MINUTES OF THE MEETING
STATE ADMINISTRATION COMMITTEE
MONTANA STATE SENATE

MARCH 27, 1986

The first meeting of the State Administration Committee of the 49th Legislature, Second Special Session, was called to order by Chairman Jack Haffey on Thursday, March 27, 1986 at 9:00 a.m. in Room 331 of the State Capitol.

ROLL CALL: All members were present, however, Senator Manning arrived late. John McMaster, staff attorney, was also present.

CONSIDERATION OF SENATE JOINT RESOLUTION 1: Senator Tom Towe of Senate District 46,the chief sponsor of Senate Joint Resolution 1, gave a brief summary of the bill. This is a joint resolution of the Senate and the House of Representatives of the state of Montana requesting an interim study of insurance-related problems, including the high cost or unavailability of liability insurance, proposal for general tort reform, and general questions involving public and private liability issues; requiring a report of the findings of the study to the 50th Legislature.

Senator Towe stated that this resolution is being introduced because of the "insurance crisis" in the state at the present time. He told of an example, that many small towns in Montana face the possibility of losing their obstetrics departments because of the high cost of insurance and the unavailability of it. Many people may be at fault for the complex situtation which is recognized by the governor. It is something that cannot be solved in a just a few days because of the complexity of the issue. This resolution is in no way meant to replace the proposed insurance bills. An interim committee is needed to study all of the problems and possibilities and talk with the experts. Nobody knows what needs to be done. The situation is very important and it is very real.

Gerald Neely, an attorney from Billings, spoke on behalf of the Montana Medical Association. He stated that hasty legislation which has not yet even been publicily presented may not be in the best interest of the people of this state. There is not adequate time for in depth study of the entire liability issue.

He suggested the resolution be amended to include subpoena power for the legislature and the legislative council, and also wrongful discharge.

The Montana Medical Association and the Montana Physicians believe that the insurance costs and the availability problem has been and will seriously affect the delivery of medical care in Montana. The MMA is prepared to lend expert assistance in its determination of the facts essential for sound legislative decisions and believes it can contribute much from its lengthy study of these matters which will have broad applicability to all areas of insurance. Mr. Neely handed in three small booklets and other papers for the committee to review. See attachments.

Bill Rossback, representing the Montana Trial Lawyers Association, spoke in favor of the bill. The Trial Lawyers met with the Independent Insurance Agents of Montana and tried to come up with a much needed solution to the problem. He,too, felt that the resolution needed to be amended to include "subpoena powers". Mr. Rossback stated that he felt that perhaps the area of reinsurance should also be addressed. He suggested to the committee that they should not be too specific. This is a very necessary resolution.

Don Judge, representing the Montana AFL-CIO, spoke in favor of the bill. He stated that this is a very necessary measure. He told the committee that whatever they do, it is going to affect the workers in our state. He hoped that this resolution would be adequately funded.

John Hoyt, a lawyer representing the United Transportation Union, spoke in favor of the bill. He stated that UTU does not have Workers' Compensation and they, therefore, must use the court system. Mr. Hoyt was concerned that perhaps frivolous lawsuits would not be addressed in the interim committee. He urged the committee to do something about this grave situation.

With no further proponents, the chairman called on the opponents to SJR 1. Hearing none, the meeting was opened to a question and answer period from the committee.

Senator Mohar asked Senator Towe if he was comfortable with putting "subpoena power" as an amendment in the bill. Senator Towe stated that he felt that perhaps the bill should be amended to include "subpoena power".

Senator Haffey asked Senator Towe if he would have any objection to the committee cleaning up the language in the bill. This would be in the best interest of the public. Senator Towe agreed to this.

With no further questions from the committee, Senator Towe closed.

DISPOSITION OF SENATE JOINT RESOLUTION 1:

A motion was made by Senator Mohar that the proposed amendments be adopted. Motion carried. See attachments for the amendments.

There is another bill which will allocate $12,000 to fund this study.

A motion was made by Senator Mohar that SJR DO PASS AS AMENDED. Motion carried.

ADJOURN: With no further business the meeting was adjourned.

Jack Haffey

Senator Jack Haffey
Chairman

eg

ROLL CALL

STATE ADMINISTRATION COMMITTEE

49th LEGISLATIVE SESSION -- 1986 Date 3/27/86

SENATE SEAT #	NAME	PRESENT	ABSENT	EXCUSED
# 9	SENATOR JACK HAFFEY, CHRMN.	✓		
#47	SENATOR LES HIRSCH, V. CHRMN.	✓		
#22	SENATOR JOHN ANDERSON	✓		
#29	SENATOR MAX CONOVER	✓		
#32	SENATOR WILLIAM FARRELL	✓		
#11	SENATOR ETHEL HARDING	✓		
#15	SENATOR J. D. LYNCH	✓		
#49	SENATOR DICK MANNING	late		
#28	SENATOR JOHN MOHAR	✓		
# 3	SENATOR LARRY TVEIT	✓		

Each day attach to minutes.

DATE 3-26-86

COMMITTEE ON State Administration

S.J.R. 1

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One: Support	Check One: Oppose
Gerald J. Neely	Montana Medical Assoc.	SJR1	✓	
Bill Rossbach	Montana Trial Lawyers	SJR 1		
John C Hoyt	UTU		✓	
Don Judge	MT STATE AFL-CIO	SJR 1	✓	
Joe Brand	UTU	SJR 1	✓	
Mike Ellis	MCC Medical Assn	SJR 1	X	

(Please leave prepared statement with Secretary)

NAME: Gerald J. Neely DATE: 3/27/86

ADDRESS: 2525 - 6th Ave. N. Billings, MT

PHONE: 252-5179

REPRESENTING WHOM? Montana Medical Assoc.)

APPEARING ON WHICH PROPOSAL: SJR1

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENTS: Attached

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

MONTANA MEDICAL ASSOCIATION POSITION ON - Proposed Constitutional Amendments on Liability Insurance	March 27, 1986

Montana physicians have a serious medical liability insurance problem. That problem has become a problem of the public because of their extensive contact with physicians.

It is not only physicians who have this concern. The same concern is apparent for cities and other governmental units, day care centers, manufacturers, midwives, and -- yes -- even lawyers.

Because of this concern, the Montana Medical Association will at the appropriate time recommend major changes in the legal setting in Montana. Certain other areas of potential change should be the subject of further study.

The recommendations for major legislative changes that will be made are based on the following factually-supportable propositions:

- There is, in Montana, a diminishing availability and affordability of insurance coverage for the negligent acts and omissions of insureds, including but not limited to the medical profession. In physician terms, each year, fewer and fewer companies are selling insurance for medical malpractice or medical liability, and to some medical specialties at prices which -- simply put -- boggle ones mind.

- The result of that insurance problem is inevitably a serious concern for all Montanans. That serious concern is manifested in one of two ways, including but not limited to the medical profession:

  - Increased costs for services where insurance is available. In physician terms that means higher medical costs, because the patient in fact pays for insurance when the physician is able or willing to pass on that cost or because the physician takes "defensive" medical steps, at high cost, to reduce the likelihood of a lawsuit.

  - Shrinking availability of certain services where insurance is either not actually available or is not economically available because the insured cannot afford the insurance or is unable to pass its costs on to the consumer or taxpayer. In physician terms that means that if a doctor cannot purchase insurance to perform a specific medical procedure, the doctor must stop performing that procedure, or, if the cost per year for insurance for a procedure far exceeds the doctor's income from a procedure, then the doctor probably will quite offering that service if the cost of it cannot be passed on to the patient.

The Montana Medical Association also makes the following assumptions:

- Various attempts can and will be made to provide long-term solutions to the problem, with varying degrees of success likely.

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▪ Only by the use of dramatic, untried, and different methods and proposed solutions can there be any possible immediate solution, and those methods might be unpalatable. The reason for this needed approach is that the current litigation-insurance-insured system is not capable of dealing with the complexities of the problems presented and that entire system is crumbling on our heads.

▪ There are a multitude of causes of the problem, too numerous for proper isolation, each contributing their own fair share to the problem, which involve the very nature of our lawsuit system, the lawyers, the insurance industry, the public itself, and the insureds, whether they be physicians or other groups or individuals.

▪ The attitude that the whole problem will go away if one of those groups will only do or not do certain things is simplistic, misleading, destructive, and incorrect, and merely is a device for the group or person pointing the finger to protect their current interests or to avoid their proper responsibilities in finding a solution to a problem that can be laid at everyone's door.

▪ Dealing with the proponents of the simplistic, finger-pointing approach can, if not handled properly, lead to a very acrimonious situation within and between interest groups and the public. That regardless of what measures are introduced or undertaken, if they at all involve any legislation or modification of the existing legal system, certain interest groups with a vested economic interest in continuing the current system can be expected to respond with vigorous opposition that is largely predictable as to its tone and content.

▪ It is personally irresponsible for a physician to be uninsured and that it is socially irresponsible for large numbers of physicians to be uninsured. Injured patients should be compensated for their injuries. Physicians should not be bankrupted by lawsuits.

The ideal situation from the patient's and physicians' point of view, i.e. the "solution" to the "problem", is the:

▪▪ prompt payment of all net economic loss to patients who are injured by Montana physicians, with a minimum of administrative cost and a charge to the physicians of Montana based only on the likely amounts to be paid out in Montana plus the minimum administrative cost;

▪▪ reduction in the numbers of injuries and the severity of injury to patients.

The Montana Medical Association last week took the following position as to the liability question and this Special Session:

1. Hasty legislation which has not yet even been publicily presented, be it legislative or a constitutional amendment, may not be in the best interest of the public.

2. It is apparent there is not adequate time for discussion and study in a special session.

3. The legislature is urged to create a bipartisan interim committee from the House and Senate to review in depth the entire liability issue prior to the next regular session in 1987, with the power of subpoena and the power to present specific proposals which will favorably affect the cost and availability of liability coverage in Montana.

In conjunction with that public position, the Montana Medical Association announces its support for the following propositions:

- The Montana Legislature should exercise its power, and obtain that power if it believes -- after due deliberation -- that it lacks it, to enact legislation which has a rational basis, so long as such power does not extend to the limitation of economic damages due injured parties as a result of the actions of another.

- In the context of liability insurance matters, the tests which should be imposed for such a constitutional amendment and any legislation enacted under it are one or more of the following:

  - Is there a reasonable basis to believe that the legislation will provide some measure of immediate downward trends on insurance costs, and hence premium costs and costs to consumers if properly passed on?

  - Is there a reasonable basis to believe that the legislation will provide a major long-term downward trend on insurance costs, and hence premium costs and consumer costs, if properly passed on?

  - Is there a reasonable basis to believe that the legislation will lead to more stable insurance carriers in Montana or will reduce the likelihood of reduced availability of insurance or carriers in Montana?

  - Is there a reasonable basis to believe that the legislation will reduce the number of injuries to persons, or will improve the quality of of goods or services provided, if those goods or services are the source of the injury?

The Montana Medical Association has reviewed as many of the available proposals as possible, and has concluded that none has so far fit the

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standards which have been applied by the Association or are technically deficient in a way which makes support of them difficult in the atmosphere of a hurried legislative session.

If the legislature determines that there is a need for such an amendment or amendments, one variation which would have the support of the Montana Medical Association is as follows:

> "Nothing contained in this Constitution shall restrict the power of the legislature to limit the amount, type, or period of payment of damages in civil actions, unless such legislation has no rational basis, except that all economic damages must ultimately be recoverable."

The Montana Medical Association further believes that nothing should preclude the Legislature from further consideration of the propriety of a constitutional amendment or amendments in subsequent legislative sessions.

Since the mid-1970's, the Montana Medical Association has been devoting substantial time to the question of legislative solutions to professional liability insurance.

A significant number of proposals advanced involve changes in the tort or courtroom system of determining medical liability, apart from the other categories of legislation which might have some impact on the problem advanced.

The Committee, in its Report, recommends legislation causing reform of the current lawsuit, litigation, or tort system in the following major areas:

- Provision For Periodic Payments For Future Damages
- Changes In The Award Of Non-Economic Damages
- Changes In The Collateral Source Rule
- Changes In The Awarding Of And Allowance Of Attorney Fees
- Provision For A Medical Patient Assured Compensation Fund

Each of the above items finds support in independent scientific studies and received -- to varying degrees -- the support of the 1977 American Bar Association Report Of The Commission On Medical Professional Liability.

With certain exceptions for stated reasons, all other tort reform legislation has been excluded from consideration because of:

- the lack of available evidence that such legislation will fit the tests imposed by the Committee in considering such legislation, or specific evidence that it will not.

- legislation which is already in effect in Montana, or which even though in effect and even if somewhat defective, does not warrant substantial legislative efforts at this time.

- other stated reasons

The following tort reform measures have been determined, by competent independent study, to have the effects desired in the degree indicated:

Type Tort Reform Legislation	Effect Of Implementation - Various Studies
Periodic Payments	6% - 14% initial reduction in premium outlays
Limit On Damages	12% - 19% initial reduction in premium outlays
Collateral Source	8% - 50% initial reduction in premium outlays
Contingency Fees	9% initial reduction in premium outlays-reduced number of trials
Stat of Limit-Minors	Stabilizing effect on prices - statistically significant influence
Informed Consent	Statistically-significant influence
Ad Damnum	30% initial reduction in premium outlays - reduced claims costs
Mandatory Panels	Statistically-significant influence

The first four of these items are included in the recommendations of this Committee.

The topics of statutes of limitations of minor and informed consent were deferred for further study in the recommendations devoted to that area below.

Mandatory Panels and Ad Damnum legislation already exists in Montana, with recommendations as to ad damnum included in the material indicated for future study.

Attached to this statement is a Summary of the legislation supported by the Montana Medical Association.

The Montana Medical Association is unsure whether a constitutional amendment is or is not needed to guarantee the passage of such legislation. Legal counsel has advised us that given the right factual determinations, that legislation could pass muster with the Montana Supreme Court. If that opinion is not correct -- and apparently lawyers in Montana are divided on the question of what the Montana Supreme Court has actually done -- then there would be a need for a constitutional amendment.

