	350,000*
New Mexico	600,000 (total damages)
North Dakota	500,000
Ohio	350,000*
Oklahoma	300,000*
South Dakota	500,000
Texas	250,000
Utah	400,000
Virginia	1,700,000 (total damages)
West Virginia	250,000*
Wisconsin	410,000

*Indicates exceptions to cap; **bold** notes annual adjustments.

Source: AMA Advocacy Resource Center.

itous acts to assist affected persons *shall not be admissible* to prove negligence.”

Oklahoma used slightly different language in its “I’m Sorry” law, which is modeled on the Colorado statute. Those states permit a physician to express sympathy, commiseration, condolence, compassion, or a general sense of benevolence to the patient, the patient’s family, or a representative of the patient for an injury sustained as the result of an unintended outcome. If a physician makes such a statement, it cannot be admitted into evidence and used as an admission of liability.

2. *Letting the voters decide.* Some state constitutions prohibit caps on noneconomic damages. In those cases, it has been necessary to take the issue to the voters, with Oregon and Wyoming doing so in 2004. Both states have ballot initiatives in November asking voters to approve constitutional amendments, and with public opinion polls showing strong support, these amendments are expected to pass despite a bitter fight by the personal injury lobby.

Ballot initiatives in Florida deal with issues beyond caps on noneconomic damages. The Florida Supreme Court has approved four constitutional amendments: one from physicians and three from trial attorneys. The physician initiative would restrict attorney contingency fees to 30 percent of the first \$250,000 awarded in a medical liability lawsuit and 10 percent of all damages in excess of \$250,000. On the opposing side, the trial attorneys will likely procure a spot on the ballot for two amendments. The first would revoke the medical licenses of physicians who have been found at fault in three or more cases of medical malpractice, and the second would entitle patients and their families to have access to all medical records.

Nevada voters will decide on a series of ballot initiatives relating to medical liability reform. Ballot Question #3, supported by the medical community, would impose a firm cap of \$350,000 on noneconomic damages per action; repeal joint and several liability for economic damages as is currently the case for noneconomic damages; limit attorney contingency fees; and permit periodic payment of future damages. Two others, Ballot Questions #4 and #5, written by personal injury lawyers, would repeal existing medical liability reforms and make it impossible for the

Nevada legislature to enact any reforms in the future.

A few states have taken a slightly different approach. Although their constitutions may not directly prevent the enactment of caps on noneconomic damages, there is fear that a less-than-sympathetic state supreme court could hear a case and declare the caps unconstitutional, which has happened in Illinois and Ohio. Physicians in Michigan, Ohio, and Texas realized that one way to address this threat was to elect supreme court justices who support caps on noneconomic damages. They were successful in their efforts, but Texas went a step further in 2003 with voters approving a constitutional amendment clearly allowing the legislature to enact caps.

3. *Municipalities enact reforms.* An innovative approach to enacting medical liability reform is under way in Illinois. In response to the Illinois General Assembly’s refusal to pass meaningful medical liability reforms, two municipalities enacted reforms of their own. Marion and Carbondale, two downstate Illinois cities severely affected by the loss of surgeons and other high-risk specialists, approved similar ordinances under the rubric of home rule authority granted by state statute. Because there is some question as to whether home rule actually permits the towns to enact reforms in this way, it will be up to the courts to decide when cases may be filed under these city ordinances.

The reforms in the Marion ordinance include: limiting noneconomic damages to no more than three times the damages awarded for economic loss; requiring that lawsuits resulting from treatment given in Marion be filed in the local Williamson County circuit court; holding the losing party responsible for all costs, including court costs and attorneys’ fees; basing economic damages on tangible loss for cost of past and future medical and hospital expenses, loss of income, and other property loss; and exempting from liability emergent or acute care that is provided within the city in a usual and customary manner.

4. *Alternative dispute resolution (ADR).* The principal objective of alternative dispute resolution is to promote quicker and less costly resolution of claims. Because the U.S. civil justice system has exceptionally high administrative costs (lawyer fees, expert witness fees, insurance com-

pany overhead), most of the business sector has aggressively adopted ADR. The health care community has lagged behind.

ADR can take many forms, such as mediation, arbitration, mini-trials, summary jury trials, moderated settlement conferences, and hybrids of any of these approaches. Some ADR programs are voluntary (both parties voluntarily agree to try to resolve their dispute with a particular ADR system), while others are mandatory (the parties have no choice; they are required by statute or contract to participate in the ADR process). If participation is voluntary, the ADR decision is more likely to be binding on the parties. If participation is mandatory, the ADR decision is often, but not always, nonbinding.

The College supports the inclusion of statutory provisions in federal medical liability reform directing the U.S. Secretary of Health and Human Services to provide grants to states for the development and implementation of ADR programs. States would have flexibility in devising their ADR programs as long as federal standards were met. These standards should require ADR systems to incorporate some sort of disincentive to proceeding through the court system so that ADR would be a cost-effective and faster way of resolving claims rather than a costly "add-on" to the litigation process. At a minimum, the ADR decision should be admissible in court if the parties proceed to litigation.

Utah is one state that has adopted an ADR process, which includes pretrial screening, mediation, and arbitration. State law requires that a prelitigation hearing be conducted on a medical malpractice claim to determine its merit before a lawsuit may be filed in court. The panel is composed of an attorney, a physician, and a member of the public. The decision of the panel is nonbinding and cannot be referenced in any future legal proceeding.

Under Utah's arbitration statute, physicians may enter into a predispute binding arbitration agreement with a patient. The physician must give a special, easy-to-read written disclosure to the patient when presenting the arbitration agreement, must ask the patient to read it, and must answer any questions the patient might have. Patients may decline to sign the agreement but must still receive care. A patient also may rescind an agree-

ment within 10 days of signing it. Agreements are automatically renewed annually unless terminated with written notice at the anniversary of the agreement.

Patients may have legal counsel for an arbitration proceeding, and may request mandatory mediation before arbitration. If arbitration is selected, both parties may agree to a single arbitrator. In other cases, a three-arbitrator panel is selected: one by the patient, one by the health care provider, and the third agreed to by both parties. The arbitration proceeding may be split into the issues of fault and damages, and the parties may agree to change the arbitrator on damages if they wish. Once the panel is finished with its deliberations and an award is determined, the damages are filed as a judgment against the provider in the appropriate district court.

Moving forward

As states continue to struggle with the medical liability insurance crisis, surgeons can expect legislatures to consider various solutions to the problem. While many of the approaches discussed in this article fall short of MICRA, they are positive steps toward stabilizing the marketplace and should be considered part of an overall medical liability reform strategy. For those states that have enacted tort reforms, the approaches in this article may add to and enhance their liability laws.

When many legislatures convene in early 2005, reform advocates will again take their case to policymakers, the courts, and the people. ACS chapters are encouraged to actively participate in these reform efforts by joining medical liability reform coalitions, contacting state legislators, holding advocacy days at the capitol, and other grassroots activities. To help the chapters in these efforts, the College has created a *Medical Liability Reform Action Guide* that contains valuable advocacy resources. It may be accessed at <http://www.facs.org/ahp/proliability.html>. In addition, State Affairs staff are available to assist with grassroots advocacy. □