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LEGISLATIVE PROPOSALS OF THE MONTANA MEDICAL ASSOCIATION

SUMMARY

The Montana Medical Association supports legislation which provides for the following in all medical malpractice cases against physicians or professional service corporations (such as Clinics) which are owned by physicians:

A. ATTORNEY FEES LEGISLATION

- REGULATION AND DISCLOSURE OF ALL FEES
- AWARD OF ATTORNEY FEES TO SUCCESSFUL PARTIES IF LOSING PARTY ABLE TO PAY
- ADVANCE AND FULL PAYMENT OF PATIENT'S ATTORNEY FEES UNDER A VOLUNTARY PATIENT ASSURED COMPENSATION ACT

B. DUPLICATE PAYMENTS TO PATIENTS -COLLATERAL SOURCE LEGISLATION

- CASES INVOLVING MORE THAN $15,000 IN ECONOMIC DAMAGES
- MANDATORY REDUCTION OF AWARDS BY AMOUNT OF CERTAIN (BUT NOT ALL) DUPLICATE PAYMENTS
- CREDITS TO PATIENTS
- MAXIMUM REDUCTION OF AWARD OR SETTLEMENT
- COURT REDUCTION AND APPROVAL
- ABOLITION OF RIGHT OF THIRD PARTIES TO RECOVER BENEFITS FROM PATIENTS
- FUTURE DUPLICATE PAYMENTS - HEALTH POLICY FOR PATIENTS

C. PERIODIC PAYMENTS LEGISLATION

- PERIODIC PAYMENT OF FUTURE DAMAGES PAID BY INFLATION-INDEXED ANNUITY - FUTURE DAMAGES IN EXCESS OF $50,000
- PAYABLE UNTIL DEATH OR TERMINATION OF DISABILITY UNLESS ORDERED OTHERWISE BY COURT FOR THE SUPPORT OF RELATIVES

D. PATIENT ASSURED COMPENSATION ACT LEGISLATION

- ESTABLISHMENT OF PATIENT ASSURED COMPENSATION ACT
- VOLUNTARY PARTICIPATION BY PATIENTS AND PHYSICIANS
- REQUEST FOR PAYMENT OF ECONOMIC DAMAGES AND ADMISSION OF RESPONSIBILITY BY PHYSICIAN
- PAYMENT OF ECONOMIC DAMAGES OR A COURT DETERMINATION OF THE SAME
- ECONOMIC COURT DAMAGES AVAILABLE AND LIMITED NON-ECONOMIC DAMAGES AVAILABLE UNDER CERTAIN CIRCUMSTANCES
- ADVANCE AND FULL PAYMENT OF PATIENT'S ATTORNEY FEES
- USE OF SURPLUS FUNDS TO FUND MEDICAID
- CERTAIN EVENTS MAKING PATIENT ASSURED COMPENSATION ACT MANDATORY

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METHODS OF CLOSURE OF CLAIMS BEFORE THE MONTANA MEDICAL LEGAL PANEL: CLOSURE YEARS 1977-1985

Montana Medical Legal Panel
2021 11th Ave.
Helena, Montana 59601

EXHIBIT NO. 1
DATE 03-27-86

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METHODS OF CLOSURE OF CLAIMS BEFORE THE MONTANA MEDICAL LEGAL PANEL: CLOSURE YEARS 1977-1985

1. SUMMARY OF DATA ON METHODS OF CLOSURE.

A. Cumulative 1977-1985: By Number of Claimants/Claims

Number of Claimants:			415
Number Of Claimants With No Hearings		79	
Withdrawl & Settlement To Claimant On All	24		
Withdrawl & No Settlement To Claimant On All	54		
Withdrawl: Mixture Of Settlement & No Settlement	1		
Number Of Claimants With Hearings:		336	
Hearings Just With One Or More Physicians, No Facility In Claim		174	
Hearings Just With A Facility, No Physician In Claim		28	
Hearings Involving A Facility, One Or More Physicians In Claim		122	
Hearing Facility Only	1		
Hearing Facility And Physician(s)	121		
Hearings Just With One Or More Physicians, Facilities Involved In Claim		12	
Number Of Claimants Settling With One Or More Health Care Providers	24		
Number Of Claimants With-drawing As To One or More H Care Providers W/O Settlement	76		

B. Cumulative 1977-1985: By Number of Physicians

Physicians With Claims Against		565
Hearing	442	
Withdrawn No Settlement	98	
Withdrawn Settlement	25	

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C. Cumulative 1977-1985: By Number of Facilities

Facilities With Claims Against, With & Without Physicians		197
Hearing	152	
Withdrawn No Settlement	33	
Withdrawn Settlement	12	
Facilities With Claims Against, No Physicians		36
Hearing	29	
Withdrawn No Settlement	4	
Withdrawn Settlement	3	
Facility With Claims Against, With Physicians		161
Hearing	123	
Withdrawn No Settlement	29	
Withdrawn Settlement	9	

D. By Year Of Closure 1977-1985: Comparison Of Physicians And Facilities

Involved In Claims As Percentage Of Total Health Care Providers		
Physicians		73.95 %
Facilities		26.05 %
Hospital	25.66 %	
Nursing Homes(3)	.39 %	
Involved In Withdrawn/No Settlement Claims As Percentage Of Total Health Care Providers		
Physicians		72.95 %
Facilities		27.05 %
Hospital	26.23 %	
Nursing Homes(1)	.82 %	
Involved In Withdrawn/With Settlement Claims As Percentage Of Total Health Care Providers		
Physicians		67.57 %
Facilities		32.43 %
Hospital	27.02 %	
Nursing Homes(2)	5.41 %	
Involved In Hearings As Percentage Of Total Health Care Providers		
Physicians		74.49 %
Facilities		25.51 %
Hospital	25.51 %	
Nursing Homes(0)	.00 %	

E. Cumulative 1977-1985: By Number Of Health Care Providers

Health Care Providers With Claims Against		762
Hearing	594	
Withdrawn No Settlement	131	
Withdrawn Settlement	37	

F. By Year Of Closure 1977-1985: All Health Care Providers

Closure Year	Hearing	Claim Withdrawn No Settlement	Settlement
1977	0	0	0
1978	0	0	0
1979	27	5	1
1980	32	7	1
1981	55	10	2
1982	74	19	7
1983	109	27	7
1984	157	25	7
1985	134	38	12
TOTAL	594	131	37

G. By Year Of Closure 1977-1985: By Number of Physicians

Closure Year	Hearing	Claim Withdrawn No Settlement	Settlement
1977	0	0	0
1978	0	0	0
1979	18	5	1
1980	24	3	0
1981	37	8	2
1982	56	15	5
1983	84	18	4
1984	121	18	4
1985	102	31	9
TOTAL	442	98	25

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H. By Year Of Closure 1977-1985: By Number of Facilities

Closure Year	Hearing	Claim Withdrawn No Settlement	Claim Withdrawn Settlement
1977	0	0	0
1978	0	0	0
1979	9	0	0
1980	8	4	1
1981	18	2	0
1982	18	4	2
1983	25	9	3
1984	36	7	3
1985	38	7	3
TOTAL	152	33	12

I. Annual And Cumulative Claims Withdrawn (Settled & Not Settled) As A Percentage Of Total Claims Closed

Closure Year	As A Percentage Of Total Claims Closed Annual	Cumulative
1977	0.00 %	0.00 %
1978	0.00 %	0.00 %
1979	25.00 %	25.00 %
1980	7.69 %	14.29 %
1981	17.50 %	15.85 %
1982	20.00 %	17.52 %
1983	20.51 %	18.60 %
1984	14.71 %	17.35 %
1985	24.49 %	19.04 %

2. RAW DATA ON METHODS OF CLOSURE:

Note: See Additional Parties Information for two claims, one involving a 7th physician and one a 2nd facility, not reflected here

1. Claims - Closure Years 1977-1985: Total Number of Closed Claims - Number of Claimants With Claims

CLAIM# Count = 415

2. Claims - Closure Years 1977-1985: Total Number of Claims Where At Least One Health Care Provider (Or More) Went To Hearing - Number Of Claimants With Hearings

a. Claims With Hearings - Physicians And/Or Facilities

CLAIM# Count = 336

b. One Or More Physicians With Hearing And No Facility In Claim

CLAIM# Count = 174

c. Facility With Hearing And No Physicians In Claim

CLAIM# Count = 28

d. Facility With Hearing And Physicians In Claim But No Hearing For Physician

CLAIM# Count = 1

3. Claims - Closure Years 1977-1985: Number of Claims Where Claimant Settled With One or More Health Care Providers

CLAIM# Count = 24

4. Claims: Closure Years 1977-1985: Number of Claims Where Claimant Withdrew As To One Or More Health Care Providers Without Settlement

CLAIM# Count = 76

5. Physicians - Closure Years 1977-1985: Method of Closure

a. TOTAL PHYSICIANS AGAINST WHOM CLAIMS CLOSED: 1977-1985

P1METHCL Count = 379
P2METHCL Count = 108
P3METHCL Count = 39
P4METHCL Count = 13
P5METHCL Count = 9
P6METHCL Count = 4

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b. PHYSICIAN METHODS OF CLOSURE, WHETHER PHYSICIAN ALONE IN CLAIM OR WITH FACILITIES: 1977-1985

P1METHCL	Number of Occurrences
A	55
H	304
S	20

P2METHCL	Number of Occurrences
A	18
H	85
S	5

P3METHCL	Number of Occurrences
A	9
H	30

P4METHCL	Number of Occurrences
A	3
H	10

P5METHCL	Number of Occurrences
A	2
H	7

P6METHCL	Number of Occurrences
A	2
H	2

6. Facilities - Closure Years 1977-1985: Method Of Closure

a. TOTAL FACILITIES AGAINST WHOM CLAIMS CLOSED: 1977-1985

F1METHCL Count = 195

b. FACILITY METHODS OF CLOSURE, WHETHER FACILITY ALONE IN CLAIM OR WITH PHYSICIANS: 1977-1985

F1METHCL	Number of Occurrences
A	33
H	150
S	12

c. FACILITY METHODS OF CLOSURE, FACILITY IN CLAIM ALONE: 1977-1985

F1METHCL	Number of Occurrences
A	4
H	28
S	3

d. FACILITY METHODS OF CLOSURE, FACILITY NOT IN CLAIM ALONE: 1977-1985

F1METHCL	Number of Occurrences
A	29
H	122
S	9

BY YEAR OF CLOSURE, 1977-1985 PANEL METHOD OF CLOSURE

7. Closure Year 1977 - Physicians: Method of Closure
8. Closure Year 1978 - Physicians: Method of Closure
9. Closure Year 1979 - Physicians: Method of Closure

P1METHCL	Number of Occurrences
A	3
H	11
S	1

P2METHCL	Number of Occurrences
A	2
H	3

P3METHCL	Number of Occurrences
H	2

P4METHCL	Number of Occurrences
H	1

P5METHCL	Number of Occurrences
H	1

10. Closure Year 1980 - Physicians Method Of Closure

P1METHCL	Number of Occurrences
A	3
H	21

P2METHCL	Number of Occurrences
H	3

11. Closure Year 1981 - Physicians Method Of Closure

P1METHCL	Number of Occurrences
A	5
H	27
S	1

P2METHCL	Number of Occurrences
A	3
H	8
S	1

P3METHCL	Number of Occurrences
H	2

12. Closure Year 1982 - Physicians Method Of Closure

P1METHCL	Number of Occurrences
A	8
H	40
S	3

P2METHCL	Number of Occurrences
A	1
H	11
S	2

P3METHCL	Number of Occurrences
A	3
H	5

P4METHCL	Number of Occurrences
A	1

P5METHCL	Number of Occurrences
A	1

P6METHCL	Number of Occurrences
A	1

13. Closure Year 1983 - Physicians Method Of Closure

P1METHCL	Number of Occurrences
A	12
H	57
S	3

P2METHCL	Number of Occurrences
A	3
H	19
S	1

P3METHCL	Number of Occurrences
A	3
H	5

P4METHCL	Number of Occurrences
H	2

P5METHCL	Number of Occurrences
H	1

14. Closure Year 1984 - Physicians Method Of Closure

P1METHCL	Number of Occurrences
A	11
H	81
S	3

P2METHCL	Number of Occurrences
A	4
H	19
S	1

P3METHCL	Number of Occurrences
A	2
H	8

P4METHCL	Number of Occurrences
A	1
H	6

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P5METHCL	Number of Occurrences
H	4

P6METHCL	Number of Occurrences
H	2

14a. Closure Year 1985 - Physicians Method Of Closure)

P1METHCL	Number of Occurrences
A	13
H	67
S	9

P2METHCL	Number of Occurrences
A	4
H	22
S	1

P3METHCL	Number of Occurrences
A	1
H	8

P4METHCL	Number of Occurrences
A	1
H	1

P5METHCL	Number of Occurrences
A	1
H	1

P6METHCL	Number of Occurrences
A	1

15. Closure Year 1977 - Facilities: Method of Closure
16. Closure Year 1978 - Facilities: Method of Closure
17. Closure Year 1979 - Facilities Method Of Closure

F1METHCL	Number of Occurrences
H	9

18. Closure Year 1980 - Facilities Method Of Closure

F1METHCL	Number of Occurrences
A	4
H	8
S	1

19. Closure Year 1981 - Facilities Method Of Closure

F1METHCL	Number of Occurrences
A	2
H	18

20. Closure Year 1982 - Facilities Method Of Closure

F1METHCL	Number of Occurrences
A	4
H	18
S	2

21. Closure Year 1983 - Facilities Method Of Closure

F1METHCL	Number of Occurrences
A	9
H	25
S	3

22. Closure Year 1984 - Facilities Method Of Closure

F1METHCL	Number of Occurrences
A	7
H	36
S	3

22a. Closure Year 1985 - Facilities Method Of Closure)

F1METHCL	Number of Occurrences
A	7
H	36
S	4

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23. FULL DATA ON METHODS OF CLOSURE: Closure Years 1977-1985

CLAIM#	P1	P2	P3	P4	P5	P6	F1
#7801	H	-0	-0	-0	-0	-0	H
#7802	H	H	-0	-0	-0	-0	H
#7803	H	-0	-0	-0	-0	-0	H
#7804	H	-0	-0	-0	-0	-0	H
#7805	H	-0	-0	-0	-0	-0	H
#7901	H	-0	-0	-0	-0	-0	-0
#7902	A	A	-0	-0	-0	-0	-0
#7903	A	A	-0	-0	-0	-0	-0
#7904	A	-0	-0	-0	-0	-0	-0
#7905	A	-0	-0	-0	-0	-0	S
#7907	H	-0	-0	-0	-0	-0	-0
#7908	H	-0	-0	-0	-0	-0	-0
#7909	S	-0	-0	-0	-0	-0	-0
#7910	-0	-0	-0	-0	-0	-0	H
#7912	H	H	H	-0	-0	-0	H
#7913	H	-0	-0	-0	-0	-0	H
#7914	H	H	H	H	H	-0	H
#7915	H	-0	-0	-0	-0	-0	A
#7916	H	-0	-0	-0	-0	-0	H
#7917	H	-0	-0	-0	-0	-0	-0
CLAIM#	P1	P2	P3	P4	P5	P6	F1
#7919	H	-0	-0	-0	-0	-0	-0
#7920	H	-0	-0	-0	-0	-0	-0
#7921	H	-0	-0	-0	-0	-0	H
#7922	H	-0	-0	-0	-0	-0	-0
#7923	H	-0	-0	-0	-0	-0	-0
#7924	H	-0	-0	-0	-0	-0	-0
#7925	-0	-0	-0	-0	-0	-0	H
#7926	H	-0	-0	-0	-0	-0	H
#7927	H	H	-0	-0	-0	-0	A
#8001	H	H	-0	-0	-0	-0	-0
#8002	H	H	-0	-0	-0	-0	H
#8003	H	-0	-0	-0	-0	-0	H
#8004	-0	-0	-0	-0	-0	-0	H
#8005	A	-0	-0	-0	-0	-0	H
#8006	H	-0	-0	-0	-0	-0	-0
#8008	A	-0	-0	-0	-0	-0	A
#8009	H	-0	-0	-0	-0	-0	-0
#8010	H	-0	-0	-0	-0	-0	-0
#8011	H	-0	-0	-0	-0	-0	A
#8012	H	-0	-0	-0	-0	-0	-0

CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8013	H	-0	-0	-0	-0	-0	-0
#8014	H	-0	-0	-0	-0	-0	-0
#8015	H	H	-0	-0	-0	-0	H
#8016	-0	-0	-0	-0	-0	-0	H
#8017	H	-0	-0	-0	-0	-0	H
#8018	H	-0	-0	-0	-0	-0	-0
#8019	-0	-0	-0	-0	-0	-0	A
#8020	H	-0	-0	-0	-0	-0	H
#8021	H	H	H	-0	-0	-0	-0
#8022	H	-0	-0	-0	-0	-0	-0
#8023	A	A	-0	-0	-0	-0	A
#8024	H	H	-0	-0	-0	-0	H
#8025	-0	-0	-0	-0	-0	-0	H
#8026	H	-0	-0	-0	-0	-0	-0
#8027	H	-0	-0	-0	-0	-0	-0
#8028	-0	-0	-0	-0	-0	-0	H
#8029	-0	-0	-0	-0	-0	-0	H
#8030	S	S	-0	-0	-0	-0	-0
#8031	H	-0	-0	-0	-0	-0	-0
#8032	H	-0	-0	-0	-0	-0	-0

CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8101	H	-0	-0	-0	-0	-0	-0
#8102	H	-0	-0	-0	-0	-0	H
#8103	H	-0	-0	-0	-0	-0	H
#8104	H	H	H	-0	-0	-0	H
#8105	H	-0	-0	-0	-0	-0	-0
#8106	H	H	-0	-0	-0	-0	H
#8107	A	A	-0	-0	-0	-0	-0
#8108	-0	-0	-0	-0	-0	-0	H
#8109	H	-0	-0	-0	-0	-0	-0
#8110	H	-0	-0	-0	-0	-0	-0
#8111	H	-0	-0	-0	-0	-0	H
#8112	H	-0	-0	-0	-0	-0	-0
#8113	H	-0	-0	-0	-0	-0	H
#8114	A	A	-0	-0	-0	-0	-0
#8115	H	H	-0	-0	-0	-0	-0
#8116	H	-0	-0	-0	-0	-0	-0
#8117	H	H	-0	-0	-0	-0	H
#8118	-0	-0	-0	-0	-0	-0	H
#8119	H	H	-0	-0	-0	-0	-0
#8120	A	-0	-0	-0	-0	-0	-0

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CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8121	H	H	H	-0	-0	-0	-0
#8122	A	-0	-0	-0	-0	-0	-0
#8123	H	-0	-0	-0	-0	-0	H
#8124	A	H	A	-0	-0	-0	A
#8230	A	-0	-0	-0	-0	-0	-0
#8231	S	-0	-0	-0	-0	-0	-0
#8232	H	-0	-0	-0	-0	-0	-0
#8233	H	-0	-0	-0	-0	-0	-0
#8234	H	H	-0	-0	-0	-0	-0
#8235	H	-0	-0	-0	-0	-0	-0
#8236	H	H	H	-0	-0	-0	-0
#8237	H	-0	-0	-0	-0	-0	-0
#8238	-0	-0	-0	-0	-0	-0	S
#8239	H	H	H	-0	-0	-0	H
#8240	H	H	-0	-0	-0	-0	-0
#8241	S	S	-0	-0	-0	-0	S
#8242	-0	-0	-0	-0	-0	-0	S
#8243	H	A	A	-0	-0	-0	A
#8244	A	-0	-0	-0	-0	-0	-0
#8245	H	-0	-0	-0	-0	-0	H
CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8246	H	H	-0	-0	-0	-0	H
#8247	A	-0	-0	-0	-0	-0	-0
#8248	H	H	-0	-0	-0	-0	-0
#8249	H	H	A	-0	-0	-0	H
#8250	-0	-0	-0	-0	-0	-0	H
#8251	H	H	-0	-0	-0	-0	H
#8252	-0	-0	-0	-0	-0	-0	H
#8253	H	-0	-0	-0	-0	-0	H
#8254	H	-0	-0	-0	-0	-0	-0
#8255	H	-0	-0	-0	-0	-0	-0
#8256	H	H	-0	-0	-0	-0	-0
#8257	A	-0	-0	-0	-0	-0	-0
#8258	H	H	-0	-0	-0	-0	H
#8259	H	-0	-0	-0	-0	-0	-0
#8260	H	-0	-0	-0	-0	-0	-0
#8261	H	-0	-0	-0	-0	-0	-0
#8262	H	-0	-0	-0	-0	-0	-0
#8263	H	-0	-0	-0	-0	-0	-0
#8264	H	-0	-0	-0	-0	-0	A
#8265	-0	-0	-0	-0	-0	-0	A

CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8266	A	A	-0	-0	-0	-0	-0
#8267	-0	-0	-0	-0	-0	-0	H
#8268	H	H	-0	-0	-0	-0	H
#8269	A	-0	-0	-0	-0	-0	-0
#8270	H	H	H	-0	-0	-0	H
#8271	H	-0	-0	-0	-0	-0	-0
#8125	H	-0	-0	-0	-0	-0	H
#8126	H	H	H	-0	-0	-0	-0
#8127	H	-0	-0	-0	-0	-0	-0
#8128	H	-0	-0	-0	-0	-0	H
#8129	H	-0	-0	-0	-0	-0	-0
#8130	-0	-0	-0	-0	-0	-0	H
#8131	H	-0	-0	-0	-0	-0	-0
#8132	H	H	-0	-0	-0	-0	-0
#8133	H	-0	-0	-0	-0	-0	-0
#8134	H	H	H	-0	-0	-0	H
#8135	H	-0	-0	-0	-0	-0	H
#8136	H	H	H	-0	-0	-0	H
#8137	H	-0	-0	-0	-0	-0	H
#8201	A	-0	-0	-0	-0	-0	A
CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8202	H	-0	-0	-0	-0	-0	-0
#8203	A	-0	-0	-0	-0	-0	A
#8204	H	-0	-0	-0	-0	-0	H
#8205	A	-0	-0	-0	-0	-0	-0
#8206	A	A	A	A	A	A	A
#8207	H	H	-0	-0	-0	-0	-0
#8208	H	-0	-0	-0	-0	-0	-0
#8209	H	-0	-0	-0	-0	-0	-0
#8210	H	-0	-0	-0	-0	-0	H
#8211	H	-0	-0	-0	-0	-0	H
#8212	A	-0	-0	-0	-0	-0	-0
#8213	H	-0	-0	-0	-0	-0	H
#8214	H	-0	-0	-0	-0	-0	-0
#8215	H	-0	-0	-0	-0	-0	H
#8216	H	-0	-0	-0	-0	-0	-0
#8217	H	H	-0	-0	-0	-0	-0
#8218	H	-0	-0	-0	-0	-0	-0
#8219	H	H	A	-0	-0	-0	-0
#8220	-0	-0	-0	-0	-0	-0	H
#8221	H	-0	-0	-0	-0	-0	H

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CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8222	H	-0	-0	-0	-0	-0	H
#8223	H	-0	-0	-0	-0	-0	-0
#8224	H	-0	-0	-0	-0	-0	H
#8225	H	-0	-0	-0	-0	-0	-0
#8226	-0	-0	-0	-0	-0	-0	H
#8227	H	-0	-0	-0	-0	-0	H
#8228	S	S	-0	-0	-0	-0	-0
#8229	H	-0	-0	-0	-0	-0	-0
#8272	A	H	A	-0	-0	-0	H
#8273	H	-0	-0	-0	-0	-0	A
#8274	H	-0	-0	-0	-0	-0	H
#8275	H	H	-0	-0	-0	-0	H
#8276	H	-0	-0	-0	-0	-0	-0
#8277	H	H	H	H	H	-0	H
#8278	A	-0	-0	-0	-0	-0	-0
#8301	H	H	-0	-0	-0	-0	-0
#8302	S	-0	-0	-0	-0	-0	-0
#8303	H	-0	-0	-0	-0	-0	-0
#8304	H	H	-0	-0	-0	-0	-0
#8305	A	-0	-0	-0	-0	-0	-0
CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8306	H	H	H	H	-0	-0	H
#8307	H	-0	-0	-0	-0	-0	-0
#8308	H	-0	-0	-0	-0	-0	-0
#8309	H	-0	-0	-0	-0	-0	-0
#8310	H	-0	-0	-0	-0	-0	H
#8311	H	-0	-0	-0	-0	-0	-0
#8312	H	-0	-0	-0	-0	-0	H
#8314	S	-0	-0	-0	-0	-0	S
#8315	H	-0	-0	-0	-0	-0	-0
#8316	H	A	-0	-0	-0	-0	H
#8317	H	-0	-0	-0	-0	-0	A
#8318	S	-0	-0	-0	-0	-0	S
#8319	H	-0	-0	-0	-0	-0	-0
#8320	H	-0	-0	-0	-0	-0	-0
#8321	H	-0	-0	-0	-0	-0	-0
#8322	H	-0	-0	-0	-0	-0	H
#8323	H	-0	-0	-0	-0	-0	A
#8324	H	H	H	-0	-0	-0	H
#8325	H	-0	-0	-0	-0	-0	-0
#8326	H	H	-0	-0	-0	-0	-0

CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8327	H	-0	-0	-0	-0	-0	-0
#8328	A	-0	-0	-0	-0	-0	-0
#8329	A	-0	-0	-0	-0	-0	A
#8330	H	H	-0	-0	-0	-0	-0
#8331	H	-0	-0	-0	-0	-0	H
#8332	H	-0	-0	-0	-0	-0	-0
#8334	A	-0	-0	-0	-0	-0	A
#8335	A	-0	-0	-0	-0	-0	A
#8336	H	H	-0	-0	-0	-0	-0
#8337	A	-0	-0	-0	-0	-0	A
#8338	-0	-0	-0	-0	-0	-0	H
#8339	H	-0	-0	-0	-0	-0	H
#8340	H	-0	-0	-0	-0	-0	H
#8341	A	A	-0	-0	-0	-0	-0
#8342	H	-0	-0	-0	-0	-0	-0
#8343	H	-0	-0	-0	-0	-0	-0
#8344	A	-0	-0	-0	-0	-0	-0
#8345	H	-0	-0	-0	-0	-0	-0
#8346	H	-0	-0	-0	-0	-0	-0
#8347	H	-0	-0	-0	-0	-0	-0

CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8348	H	H	A	A	-0	-0	H
#8349	H	H	H	H	H	-0	H
#8350	H	-0	-0	-0	-0	-0	H
#8351	H	H	H	H	-0	-0	H
#8352	H	H	H	-0	-0	-0	H
#8353	A	-0	-0	-0	-0	-0	A
#8354	H	-0	-0	-0	-0	-0	-0
#8355	A	-0	-0	-0	-0	-0	-0
#8356	H	-0	-0	-0	-0	-0	-0
#8357	H	-0	-0	-0	-0	-0	-0
#8358	H	-0	-0	-0	-0	-0	-0
#8359	H	H	H	H	-0	-0	H
#8360	H	-0	-0	-0	-0	-0	H
#8361	H	-0	-0	-0	-0	-0	-0
#8362	H	H	-0	-0	-0	-0	-0
#8363	H	-0	-0	-0	-0	-0	-0
#8364	A	A	-0	-0	-0	-0	A
#8365	H	-0	-0	-0	-0	-0	-0
#8366	H	-0	-0	-0	-0	-0	H
#8367	H	-0	-0	-0	-0	-0	H

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CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8368	-0	-0	-0	-0	-0	-0	H
#8369	H	-0	-0	-0	-0	-0	-0
#8370	-0	-0	-0	-0	-0	-0	H
#8371	H	H	H	-0	-0	-0	H
#8372	A	A	A	-0	-0	-0	A
#8373	S	-0	-0	-0	-0	-0	S
#8374	H	-0	-0	-0	-0	-0	-0
#8375	H	H	-0	-0	-0	-0	H
#8376	H	-0	-0	-0	-0	-0	-0
#8377	H	-0	-0	-0	-0	-0	-0
#8378	H	-0	-0	-0	-0	-0	H
#8380	H	-0	-0	-0	-0	-0	-0
#8381	-0	-0	-0	-0	-0	-0	H
#8382	H	-0	-0	-0	-0	-0	-0
#8383	H	-0	-0	-0	-0	-0	-0
#8384	A	-0	-0	-0	-0	-0	A
#8385	H	-0	-0	-0	-0	-0	-0
#8386	A	-0	-0	-0	-0	-0	A
#8387	H	-0	-0	-0	-0	-0	-0
#8388	H	-0	-0	-0	-0	-0	-0
CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8389	H	-0	-0	-0	-0	-0	H
#8390	H	-0	-0	-0	-0	-0	-0
#8391	H	-0	-0	-0	-0	-0	-0
#8401	H	-0	-0	-0	-0	-0	H
#8402	A	-0	-0	-0	-0	-0	-0
#8403	H	H	-0	-0	-0	-0	H
#8404	H	H	H	H	H	H	H
#8405	H	-0	-0	-0	-0	-0	-0
#8406	H	-0	-0	-0	-0	-0	-0
#8407	-0	-0	-0	-0	-0	-0	-0
#8408	H	-0	-0	-0	-0	-0	-0
#8409	-0	-0	-0	-0	-0	-0	H
#8410	H	-0	-0	-0	-0	-0	H
#8411	H	-0	-0	-0	-0	-0	H
#8412	H	-0	-0	-0	-0	-0	-0
#8413	A	-0	-0	-0	-0	-0	A
#8414	H	-0	-0	-0	-0	-0	-0
#8415	H	-0	-0	-0	-0	-0	-0
#8416	S	-0	-0	-0	-0	-0	-0
#8417	H	-0	-0	-0	-0	-0	H

CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8418	H	-0	-0	-0	-0	-0	-0
#8419	H	H	-0	-0	-0	-0	-0
#8420	H	H	-0	-0	-0	-0	-0
#8421	S	S	-0	-0	-0	-0	S
#8422	H	-0	-0	-0	-0	-0	H
#8423	H	-0	-0	-0	-0	-0	-0
#8424	H	H	H	H	H	-0	H
#8425	H	H	-0	-0	-0	-0	H
#8426	-0	-0	-0	-0	-0	-0	H
#8427	H	-0	-0	-0	-0	-0	H
#8428	A	-0	-0	-0	-0	-0	-0
#8429	H	-0	-0	-0	-0	-0	H
#8430	H	-0	-0	-0	-0	-0	-0
#8431	H	-0	-0	-0	-0	-0	H
#8432	H	-0	-0	-0	-0	-0	-0
#8433	H	-0	-0	-0	-0	-0	-0
#8434	H	H	-0	-0	-0	-0	-0
#8435	A	-0	-0	-0	-0	-0	-0
#8436	H	-0	-0	-0	-0	-0	-0
#8437	H	-0	-0	-0	-0	-0	-0
CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8438	H	-0	-0	-0	-0	-0	-0
#8439	H	-0	-0	-0	-0	-0	-0
#8440	-0	-0	-0	-0	-0	-0	H
#8441	H	-0	-0	-0	-0	-0	-0
#8442	H	-0	-0	-0	-0	-0	-0
#8443	H	-0	-0	-0	-0	-0	-0
#8444	H	-0	-0	-0	-0	-0	H
#8445	H	-0	-0	-0	-0	-0	H
#8446	H	A	-0	-0	-0	-0	H
#8447	H	-0	-0	-0	-0	-0	-0
#8448	H	H	H	-0	-0	-0	-0
#8449	H	-0	-0	-0	-0	-0	-0
#8450	H	-0	-0	-0	-0	-0	-0
#8451	H	-0	-0	-0	-0	-0	-0
#8410A	H	-0	-0	-0	-0	-0	-0
#8452	H	H	-0	-0	-0	-0	-0
#8453	H	A	-0	-0	-0	-0	A
#8454	H	-0	-0	-0	-0	-0	H
#8455	H	-0	-0	-0	-0	-0	-0
#8456	H	H	-0	-0	-0	-0	H

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CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8457	H	-0	-0	-0	-0	-0	H
#8458	-0	-0	-0	-0	-0	-0	H
#8459	H	-0	-0	-0	-0	-0	-0
#8460	H	H	H	H	H	-0	H
#8461	H	H	H	H	H	H	H
#8462	H	H	-0	-0	-0	-0	-0
#8463	S	S	-0	-0	-0	-0	S
#8464	H	-0	-0	-0	-0	-0	-0
#8465	-0	-0	-0	-0	-0	-0	H
#8466	S	-0	-0	-0	-0	-0	-0
#8467	A	H	-0	-0	-0	-0	A
#8468	A	A	-0	-0	-0	-0	-0
#8469	H	-0	-0	-0	-0	-0	H
#8470	H	-0	-0	-0	-0	-0	-0
#8471	H	-0	-0	-0	-0	-0	H
#8472	H	-0	-0	-0	-0	-0	-0
#8473	H	-0	-0	-0	-0	-0	H
#8474	S	-0	-0	-0	-0	-0	-0
#8475	H	-0	-0	-0	-0	-0	-0
#8476	H	-0	-0	-0	-0	-0	-0
CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8477	A	-0	-0	-0	-0	-0	-0
#8478	H	-0	-0	-0	-0	-0	H
#8479	H	A	H	-0	-0	-0	H
#8480	H	H	H	-0	-0	-0	H
#8481	-0	-0	-0	-0	-0	-0	H
#8482	H	H	-0	-0	-0	-0	H
#8483	H	H	-0	-0	-0	-0	H
#8484	H	A	-0	-0	-0	-0	H
#8485	H	H	-0	-0	-0	-0	-0
#8486	H	-0	-0	-0	-0	-0	-0
#8487	H	-0	-0	-0	-0	-0	-0
#8488	H	-0	-0	-0	-0	-0	-0
#8489	A	-0	-0	-0	-0	-0	-0
#8490	H	-0	-0	-0	-0	-0	-0
#8491	S	-0	-0	-0	-0	-0	S
#8492	H	H	-0	-0	-0	-0	H
#8493	H	-0	-0	-0	-0	-0	H
#8494	H	-0	-0	-0	-0	-0	-0
#8495	H	-0	-0	-0	-0	-0	-0
#8496	H	-0	-0	-0	-0	-0	H

CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8497	A	-0	-0	-0	-0	-0	-0
#8498	A	-0	-0	-0	-0	-0	-0
#8499	A	-0	-0	-0	-0	-0	A
#84100	S	-0	-0	-0	-0	-0	-0
#84101	H	-0	-0	-0	-0	-0	-0
#84102	H	-0	-0	-0	-0	-0	-0
#8462A	A	A	A	A	A	A	-0
#84103	H	-0	-0	-0	-0	-0	-0
#8501	-0	-0	-0	-0	-0	-0	A
#8502	H	H	-0	-0	-0	-0	H
#8503	H	H	H	-0	-0	-0	H
#8504	H	-0	-0	-0	-0	-0	H
#8505	H	H	H	-0	-0	-0	-0
#8506	H	-0	-0	-0	-0	-0	-0
#8507	H	H	H	-0	-0	-0	H
#8508	H	-0	-0	-0	-0	-0	-0
#8509	H	H	-0	-0	-0	-0	-0
#8510	H	-0	-0	-0	-0	-0	H
#8511	H	-0	-0	-0	-0	-0	H
#8366A	H	-0	-0	-0	-0	-0	-0
CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8513	H	-0	-0	-0	-0	-0	-0
#8514	H	H	-0	-0	-0	-0	H
#8516	H	-0	-0	-0	-0	-0	-0
#8517	H	-0	-0	-0	-0	-0	H
#8518	H	-0	-0	-0	-0	-0	H
#8519	H	H	-0	-0	-0	-0	H
#8520	S	-0	-0	-0	-0	-0	-0
#8521	H	-0	-0	-0	-0	-0	-0
#8522	-0	-0	-0	-0	-0	-0	H
#8523	H	-0	-0	-0	-0	-0	-0
#8524	H	-0	-0	-0	-0	-0	-0
#8525	H	H	-0	-0	-0	-0	H
#8526	S	-0	-0	-0	-0	-0	-0
#8527	H	-0	-0	-0	-0	-0	H
#8528	-0	-0	-0	-0	-0	-0	S
#8529	H	H	-0	-0	-0	-0	A
#8530	A	-0	-0	-0	-0	-0	-0
#8531	H	H	-0	-0	-0	-0	-0
#8532	A	-0	-0	-0	-0	-0	-0
#8533	H	-0	-0	-0	-0	-0	-0

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CLAIM#	P1	P2	P3	P4	P5	P6	F1
#8534	H	-0	-0	-0	-0	-0	H
#8535	A	-0	-0	-0	-0	-0	A
#8536	S	-0	-0	-0	-0	-0	-0
#8537	H	-0	-0	-0	-0	-0	-0
#8539	S	-0	-0	-0	-0	-0	S
#8333	A	-0	-0	-0	-0	-0	-0
#8540	-0	-0	-0	-0	-0	-0	H
#8542	H	H	-0	-0	-0	-0	H
#8543	-0	-0	-0	-0	-0	-0	H
#8544	H	-0	-0	-0	-0	-0	-0
#8545	H	-0	-0	-0	-0	-0	-0
#8546	H	-0	-0	-0	-0	-0	-0
#8547	H	H	H	-0	-0	-0	-0
#8548	-0	-0	-0	-0	-0	-0	A
#8554	H	H	-0	-0	-0	-0	-0

APPENDIX

1. DATA CODING. The data below is coded as follows:

A=Claim Withdrawn Before Hearing By Panel, Without Settlement to Patient

S=Claim Withdrawn Before Hearing By Panel, With Settlement to Patient

H=Hearing

2. DATA LIMITATIONS. The data below pertains only to those claims required to be heard by the Panel, i.e. the data does not include certain claims occurring prior to the effective date of the Panel in 1977, which by consent of the parties were brought before the Panel. Such data is used only for purposes of costs per claim and assessment determination. The claims are limited in number.

3. DATA SOURCES. The data below is taken from the database CLAIMS, a compilation of computerized data of claims before the Panel, after running error-checking routines CLAIMSn.CHK (where "n" = 1, 2, 3, 4, & 5) and correcting any database errors.

All claims with between one and six physicians and/or a facility are contained in the relation CLCLAIMS (Closed Claims) of the CLAIMS database were accessed by the command file PMTHCL85.CMD (Panel Methods of Closure Thru 1985), with subsequent years being accessed by the command file PMTHCLxx.CMD, where "xx" is the last closure year considered. The data below is from that command file output (or arithmetic operations on it) except for the data on two claims containing more than six physicians.

Data on claims with more than six physicians are contained, as to the physicians in excess of the first six, in the COMMENTS relation of the TASKS database and are cross-referenced in the CLCLAIMS under CLMNOTES (Claim Notes), which indicates whether added comments exist.

Methods of annual update are contained in PMTHCL.UPD.

4. NURSING HOMES. All differentiation between hospitals and nursing homes was taken directly from the database and not by use of a command file, and such data is as follows: CLAIM#s #8004 and #8265 are the only claims in the database pertaining to nursing homes through claims closed through year-end 1984. The methods of closure for those two nursing homes were "H" and "A". In 1985, a third claim against a nursing home was closed, with the method of closure being "S" in claim# #8407, includable in the 1985 Reports.

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5. ADDITIONAL PARTIES INFORMATION. As of the end of 1985, seven claims had in excess of the six physicians and/or 1 facility. These claims and the method of their disposition were as follows:

Claim No.	Phy7	Phy8	Phy9	Phy10	Phy11	Phy12	Phy13	Fac2
8404	H							
8467								H
8461	H	H	H	A	A			
8462A	A	A	A	A	A	A	A	
8553								H

Through 1985, there were thus 13 additional physicians and two additional hospitals. As to four of the physicians there were hearings, with a withdrawn claim without settlement as to the other nine physicians. Each of the two facilities went to hearing.

THE HEALTH CARE CRISIS IN MONTANA:

Our Montana Physicians And The Public Speak Out - Part One

THE HIGHER COST AND REDUCED AVAILABILITY OF MEDICAL SERVICES

G. Brian Zins, Executive Director
Montana Medical Association
2021-11th Avenue
Helena, Montana 59601

March, 1986

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SUMMARY OF SURVEY RESULTS - PART ONE

A. THE GROWING CRISIS: Medical Malpractice Suits and Awards

Whatever the validity of their conclusion, an overwhelming portion of Montanans believe that there is a growing crisis with malpractice suits and awards in this country.

As to Montana citizens alone, fully 85% of Montanans so agree -- and 57% agree so strongly -- with only 8% disagreeing.

% Agreeing Malpractice Crisis - Montanans	
Agree Strongly	56.50%
Agree Somewhat	28.75%
Disagree Somewhat	5.25%
Disagree Strongly	2.75%
Not Sure	6.75%

As to Montana physicians, the balance of this Report reflects their agreement with this proposition, as shown by the alteration that has taken place in their medical practice -- and will take place to a higher degree if the trends continue.

B. CLAIMS ULTIMATELY LACKING MERIT: What Percentage Of Medical Malpractice Claims Against Physicians Involve Actual Medical Malpractice?

While incidents of medical malpractice are known to occur, it is clear that a large part of the:

• public • physicians • expert Panelists reviewing claims

confirm the available statistical evidence that a significantly large percentage of medical malpractice claims brought against physicians DO NOT involve medical negligence on the part of those physicians:

- Statistical indicators suggest that approximately 71% of medical malpractice claims do not involve the negligence of physicians
- Eighty-six percent (86%) of all Montana physicians believe that less than 25% of the claims against physicians involve such malpractice.
- Only twenty-six percent (26%) of the Montana public believes suits against physicians are usually justified
- During the first seven years of operation of the Montana Medical Legal Panel, 78% of the physicians with claims against them had the claims disposed of in their favor.

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Montana Physician Opinion	
% Of Claims Resulting From Medical Negligence	
Less Than 10%	50.3%
10% - 24%	35.3%
25% - 49%	9.1%
50% - 74%	2.9%
75% - 100%	.3%
No Response	2.2%

% Suits Against Physicians Justified - Public	
National	Montana
43%	26%

C. THE HARM TO PATIENTS FROM THE LEVEL OF MALPRACTICE PREMIUMS AND UNJUSTIFIED LAWSUITS: How Has And Will The Level Of Malpractice Premiums In Montana Or Physicians' Concern Over Being Sued Alter The Manner In Which They Practice Medicine?

Because of large premium increases and the fear of unjustified lawsuits within the last few years, 82% of Montana physicians have taken actions in limiting their practices -- and other steps -- which have reduced the availability of medical services in Montana and otherwise altered the medical field.

If premiums substantially increase over the next two or three years, 92% of Montana physicians intend to take further steps in the same direction:

Montana Physician Opinion		
Specific Past And Future Alterations Of Practice		
	Past Alteration	Future Alteration
Reduced Level of Insurance	6.1%	9.4%
Cancel Insurance	2.5%	2.6%
Referred More Cases	40.2%	30.6%
Increased Fees	41.9%	66.7%
Avoid high risk procedures	43.0%	43.8%
Order extra lab tests, x-rays, or other diagnostic procedures	63.1%	41.5%
Cease seeing emerg room patients	4.0%	11.4%
Cease seeing first time patients	1.1%	3.3%
Early retirement	7.7%	24.1%
Move to larger community	1.1%	5.0%
Other Methods Of Alteration	11.3%	12.9%

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1. INTRODUCTION

A. THE SURVEYS. In December, 1985 the Montana Medical Association sent a written opinion survey to Montana physicians concerning their beliefs and feelings concerning the problems of the cost and availability of insurance. The Association received responses from 726 of the 1151 (63%) physicians active in the practice of medicine by the cutoff date for tabulation of the survey results.

This material focuses on some of the results of that survey, with full survey results being released in three Reports because of the large amount of data involved.

Where available, other survey results on the same or similar questions are presented, including results based on surveys of public attitudes on the same questions, both nationally and as to the Montana public.

A summary of survey results is found in "SUMMARY OF SURVEY RESULTS" A discussion of the survey results and a comparison to other surveys, nationally and in Montana, is set out in "2. SURVEY RESULTS."

Various Appendices are included with these survey results. [1]

B. THE BACKGROUND OF MONTANA PHYSICIANS.

As part of the survey, certain demographic questions were asked as to the location of their practice within the community, the county in which they were located, the type and specialty of practice they have, and the number of years they were in practice, among others. [2]

Based on the survey, Montana physicians have the following characteristics: [3]

---

[1] Appendix A provides background on the survey data quality and the analytic and statistical methods used in the survey. Appendix B provides the actual tabulated results of those portions of the survey included in this Report. Appendix C presents the results of other surveys involving national and Montana physician and public attitudes.

[2] For in-depth results, see Appendix B, Montana Physician Survey, December, 1985.

[3] The survey response was slightly weighted towards the rural areas of Montana, but not beyond the normal ranges of statistical deviation necessary for an accurate survey. The rural population of physicians is 23.5% of the physician population, but 29.9% of the respondents in the survey were from rural areas, i.e. rural practitioners responded 6.4 percentile points higher than their representation in the state. See Appendix A, "Analytic And Statistical Methods". The urban areas of the survey had a deviation average of 1.6 percentile points from their actual physician representation, with a range of from .5 to 2.5 percentile points.

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Type Of Practice
- 80% of the physicians have just an office-based practice
- 10% of the physicians have just a hospital-based practice
- 3% of the physicians are in government employment

- 50% of the physicians are just in group practice
- 40% of the physicians are just in solo practice

Years Of Practice
- 77% of the physicians have been in practice less than 20 years
  - 49% have been in practice less than 10 years
  - 10% have been in practice more than 29 years
- 23% of the physicians have been in practice more than 20 years

Place Of Practice. Physicians in Montana are located:
- 30% in rural areas
- 70% in urban areas

Specialty Of Practice For Insurance Purposes
- 7% in obstetrics
  - 1% in family practice and obstetrics/gynecology
  - 6% in obstetrics/gynecology
- 26% in other surgery
- 27% in general practice/family practice
- 38% in other medicine
- 2% no response to question or no insurance

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2. SURVEY RESULTS

A. THE GROWING CRISIS: Medical Malpractice Suits and Awards

Whatever the validity of their conclusion, Montanans generally believe that there is a growing crisis with respect to malpractice suits and awards in this country.

People nationwide and Montanans were asked to what degree they believed that a growing crisis exists. They were asked as follows: [4]

> "Please tell me if you agree strongly, agree somewhat, disagree somewhat, or disagree strongly with the following statement about medicine and health: 'There is a growing crisis with malpractice suits and awards in this country.'"

% Agreeing Malpractice Crisis - Montanans	
Agree Strongly	56.50%
Agree Somewhat	28.75%
Disagree Somewhat	5.25%
Disagree Strongly	2.75%
Not Sure	6.75%

Over 85% of Montanans agreed that such a crisis exists. The level of disagreement was only 8% of Montanans.

The balance of this Report reflects the position of Montana physicians on the issue, by a look at how they have had to alter their practice of medicine, how they will continue to do so if remedies are not arrived at, at some of their feelings on certain legislative issues. Where pertinent, the feelings of Montanans on these issues are also examined.

B. CLAIMS ULTIMATELY LACKING MERIT: What Percentage Of Medical Malpractice Claims Against Physicians Involve Actual Medical Malpractice?

(1) The Key Issues.

A key issue in the debate over the pricing and availability of insurance is the extent to which malpractice claims are actually the result of medical negligence and to what extent claims are based on a result that

[4] See Appendix D(2), V. Tarrance and Associates, nationwide random sample telephone survey of the adult American population, including 400 adults in Montana.

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was not intended but which involves no bad medical care on the part of the physician. [5]

To the extent that those claims do not involve actual medical negligence on the part of the physicians involved, substantial extra costs are imposed on:

- insurance carriers, in the form of higher claim and defense costs. and passed from them to physicians and on to the patients in the form of higher medical costs.

- physicians, in the form of higher insurance premiums and necessary alterations in the practice of their medicine and added personal burdens which result because of claims being filed against them.

- patients, in the form of higher medical costs and reduced availability of medical services because of alterations in the practice of medicine.

While what Montanans and Montana Physicians "feel" about the validity of claims is not automatically indicative of how many claims are in actuality without foundation, there are valid statistical benchmarks available against which to measure those feelings. Statistical indicators suggest that 71% of medical malpractice claims do not involve the negligence of physicians.

From data available in a survey of medical malpractice claims closed nationwide and over a period of years, it is likely that the number of claims not involving malpractice on the part of the physician is approximately 71% of all medical malpractice claims:

- The National Association of Insurance Commissioners reported that 62% of all claims are ultimately disposed of in favor of the physician;
- The insurance carriers reporting to the NAIC estimated that an additional 9% of claims (all involving payment to patients) were

[5] Various "causes" have been associated with claims being made against physicians which do not involve actual malpractice, such as: a deficient tort law system; a lawsuit-oriented public; complex cases requiring a claim to be made before it can be determined whether negligence exists; inexperienced attorneys bringing claims without merit, etc. It is not the purpose of this material to assign blame nor to suggest any willful bringing of claims without merit. Nor is it being suggested that such claims should never be brought. Rather, the focus is the significant cost in personal and dollar terms of such actions, with the question being "What steps can be taken to ensure, without violating the rights of patients, that only those claims with a higher likelihood of malpractice having occurred are brought against physicians.

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"bad result" cases where the result intended was not accomplished but negligence was not a factor. [6]

From data available in surveys of medical malpractice claims originating in Montana, it is likely that the number of claims not involving malpractice on the part of the physician is approximately 75%:

- In Montana, during the first seven years of the existence of the Montana Medical Legal Panel, separate expert Panels composed of attorneys and physicians concluded that there was not sufficient evidence of medical malpractice to warrant a trial by a jury or patients withdrew their claims without any payment as to 78% of the claims brought before the Panel. [7]

- Prior to a Panel hearing, 15% of all closed claims were concluded in favor of physicians. Subsequent to a Panel hearing, 54% of the results favored physicians. Thus 69% of all closed claims favored physicians. [8] If the same proportion of the claims closed in Montana in favor of the patient are claims involving "bad results", as in the NAIC study, an additional 9%

---

[6] See Appendix D(3) for description of statistics taken from National Association of Insurance Commissioners, NAIC MALPRACTICE CLAIMS, Vol. 2, No. 1, December, 1978, p. 127 - 128.

[7] Montana Medical Legal Panel, "Claims Before the Montana Medical Legal Panel Through 1983", February, 1985, p. 3, Published Report Of The Montana Medical Legal Panel:

Result Favorable To Claimant	Percentage Of Physicians
At Panel	22.1 %
Subsequent To Panel	33.7%

A total of 71% of all Panel decisions were by unanimous ballot. Under Montana Law, before a malpractice claim can be brought to court, it must first be reviewed by a Panel composed of three lawyers and three physicians. They provide an opinion as to whether there is substantial evidence that malpractice occurred, sufficient to warrant the taking of a case to a jury. From 1977 - 1984, there were claims filed by 317 patients against 423 Montana physicians. Montana Medical Legal Panel, "Methods Of Closure 1977 - 1984".

[8] Montana Medical Legal Panel, "Claims Before the Montana Medical Legal Panel Through 1983", February, 1985, p. 3. Published Report Of The Montana Medical Legal Panel:

Result Favored	Closed Before Panel H	Closed After Panel H	Total
Physician	14.5%	54.0%	68.5%
Patient	4.0%	27.5%	31.5%

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of total claims do not involve negligence on the part of the physicians, i.e. a total of 78% of all claims subsequent to the Panel do not involve negligence on the part of physicians.

(2) Survey Of Montana Physicians. [9]

To examine Montana physicians' views about the relationship between medical negligence and malpractice claims, they were asked:

> "In your own opinion, what percentage of medical malpractice claims against physicians are the result of medical negligence?"

Montana Physician Opinion	
% Of Claims Resulting From Medical Negligence	
Less Than 10%	50.3%
10% - 24%	35.3%
25% - 49%	9.1%
50% - 74%	2.9%
75% - 100%	.3%
No Response	2.2%

Fifty percent of Montana physicians believe that less than 10% of the claims against physicians involve medical malpractice.

Eight-six percent of Montana physicians believe that less than 25% of the claims against physicians involve such malpractice.

Three percent of Montana physicians believe that 50% or more of malpractice claims involve physicians at fault.

By comparison, fifteen percent of the nation's physicians believe that 50% or more of the claims involve medical negligence on the part of

[9] See Appendix A - C, Montana Physician Survey, December, 1985.

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physicians, while 3% of Montana physicians believe that 50% or more of malpractice claims involve physicians at fault. [10]

(2) Survey Of The Montana Public. [11]

In a similar vein, adult Montanans were asked whether they think people who sue physicians for malpractice are usually justified in bringing suit, and their response was as follows:

% Suits Against Physicians Justified - Public

National	Montana
43%	26%

While 43% of the American Public believes that suits against physicians are usually justified, only 26% of Montanans believe that to be the case.

C. THE HARM TO PATIENTS FROM THE LEVEL OF MALPRACTICE PREMIUMS AND UNJUSTIFIED LAWSUITS: How Has And Will The Level Of Malpractice Premiums In Montana Or Physicians' Concern Over Being Sued Alter The Manner In Which They Practice Medicine?

(1) The Key Issues.

A key issue in the debate over the pricing and availability of insurance is the extent to which these problems and those of unfounded lawsuits directly impact upon the availability of medical services.

(2) Survey Of Montana Physicians. [12]

Montana physicians were asked how the cost of medical liability insurance and concern over being sued had an effect on their practice of

[10] See Appendix D(1), National Physician Surveys. In Freshnock, Larry J., Physician & Public Attitudes On Health Care Issues, American Medical Association, 1984, the identical question was asked in an independently-conducted research survey in 1982 and 1983, with the above results.

To examine the nation's physicians' views about the relationship between medical negligence and malpractice claims, they were asked the identical question asked of Montana physicians.

% Of Claims Resulting From Medical Negligence

	1982	1983
0 - 10%	28%	35%
10% - 49%	32%	33%
50% + ...22%%		15%

[11] See Appendix D(2), V. Tarrance and Associates, nationwide random sample telephone survey of the adult American population, including 400 adults in Montana, for actual question and full results.

[12] See Appendix A - C, Montana Physician Survey, December, 1985.

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medicine over the last year or two. They were also asked what would happen if those insurance rates were to increase substantially over the next two or three years.

> "In what manner, if any, has the level of medical liability insurance premiums OR your concern over being sued over the last year or two altered the manner in which you conduct the practice of medicine?"
>
> "If your premiums for medical liability insurance substantially increase over the next two or three years, in what manner, if any, will your practice of medicine be altered, if it has not been already, or further altered if it has already been altered?"

Montana Physician Opinion

Past And Future Alterations Of Practice

	Past Alteration	Future Alteration
Physicians Altering Practice	81.6%	92.1%
Physicians Not Altering Practice	17.8%	6.6%
Physicians Not Responding	.6%	1.2%

Based on the immediate past, fully 82% of Montana physicians have altered their practice of medicine in a significant way.

If current trends in premium increases continue, 92% of Montana's physicians intend to <u>further</u> alter the way they practice medicine.

The specific manner in which Montana physicians have and intend to alter their practice is indicated below:

Montana Physician Opinion

Specific Past And Future Alterations Of Practice

	Past Alteration	Future Alteration
Reduced Level of Insurance	6.1%	9.4%
Cancel Insurance	2.5%	2.6%
Referred More Cases	40.2%	30.6%
Increased Fees	41.9%	66.7%
Avoid high risk procedures	43.0%	43.8%
Order extra lab tests, x-rays, or other diagnostic procedures	63.1%	41.5%
Cease seeing emerg room patients	4.0%	11.4%
Cease seeing first time patients	1.1%	3.3%
Early retirement	7.7%	24.1%
Move to larger community	1.1%	5.0%
Other Methods Of Alteration	11.3%	12.9%

Some physicians have and would reduce their levels of insurance or cancel their insurance -- nearly 9% have so acted and 12% plan to do so under circumstances of increased premiums. To the degree that this takes place, unless the assets of those physicians are sufficient to pay for damage claims, Montanans injured who seek redress could be denied that redress.

Nearly 42% of Montana's physicians have increased their fees in the past because of the problems advanced; fully 67% intend to do so if rates continue to climb.

The availability of medical services will clearly be substantially curtailed if premium levels continue to increase. Nearly a third of Montana physicians intend to refer more of their cases to a declining base of Montana physicians handling certain problems.

Eleven percent of Montana physicians intend to cease seeing emergency room patients and 3% intend to cease seeing first time patients.

Five percent of Montana physicians intend to move to larger communities from the small communities of Montana.

More significant, a full 24% of Montana physicians intend to retire early if the trends continue.

APPENDIX A: Background On Montana Physician Survey Data And Analytic And Statistical Methods

1. Participating Physicians

The data for this survey was provided by Montana physicians in response to a written survey, set out in Appendix C.

Surveys were sent to 1309 physicians in early December, 1985. These were 1151 active and 158 retired physicians. As of the cutoff date of February 4, 1986 for tabulation of results, a total of 726 surveys from active Montana physicians were used, which is a response rate of 63.08%, a significantly high return for a mail survey. The cover letter used in the survey is available upon request from the Montana Medical Association.

A subsequent annotation to this survey will include the results of approximately 20 surveys which came in after the cutoff date for tabulation of results, as well as the results from retired physicians.

2. Analytic And Statistical Methods.

Upon receipt of each survey, it was numbered and the results of each question tabulated in a computer spreadsheet program, which compiled the total results and computed the percentage calculations set forth in Appendix B. Actual survey forms and survey results in computer form are available for review upon written request made to the Director of the Montana Medical Association, G. Brian Zins, at 2021-11th Avenue, Helena, Montana.

The following sample characteristics of active physicians versus population characteristics (known characteristics of active Montana physicians as a whole) were determined.

Questionnaires having a "no response" as to the demographic characteristics being assigned to the areas in proportion to the overall results, e.g. 32 respondents did not indicate which county they were from; as 19.3% of the respondents were from Yellowstone, that percentage of the non-responses were allocated to Yellowstone.

The results of the survey as to various demographics are charted below against the actual demographics in the active physician population in Montana.

A. COUNTY LOCATION OF PHYSICIAN'S PRACTICE

1. STATE AS A WHOLE. The survey resulted in a response from 63% of the active physicians in Montana.

• To Which Survey Sent	1151
• Responding To Survey	726
% Response	63%

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2. BY URBAN-RURAL. The survey response was slightly weighted towards the rural areas of Montana. The rural population of physicians is 24% of the physician population, but 29% of the respondents in the survey were from rural areas, i.e. rural practitioners responded 5 percentile points higher than their representation in the state.

			Survey Deviation From Actual	
			% Respon Pop	% Physician Pop
URBAN				
• To Which Survey Sent	880			
• Responding To Survey	487			
• No Response Allocation	22			
Deviation From Actual	6.4	% Pts	70.1%	76.5%
RURAL				
• To Which Survey Sent	271			
• Responding To Survey	207			
• No Response Allocation	10			
Deviation From Actual	6.4	% Pts	29.9%	23.5%
3. BY COUNTY				
Yellowstone				
• To Which Survey Sent	247			
• Responding To Survey	140			
• No Response Allocation	6			
Deviation From Actual	1.4	% Pts	20.1%	21.5%
Flathead				
• To Which Survey Sent	103			
• Responding To Survey	54			
• No Response Allocation	2			
Deviation From Actual	1.3	% Pts	7.7%	9.0%
Lewis & Clark				
• To Which Survey Sent	98			
• Responding To Survey	48			
• No Response Allocation	2			
Deviation From Actual	1.6	% Pts	6.9%	8.5%
Missoula				
• To Which Survey Sent	187			
• Responding To Survey	96			
• No Response Allocation	4			
Deviation From Actual	2.5	% Pts	13.8%	16.3%
Gallatin				
• To Which Survey Sent	79			
• Responding To Survey	52			
• No Response Allocation	2			
Deviation From Actual	.5	% Pts	7.4%	6.9%

Ex. #2
3-27-86

Cascade				
• To Which Survey Sent		166		
• Responding To Survey		97		
• No Response Allocation		4		
Deviation From Actual	.5	% Pts	13.9%	14.4%
Other (Rural)				
• To Which Survey Sent		271		
• Responding To Survey		207		
• No Response Allocation		10		
Deviation From Actual	6.4	% Pts	29.9%	23.5%

APPENDIX B: Tabulated Results of Questionnaire Of Montana Medical Association To Montana Physicians, December, 1985

Below are the tabulated results of the survey as to those questions contained in the text material. The full survey results are available from the offices of the Montana Medical Association.

Question 1.0: Place of Medical Practice?

"What type of medical practice do you have?"

Practice Place	# Respond	% Respond
OFFICE	580	79.89%
GOVERNMENT	25	3.44%
HOSPITAL	74	10.19%
OTHER	47	6.47%
NO RESP	0	0.00%
TOTAL	726	100.0%

Combined Summary

OFFICE	580	79.9%
OTHER	146	20.1%
NO RESP	0	0.0%
TOTAL	726	100.0%

Question 2.0: Type Of Practice?

"Are you in group or solo practice?"

Practice Type	# Respond	% Respond
GROUP	366	50.4%
SOLO	293	40.4%
OTHER	41	5.6%
NO RESP	26	3.6%
TOTAL	726	100.0%

Question 3.0: Years Of Practice?

"How many years have you practiced medicine in Montana?"

Practice Years	# Respond	% Respond
1 - 9 Yrs	358	49.3%
10 -19 Yrs	199	27.4%
20- 29 Yrs	93	12.8%
> 29 Yrs	70	9.6%
NO RESP	6	0.8%
Total	726	100.0%

Combined Summary

< 20 Yr	557	76.7%
20 Yr Or >	163	22.5%
NO RESP	6	0.8%
Total	726	100.0%

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Question 4.0: County Of Practice?

"In what county in Montana is your medical practice located?"

Practice County	# Respond	% Respond
YELLOWSTON	140	19.3%
FLATHEAD	54	7.4%
LEWIS & C	48	6.6%
MISSOULA	96	13.2%
GALLATIN	52	7.2%
CASCADE	97	13.4%
OTHER	207	28.5%
NO RESP	32	4.4%
Total	726	100.0%

Combined Summary		
URBAN	487	67.1%
RURAL	207	28.5%
NO RESP	32	4.4%
Total	726	100.0%

Question 5.0: Specialty?

"In what specialty were you included for the issuance of your current medical liability insurance policy?"

[Definition of Responses at Footnotes]

Practice Specialty	# Respond	% Respond
GP/FP+OBG [13]	6	0.8%
GP/FP [14]	199	27.4%
OBG [15]	45	6.2%
OTH SURG [16]	186	25.6%
OTH MED [17]	277	38.2%
NO RESP [18]	12	1.7%
NO INSURAN [19]	1	0.1%
Total	726	100.0%

Combined Summary		
OBG - All	51	7.0%
OTHER	663	91.3%
NO RESP	12	1.7%
Total	726	100.0%

13 General Practice-Family Practice Plus Obstetrics/Gynecology
14 General Practice-Family Practice Only
15 Obstetrics/Gynecology Only
16 Surgical Specialties Other Than Obstetrical
17 Other Medical Specialties Other Than Those Above
18 No Response To Question
19 No Insurance Specifically Indicated As Reason For No Response

Ex. #2
3-27-86
S.J.R. 1

Question 7.0: Percent Claims Are Malpractice?

"In your own opinion, what percentage of medical malpractice claims against physicians are the result of medical negligence?"

% Claims Malprac	# Respond	% Respond
<10%	365	50.3%
10-24%	256	35.3%
25-49%	66	9.1%
50-74%	21	2.9%
75-100%	2	0.3%
NO RESP	16	2.2%
Total	726	100.0%

Combined Summary

LT 25%	621	85.5%
25% Or >	89	12.3%
NO RESP	16	2.2%
Total	726	100.0%

Question 11.0: Past Alteration of Practice?

"In what manner, if any, has the level of medical liability insurance premiums OR your concern over being sued over the last year or two altered the manner in which you conduct the practice of medicine?"

Past Alterat	# Respond	% Respond
Reduced [20]	44	6.1%
Canceled [21]	18	2.5%
Referred [22]	292	40.2%
Increased [23]	304	41.9%
Avoid [24]	312	43.0%
Ordered [25]	458	63.1%
Cease-Em [26]	29	4.0%
Cease-1st [27]	8	1.1%
Early Ret [28]	56	7.7%
Moved [29]	8	1.1%
Other [30]	82	11.3%
No Alter [31]	129	17.8%
No Response	4	0.6%

[Explanation of Responses To Q 11 and 12 In Footnotes]

Combined Summary - By # Physician

Alteration	593	81.6%
No Alter	129	17.8%
No Respons	4	0.6%
Total	726	100.0%

[20] Reduced Level of Insurance
[21] Cancel Insurance
[22] Referred More Cases
[23] Increased Fees
[24] Avoid high risk procedures
[25] Order extra lab tests, x-rays, or other diagnostic procedures
[26] Cease seeing emergency room patients
[27] Cease seeing first time patients
[28] Early retirement
[29] Move to larger community
[30] Other (specify). The specified "other" categories have not yet been tabulated.
[31] No alteration of practice

Ex. #2
3-27-84

Question 12.0: Future Alteration of Practice?

"If your premiums for medical liability insurance substantially increase over the next two or three years, in what manner, if any, will your practice of medicine be altered, if it has not been already, or further altered if it has already been altered?"

Future Alterat	# Respond	% Respond
Reduced	68	9.4%
Canceled	19	2.6%
Referred	222	30.6%
Increased	484	66.7%
Avoid	318	43.8%
Ordered	301	41.5%
Cease-Em	83	11.4%
Cease-1st	24	3.3%
Early Ret	175	24.1%
Moved	36	5.0%
Other	94	12.9%
No Alter	48	6.6%
No Respons	9	1.2%

Combined Summary-By #Physician

Alteration	669	92.1%
No Alter	48	6.6%
No Respons	9	1.2%
Total	726	100%

Ex. # 2
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APPENDIX C: Related Surveys

Below are related surveys used in the main portion of this material.

1. Freshnock, Larry J., Physician & Public Attitudes On Health Care Issues, American Medical Association, 1984. Since 1977, the American Medical Association has, through independent survey companies, conducted surveys of physicians and public opinion on health care issues. These surveys represent an extension of opinion research activities that date back to 1955. The book presents these surveys, and lists the independent research organizations that conducted the interviews. The material is available upon request of the Montana Medical Association.

2. American Medical Association Public Awareness Survey. In 1985, the American Medical Association commissioned V. Tarrance and Associates to conduct a nationwide random sample telephone survey, including 400 adults in Montana in that survey. The full questionnaires and the results of the survey are available upon request at the Montana Medical Association.

The actual questions related to the text material are as follows:

"37. As you no doubt know, there have been a lot of cases recently where people have sued doctors for malpractice. Do you think people who sue physicians for malpractice are usually justified in brining suit, or are they just looking for an easy way to make some money?

Justified.....
Easy way to make money.....
Unsure (DO NOT READ).....

The actual results as to question 37 were as follows:

Q. 37 ARE PEOPLE WHO SUE PHYSICIANS JUSTIFIED

JUSTIFIED	26.0%
EASY WAY TO MAKE MONEY	51.5%
UNSURE	21.5%
OK/NO ANSWER	1.0%

"38. Do you think the amount of money awarded to patients by juries in malpractice suits is usually too much, not enough, or about right?

Too much.....
Not enough....
About right...
Unsure (DO NOT READ)...

Ex. # 2
3-27-86

3. National Association Of Insurance Commissioners. NAIC MALPRACTICE CLAIMS. Vol. 2, No. 1, December, 1978. Survey of claims closed between July 1, 1975 and June 30, 1976.

The NAIC Report indicated that there were 6,275 paid claims out of 16,592 claims during the reporting period, i.e. 62.18% of the claims involved no payment to patients.

The carriers reported that 9.08% of the total claims (all involving payment to patients) did not involve negligence, which was 24% of the total paid claims:

> "It is frequently suggested that in instances where negligence is not a factor, a 'bad result' or the failure to accomplish the intended result is the cause of a malpractice claim. This issue was reported in 24% of paid incidents [claims where money was paid out to patients]..."

Twenty-four percent of all paid claims -- bad result cases with payments to patients -- thus constitutes 9.08% of all claims.

Ex. #2
3-27-86
S.J.R. 1

THE REPORT OF THE PROFESSIONAL LIABILITY COMMITTEE OF THE MONTANA MEDICAL ASSOCIATION ON PROPOSED LEGISLATION	SOLVING THE HEALTH CARE CRISIS IN MONTANA

Professional Liability Committee

Richard C. Nelson, M.D., Chairman
Gerald J. Neely, Esq., Special Counsel
on Professional Liability

G. Brian Zins, Executive Director,
Montana Medical Association,
2021 -11th Avenue, Helena, MT 59601 406-443-4000

EXHIBIT NO. 3
DATE 03 27 86
BILL NO S.J.R. 1

LEGISLATIVE PROPOSALS OF THE MONTANA MEDICAL ASSOCIATION

SUMMARY

The Montana Medical Association supports legislation which provides for the following in all medical malpractice cases against physicians or professional service corporations (such as Clinics) which are owned by physicians:

A. ATTORNEY FEES LEGISLATION

- REGULATION AND DISCLOSURE OF ALL FEES
- AWARD OF ATTORNEY FEES TO SUCCESSFUL PARTIES IF LOSING PARTY ABLE TO PAY
- ADVANCE AND FULL PAYMENT OF PATIENT'S ATTORNEY FEES UNDER A VOLUNTARY PATIENT ASSURED COMPENSATION ACT

B. DUPLICATE PAYMENTS TO PATIENTS -COLLATERAL SOURCE LEGISLATION

- CASES INVOLVING MORE THAN $15,000 IN ECONOMIC DAMAGES
- MANDATORY REDUCTION OF AWARDS BY AMOUNT OF CERTAIN (BUT NOT ALL) DUPLICATE PAYMENTS
- CREDITS TO PATIENTS
- MAXIMUM REDUCTION OF AWARD OR SETTLEMENT
- COURT REDUCTION AND APPROVAL
- ABOLITION OF RIGHT OF THIRD PARTIES TO RECOVER BENEFITS FROM PATIENTS
- FUTURE DUPLICATE PAYMENTS - HEALTH POLICY FOR PATIENTS

C. PERIODIC PAYMENTS LEGISLATION

- PERIODIC PAYMENT OF FUTURE DAMAGES PAID BY INFLATION-INDEXED ANNUITY - FUTURE DAMAGES IN EXCESS OF $50,000
- PAYABLE UNTIL DEATH OR TERMINATION OF DISABILITY UNLESS ORDERED OTHERWISE BY COURT FOR THE SUPPORT OF RELATIVES

D. PATIENT ASSURED COMPENSATION ACT LEGISLATION

- ESTABLISHMENT OF PATIENT ASSURED COMPENSATION ACT
- VOLUNTARY PARTICIPATION BY PATIENTS AND PHYSICIANS
- REQUEST FOR PAYMENT OF ECONOMIC DAMAGES AND ADMISSION OF RESPONSIBILITY BY PHYSICIAN
- PAYMENT OF ECONOMIC DAMAGES OR A COURT DETERMINATION OF THE SAME
- ECONOMIC COURT DAMAGES AVAILABLE AND LIMITED NON-ECONOMIC DAMAGES AVAILABLE UNDER CERTAIN CIRCUMSTANCES
- ADVANCE AND FULL PAYMENT OF PATIENT'S ATTORNEY FEES
- USE OF SURPLUS FUNDS TO FUND MEDICAID
- CERTAIN EVENTS MAKING PATIENT ASSURED COMPENSATION ACT MANDATORY

THE REPORT OF THE PROFESSIONAL LIABILITY COMMITTEE OF THE MONTANA MEDICAL ASSOCIATION ON PROPOSED LEGISLATION	INTRODUCTION

Montana physicians have a serious medical liability insurance problem. That problem has become a problem of the public because of their extensive contact with physicians.

It is not only physicians who have this concern. The same concern is apparent for cities and other governmental units, day care centers, manufacturers, midwives, and -- yes -- even lawyers.

Because of this concern, this Report includes major recommended changes in the legal setting in Montana. Certain other areas of potential change which should be the subject of further study are included later in the body of this Report.

The recommendations for major legislative changes that are included in this Report are based on the following factually-supportable propositions:

• There is, in Montana, a diminishing availability and affordability of insurance coverage for the negligent acts and omissions of insureds, including but not limited to the medical profession. In physician terms, each year, fewer and fewer companies are selling insurance for medical malpractice or medical liability, and to some medical specialties at prices which -- simply put -- boggle ones mind.

• The result of that insurance problem is inevitably a serious concern for all Montanans. That serious concern is manifested in one of two ways, including but not limited to the medical profession:

•• Increased costs for services where insurance is available. In physician terms that means higher medical costs, because the patient in fact pays for insurance when the physician is able or willing to pass on that cost or because the physician takes "defensive" medical steps, at high cost, to reduce the likelihood of a lawsuit.

•• Shrinking availability of certain services where insurance is either not actually available or is not economically available because the insured cannot afford the insurance or is unable to pass its costs on to the consumer or taxpayer. In physician terms that means that if a doctor cannot purchase insurance to perform a specific medical procedure, the doctor must stop performing that procedure, or, if the cost per year for insurance for a procedure far exceeds the doctor's income from a procedure, then the doctor probably will quite offering that service if the cost of it cannot be passed on to the patient.

FURTHER ASSUMPTIONS OF THIS REPORT

The recommendations that precede this Report are based on the following assumptions:

Ex. #3

• Various attempts can and will be made to provide long-term solutions to the problem, with varying degrees of success likely.

• Only by the use of dramatic, untried, and different methods and proposed solutions can there be any possible immediate solution, and those methods might be unpalatable. The reason for this needed approach is that the current litigation-insurance-insured system is not capable of dealing with the complexities of the problems presented and that entire system is crumbling on our heads.

• There are a multitude of causes of the problem, too numerous for proper isolation, each contributing their own fair share to the problem, which involve the very nature of our lawsuit system, the lawyers, the insurance industry, the public itself, and the insureds, whether they be physicians or other groups or individuals.

• The attitude that the whole problem will go away if one of those groups will only do or not do certain things is simplistic, misleading, destructive, and incorrect, and merely is a device for the group or person pointing the finger to protect their current interests or to avoid their proper responsibilities in finding a solution to a problem that can be laid at everyone's door.

• Dealing with the proponents of the simplistic, finger-pointing approach can, if not handled properly, lead to a very acrimonious situation within and between interest groups and the public. That regardless of what measures are introduced or undertaken, if they at all involve any legislation or modification of the existing legal system, certain interest groups with a vested economic interest in continuing the current system can be expected to respond with vigorous opposition that is largely predictable as to its tone and content.

• It is personally irresponsible for a physician to be uninsured and that it is socially irresponsible for large numbers of physicians to be uninsured. Injured patients should be compensated for their injuries. Physicians should not be bankrupted by lawsuits.

The ideal situation from the patient's <u>and</u> physicians' point of view, i.e. the "solution" to the "problem", is the:

> •• prompt payment of all net economic loss to patients who are injured by Montana physicians, with a minimum of administrative cost and a charge to the physicians of Montana based only on the likely amounts to be paid out in Montana plus the minimum administrative cost;
>
> •• reduction in the numbers of injuries and the severity of injury to patients.

All legislative and non-legislative solutions are or should be variations on those two themes.

LEGISLATIVE PROPOSALS OF THE MONTANA MEDICAL ASSOCIATION

ATTORNEY FEES

A. SUMMARY - ATTORNEY FEES LEGISLATION

The Montana Medical Association supports legislation which provides for the following in all medical malpractice cases against physicians or professional service corporations (such as Clinics) which are owned by physicians:

- REGULATION AND DISCLOSURE OF ALL FEES. The statutory and court regulation and disclosure of attorney fees - both contingency fees and hourly fees - as to attorneys on all sides of cases, by a combination of reverse sliding scale contingency fee schedules and court review of the reasonableness of fees, with special provision for lower rates for minors, who are likely to have long-term economic costs

- AWARD OF ATTORNEY FEES TO SUCCESSFUL PARTIES IF LOOSING PARTY ABLE TO PAY. The awarding of attorney fees under specified, limited circumstances to parties successful in lawsuits, provided the opposing party can afford to pay for them

- ADVANCE AND FULL PAYMENT OF PATIENT'S ATTORNEY FEES. The provision for automatic advance attorney fee retainers paid on behalf of patients electing to proceed under a proposed Medical Patients Assured Compensation Act, and the full payment of such patient's attorney fees under such Act where the patient is successful in the case in an amount in excess of a required offer of settlement by the physician

B. SPECIFIC LEGISLATIVE PROPOSALS

1. CONTINGENCY FEE REGULATION

- Contingency fees limited to a maximum allowable percentage of awards, as set out in statute

  - Based on a sliding scale, where the percentage allowed decreases as the amount of the court award or settlement increases, but no so restrictive as to small or moderate recoveries that it hampers the ability of injured patients to obtain legal representation. Examples of such sliding scales would be:

    40% of the first $50,000; 33 1/3% on the next $50,000; 25% of the next $100,000; 10% for awards over $200,000

Ex. #3

or

30% of the first $ 250,000; 25% of the next $250,000; 20% of the next $500,000; 15% of the next $250,000; 10% of any amount over $1,250,000

•• With a lower percentage in each instance - by 5 percentile points - where the case involve a minor

•• Subject to the required judicial review as to reasonableness provided for all attorney fees in these proposals, with any side's attorney being able to apply to the court for approval of additional compensation where an attorney performs extraordinary services involving more than usual participation in time and effort

•• Unless the court determines that no competent counsel, after due diligence by the patient, was willing to take the case on a contingency fee basis after such counsel had determined in writing that there was substantial evidence of malpractice and the patient was otherwise unable to afford such attorney fees, in which case, the statutory limitation on attorney fees would be inapplicable but not the required review as to reasonableness

• Contingency fees prohibited under circumstances where

•• the patient opts for the protection of the proposed Medical Patient Assured Compensation Act, and hence is entitled to attorney fees to be paid from the fund of the Act

• A prohibition of the inclusion in the contingency fee calculation of

•• amounts previously paid for medical expenses by the physician

•• amounts paid to the patient from deductible collateral sources under proposed collateral source legislation, such as medical care, custodial care, rehabilitation services, loss of earned income or other economic loss, after adding back in insurance premiums paid

•• amounts previously offered by the physician or his authorized legal representative, in writing, in a binding and approved form, for the payment of future economic damages

•• future medical expenses in excess of $15,000

• A requirement that for a contingency fee contract to be enforceable, that:

•• the contract be in writing;

•• the contract state the method by which the fee is to be determined, including the percentage or percentages that accrue to the lawyer in the event of settlement, trial, or appeal, litigation and other expenses to be deducted from the recovery, and whether such expenses are to be deducted before or after the contingency fee is calculated;

•• The lawyer provides the client with a written statement stating the outcome of the matter and, if there is a recovery, showing the remittance to the client and the method of its determination.

•• The lawyer keeps adequate time records of the hours worked on the case to enable the court to review the time spent on the case

•• All required disclosures of available options to the client being included in such written contracts.

2. REQUIRED JUDICIAL REVIEW: ALL ATTORNEY FEES

• Required judicial review and a public record made of all payments in connection with such review, prior to the final payment of any attorney fees, whether by contingency fee or otherwise, of the reasonableness of any fee charged by the attorneys on either side of a case, whether by settlement or court award.

•• With power in the court to revise the amount of fees upward or downward for the attorneys on either side, even to the extent of being in excess of the statutory limit on contingency fees

•• With the court being required to take into account the following factors in its determination:

••• Time and labor required, novelty and difficulty of the legal questions involved, and the skill; requisite to perform the legal services properly
••• The amount involved and the results obtained;
••• The likelihood, if apparent to the client, that the acceptance of the particular employment precluded other employment by the lawyer;
••• The nature and length of the professional relationship with the client;
••• The experience, reputation, and ability of the lawyer or lawyers performing the services;
••• Time limitations imposed by the client or the circumstances;

Ex. #3

- - - The age of the client and the amount of future medical and other economic expenses which might be insufficient if attorney fees awarded are not diminished
- - - Unjustified use or abuse of the discovery process by the attorney seeking fees, and the degree to which any fees should be reduced to reflect such abuse

- - With the allowance of payment of interim attorney fees by a client prior to any settlement or court award where any attorney's written contract so provides, upon the posting of an appropriate bond by the attorney, for the repayment of such fees to the client to the extent such fees are not ultimately authorized by the court.

- - With provision for court approval of interim attorney fees or retainers where an attorney is operating under a written contract on an hourly basis and statutes authorize the payment of such fees from a Medical Patient Assured Compensation Act, upon the posting of an appropriate bond by the attorney, for the repayment of such fees to the fund to the extent such fees are not ultimately authorized by the court.

3. ATTORNEY FEES TO SUCCESSFUL PARTY

- Reasonable attorney fees awarded to the prevailing party to be paid by the opposing party, in a case which goes to trial, in lieu of any contingency fee contract should one exist, regardless of which side on which the attorney appears

- - if the court determines that the losing party did not have a reasonable chance of recovery or a reasonable chance of a successful defense

- - and if the losing party proceeded to trial after a unanimous Montana Medical Legal Panel decision against it

- - and if

- - - as to the losing patient, there is no recovery

- - - as to the losing physician, the amount of the recovery by the patient is in excess of any offer of settlement made by the patient in the form of a formal offer of judgment allowed and pursuant to the Montana Rules of Civil Procedure, and not timely accepted by the physician

- - unless the losing party is financially unable to pay the same - even on a minimal installment basis - in which case such attorney fees are to be paid by the attorney representing such a client, pursuant to an appropriate bond posted for such purposes

•• with a prohibition on insurance carriers from excluding such fees from policy coverage or requiring the same to be included in a deductible if the policyholder lacks any control over whether the case is settled or proceeds to trial

•• any such award of attorney fees to be determined pursuant to the requirements of reasonableness as determined by the court

4. PAYMENT OF ATTORNEY FEES OVER TIME - PERIODIC PAYMENT OF DAMAGES

• A requirement that any attorney fees payable under circumstances where the case requires a structured settlement or periodic payment of damages, under separately-proposed new legislation, be

•• paid out over the required period of payment of damages to the successful claimant

•• be based on the present value of the amount of any settlement or award, rather than the future value

5. PAYMENT OF ATTORNEY FEES - ADVANCE RETAINER FOR PATIENT'S ATTORNEY - MEDICAL PATIENT ASSURED COMPENSATION ACT

• A requirement that the reasonable attorney fees of a patient be paid, over and above any award given the patient, after crediting any advance retainer paid

•• if the lawsuit is instituted under the provisions of the separately-proposed Medical Patient Assured Compensation Act, which would prohibit the use of contingency fee contracts

•• if the patient prevails in the lawsuit in an amount in excess of the larger of the offer of settlement required by the legislation to be made by a physician to qualify under the Act (an offer of payment of economic damages) or any offer of settlement made by the physician in the form of a formal offer of judgment allowed and pursuant to the Montana Rules of Civil Procedure, and not timely accepted by the patient

•• with a specified advance retainer amount of attorney fees payable to the patient's attorney upon the filing of such a claim in court, to be credited against any subsequent award of attorney fees, and not to be repaid if the client is unsuccessful at trial, unless the court determines that the patient did not have a reasonable chance of recovery, in which case the amount is to be repaid by the patient's

attorney, pursuant to an appropriate bond given by the attorney for such purposes

• Disclosure to the jury of the availability of attorney fees and the circumstances thereof

• The reasonableness of the award to be determined as with all other attorney fees pursuant to proposed legislation

6. REQUIRED ADVANCE NOTIFICATION TO CLIENTS OF CONTENTS OF LEGISLATION

• The required notification, in writing, to all clients of all attorneys covered by the above proposed legislation, of the terms of such legislation and the options available to the client, in plain english and substantially the same as the form of notice provided pursuant to legislation

C. REASONS FOR SPECIFIC LEGISLATIVE PROPOSALS ON ATTORNEY FEES

The general objectives of legislation concerning attorney fees and contingency fees in particular are:

• to protect plaintiffs from having their recoveries directly diminished by high contingency fees and indirectly diminished by high defense fees, thus increasing the amount of the premium dollar paid out to patients

• the above reason is especially important if other legislation involving medical malpractice could have the tendency to diminish the amount of compensation paid to patients; the proposal would thus cause the legal profession to bear part of the cost of medical malpractice, thus relieving some of the concerns over the high cost of medical malpractice insurance or its very unavailability

• to provide for the payment of attorney fees in special circumstances, such as the proposed Medical Patient Assured Compensation Act

• to relate attorney fees more to the amount of legal work and expense involved in handling a case, as well as the special needs of the patient - such as in the case of a minor -- and less to the fortuity of the plaintiff's economic status and degree of injury.

• to deter attorneys from either instituting frivolous suits or encouraging their clients to hold out for unrealistically high settlements

• to reduce the temptation to adopt improper methods of prosecution which contracts for large fees contingent upon success have sometimes been supposed to encourage, the proper determination of legal fees being central to the efficient administration of justice and the maintenance of public confidence in the bench and the bar.

• to help insure that an attorney does not obtain a "windfall" simply because his or her client is very seriously injured and guaranteeing that the most seriously injured plaintiffs will retain the lion's share of any recovery secured on their behalf

D. BACKGROUND ON ATTORNEY FEES

A very important component of the costs of medical malpractice is the amount of attorney fees that are paid by the patient, a product of the tort or litigation approach to solving problems of medical malpractice. Another important component is defense fees.

One reason patients receive less than 100% of the premium dollar is the cost by the carrier in administering claims; legislative and non-legislative steps must be taken to control those costs. The medical profession in Montana has taken strong steps in this direction already by assisting in the development of physician-owned carriers in Montana and encouraging Montana physicians to participate in them; about one-half of Montana doctors are so-insured.

But another reason they receive less than 100% of the premium dollar is because of the attorney fees they have to pay.

During 1984, an amount equivalent to 55% of the premium dollar was paid to Montana Plaintiff's Attorneys and their clients -- the patients. That amount totaled $2,275,334 for medical malpractice claims. [1]

Thus, if those attorneys received a fee of 40% of the recoveries, the attorneys received $910,000 (22% of the premium dollar) and patients received $1,365,000 (33% of the premium dollar). [2]

While the $0.55 out of each premium dollar paid in Montana to patients (before attorney fees) is more than <u>twice</u> the amount paid out nationally for those injured in products liability claims, and while

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[1] Annual Statements of the carriers on file with the Montana Commissioner of Insurance for the following carriers: Standard Fire (Aetna); St. Paul Fire & Marine; Doctors Company; Insurance Corporation of America; Utah Medical Insurance Association; Glacier General Insurance Co.

[2] Discussed from a different angle, in 1973 terms, the contingent fee arrangement protects the patient from incurring an average legal fee of about $22,000 (440 hours times $50 per hour). Department of HEW. <u>Report Of The Secretary's Commission On Medical Malpractice</u>. 1973, Appendix, p. 116. In Montana during 1985, using rates of approximately $75 per hour, the patient would be saved from incurring an average legal fee of about $33,000.

the $0.33 of each premium dollar in Montana is higher than the nationwide average of $0.18, there is still significant concern. [3]

An unusually high percentage of medical malpractice cases that go to the Montana Medical Legal Panel or to trial result in defense verdicts. Those claims contribute to the cost of medical malpractice costs borne by physicians and to medical malpractice insurance costs.

A common method of the payment of attorney fees is the contingency fee: If there is no recovery, there is no fee; if there is a recovery, the fee is a percentage of the recovery, ranging from 25% to 50% of the recovery.

The purposes and benefits advanced in justification of the contingency fee are: (1) to ensure that every plaintiff with a valid legal claim has access to the legal process and is not denied access because of the inability to pay legal fees; (2) it encourages attorneys to evaluate possible claims before filing legal actions and pursue only those with legal merit; (3) it provides a financial incentive for a plaintiff's lawyer to represent his client's best interests.

The latter is sometimes expressed as a weakness of the contingent fee arrangement since it might encourage lawyers to accept non-meritorious claims if the potential recovery is large and allows unreasonably large payments for services at the expense of the client.

One standard justification for the high rate of contingency fees is that lawyers are being compensated in cases which they win for cases which they may have previously lost. If those cases are to any degree without merit, the lawyer is paid for bringing cases without merit.

Unregulated contingency fee contracts, calling for potentially huge attorney fee awards if cases are won, play at least some part in leading so many plaintiffs to pursue malpractice claims that ultimately prove unsuccessful.

The Montana Medical Association recognizes that in ordinary circumstances the contingency fee system provides a method by which the citizens of Montana are able to seek access to their courts.

But a flat fee and unregulated contingency system, unrelated to the work the attorney does on a case, provides windfalls to attorneys.

A sliding scale approach produces more equitable fees than the traditional flat contingency fee, helping to ensure that an attorney does not obtain a "windfall" simply because his client is very seriously injured and guaranteeing that the most seriously injured

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[3] The Montana information was arithmetically derived from the Annual Statements of the carriers on file with the Montana Commissioner of Insurance. The non-Montana information was taken from Tobias, Andrew, The Invisible Bankers. Linden Press. 1982, pp. 72-74

plaintiffs will retain the lion's share of any recovery secured on their behalf.

A higher percentage for low recoveries will encourage attorneys to accept meritorious small claims. The decrease in the percentage which may be charged as the amount of recovery increases prevents excessive compensation.

Such a sliding scale approach is a means of deterring attorneys from either instituting frivolous suits or encouraging their clients to hold out for unrealistically high settlements; it will discourage frivolous medical malpractice claims, thus reducing the losses to the insurance companies and enhancing the likelihood of the future availability of coverage.

This is especially true when such a measure is combined with the allowance of attorney fees to a successful party when the losing party had a frivolous case in the first instance.

Any sliding scale should allow a judge to recognize an attorney's extraordinary services or other circumstances, by an award of fees in excess of that otherwise permitted by the statute.

Any restrictions on fees should apply equally to all sides of case.

Simply put, there is a special need to protect plaintiffs from having their recoveries diminished by high contingency fees; there is a special need to reduce the temptation to adopt improper methods of pursuit of lawsuits which contracts for large fees contingent upon success encourage.

Major authorities have urged such measures as a sliding scale contingency fee system. The American Bar Association's 1977 Commission on Medical Professional Liability supported the concept of sliding scale contingency fee regulation. [4]

Strong support for such a concept was voiced by the 1973 study of the Department of Health, Education and Welfare:

> "The Commission recommends that courts adopt appropriate rules and that all states enact legislation requiring a uniform graduated scale of contingency fee rates in all medical

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[4] American Bar Association. 1977 Report On The Commission On Medical Professional Liability. p. 150-151. The Report was rejected by the full American Bar Association House in 1977. The recommendation supported a court-ordered decreasing maximum schedule for contingency fees, provided "that such schedule should not be so restrictive, particularly with respect to small to moderate recoveries, that it hampers the ability of injured patients to obtain legal representation."

malpractice litigation. The contingent fee scale should be one in which the fee rate decreases as the recovery amount increases." [5]

Attorney fee limitations are not unusual. Twenty-five states have some form of statutory limitation or court rule control on lawyer contingency fees in personal injury cases, whether applicable to all civil cases or just medical liability cases. A limited few apply those limitations to both sides of the controversy.

Arizona	California	Colorado
Delaware	Florida	Hawaii
Idaho	Illinois	Indiana
Iowa	Kansas	Maryland
Michigan	Nebraska	New Hampshire
New Jersey	New York	Oklahoma
Oregon	Pennsylvania	Rhode Island
Tennessee	Washington	Wisconsin
Wyoming		

States which have enacted provisions regarding the awarding of costs, expenses, and fees in frivolous lawsuits include: [6]

Arkansas	Colorado	Florida
Illinois	Kansas	Massachusetts
Nebraska	New Hampshire	North Carolina
North Dakota	Pennsylvania	Rhode Island
South Dakota		

New York also provides attorney fees to the prevailing party, but only if the losing party proceeded to trial after a unanimous pretrial determination there was no liability.

Montana statutes regulate the amount of attorney fees payable in estate proceedings. For example, the attorney's compensation, when hired by the personal representative for matters not involving termination of a joint tenancy or a life estate, is 4.5% of the first $40,000 in estate value and 3.0% of values in excess of $40,000, plus such additional compensation for extraordinary services, not greater than the original compensation, as may be determined by the court.

In Montana, Workmen's Compensation attorney fees are determined on the basis of whether they are "reasonable" and awards to claimants are on a "net award" basis, i.e. attorney fees are above and beyond that which is awarded to the injured workman, thereby preserving intact the eventual award recovered by the claimant, with the insurer or employer paying such attorney fees.

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[5] Department of HEW. Report Of The Secretary's Commission On Medical Malpractice. 1973, p. 34-5.

[6] The Pennsylvania statute was repealed in 1976 and the Rhode Island statute was repealed in 1981.

By statute, the Division of Workers' Compensation is given the power to require the submission to it of attorneys' employment contracts. The administrative division is given the power to regulate the amount of the attorney fees in any Workers' Compensation case. And the Division or the workers' compensation judge is given the power to set fees.

Montana also regulates the amount of attorney fees paid in defense of criminal cases and in many situations where attorney fees are allowable by statute -- such as in enforcement of a mechanic's lien -- typically limited to "reasonable" attorney fees. The reasonableness is judged by the factors set out above, and any other facts which the court might consider.

Likewise, the Federal Tort Claims Act limits fees to 25% of a judgment or settlement obtained after a court action has been filed, and 20 % of any recovery obtained prior to such filing. [7]

The Social Security Act authorizes reasonable fees not in excess of 25% of the claimant's recover. [8]

The Veterans Benefit Act contains a limit of Ten Dollars ($10.00) for anyone representing the claimant. [9]

If attorneys object to efforts to deal with problems in the area of contingency fees or other attorney fees, some major questions need to be answered by those attorneys:

1. "Do you acknowledge that contingency fees or defense attorney fees are responsible for a significant part of the diversion of the premium dollar from patients"?

2. "Do you acknowledge that few, if any, attorneys who handle medical malpractice cases on a regular basis for patients even keep track of the number of hours worked on their cases?"

3. "On average, what percentage of the recovery do Montana lawyers charge their clients, the patients? Is it higher or lower than the national average?"

4. "Is that charge to the patients regularly monitored by the courts or any other entity, and does it typically bear a reasonable relationship to the requirements of the ethical rules for Montana lawyers?

5. "In what respect do the contingency fee contracts in Montana take into account the special needs of the patient, such as minors?"

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[7] 28 U.S.C. sec. 2678.

[8] 42 U.S.C. sec 406(b)(1).

[9] 38 U.S.C. sec 3404. Although this provision has previously been upheld as constitutional, the U.S. Supreme Court currently has a case which might cause reversal of previous opinions.

Ex. #3

6. "Do you acknowledge that all areas of cost in the medical malpractice arena should be directly and responsibly dealt with, and that one of those areas of cost is attorney's fees, whether plaintiff or defendant fees?"

7. "What specific steps have you or your association taken to determine whether abuses exist in the area of contingency fees or defense attorney fees, such as studying the matter to see if a problem exists and then taking steps to correct any problem?"

Prepared by the Montana Medical Association, 2021-11th Ave., Helena, Montana 59601, G. Brian Zins, Executive Director, 406-443-4000. 2/86	LEGISLATIVE PROPOSALS - ATTORNEY FEES

LEGISLATIVE PROPOSALS OF THE MONTANA MEDICAL ASSOCIATION

DUPLICATE PAYMENTS TO PATIENTS

A. SUMMARY - COLLATERAL SOURCE LEGISLATION

The Montana Medical Association supports legislation which provides for the following in all medical malpractice cases against physicians or professional service corporations (such as Clinics) which are owned by physicians:

- CASES INVOLVING MORE THAN $15,000 IN ECONOMIC DAMAGES. The law to be applicable to any award or settlement involving past or future economic damages in excess of $15,000

- MANDATORY REDUCTION OF AWARDS BY AMOUNT OF CERTAIN (BUT NOT ALL) DUPLICATE PAYMENTS. The mandatory reduction by the judge of courtroom awards or settlements, to the extent the patient has already received or will in the future receive monies from a third party to cover economic damages as to any type of payments except allowing duplicate payments in the following circumstances

  - life insurance paid to the patient
  - direct payments by the patient
  - any payments by the patient's immediate family or any other party which the patient is obligated to repay

- CREDITS TO PATIENTS. With a credit back to the patient for any

  - insurance premiums paid directly by the patient or the employer of the patient within the previous 5 years

  - any other expenses paid directly by the patient, to acquire the duplicate payments, within the previous 5 years

- MAXIMUM REDUCTION OF AWARD OR SETTLEMENT. In no instance, even where duplicate payments exist, is the award or settlement to be reduced below 50% of the overall settlement or award

- COURT REDUCTION AND APPROVAL. The reduction to be accomplished by a judge after full hearing as to offsets, exclusions, and credits as to both judge and jury awards and out-of-court settlements, with the required filing and court approval of any settlement agreement subject to the terms of the legislation

- ABOLITION OF RIGHT OF THIRD PARTIES TO RECOVER BENEFITS FROM PATIENTS. The elimination of all lien and subrogation rights, and any rights to assign the same as to any third party paying benefits to the patient, i.e. elimination of the right of recovery of any benefits from the patient

Ex. #3

• FUTURE DUPLICATE PAYMENTS - HEALTH POLICY FOR PATIENTS. Court-supervised reductions of future duplicate payments, whether by award or settlement, if the doctor or doctor's insurance carrier has provided and maintained a required health insurance policy to provide coverage for benefits the patients believed they would receive (and hence were offset) but did not in fact receive

B. SPECIFIC LEGISLATIVE PROPOSAL - PARTIAL ELIMINATION OF THE COLLATERAL SOURCE RULE

• In all medical malpractice cases against physicians or professional service corporations (such as Clinics) which are owned by physicians

• Where the amount of economic damages, past and future, awarded by a court or jury or where the amount of economic damages to be provided the patient in the future under any settlement agreement, are in excess of the amount of $15,000

• The mandatory reduction of damages awarded to a patient by a court or jury of certain specified duplicate payments already paid or to be paid to the patient, e.g. amounts from all third parties or collateral sources, and the mandatory reduction of damages awarded to a patient in settlement of certain specified duplicate payments to be paid to the patient, including:

•• any federal state, or local government income, disability or sickness programs including:

••• Medicare, Medicaid, Public Assistance (with respect to services rendered prior to the award date), Social Security Retirement and Disability Income, Veterans Benefits, Workers' Compensation Benefits, and benefits to military personnel and their dependents

•• government or private health insurance covering health, sickness, or income disability (not including life insurance);

•• any contract or agreement with any group or organization to pay for any health care services;

•• any contractual or voluntary wage continuation plan intended to provide wages during a period of disability, such as an employer wage continuation program; and

•• any other sources intended to compensate the plaintiff for such medical injury, including but not limited to medical care, custodial care, rehabilitation services, loss of earned income or other economic loss, employee or service benefit programs;

• Excluding from such a duplicate payment offset, e.g. allowing duplicate payments to the patient, as to any payments received or to be received in the form of

•• life insurance paid to the patient
•• assets of the patient used in the direct payment for any such losses, apart from any premiums for such insurance
•• assets of the patient's immediate family which the patient is obligated to repay
•• any other gratuity or loan which the patient is obligated to repay

• Crediting back to the patient

•• any insurance premiums paid directly by the employer of the patient within the previous 5 year period, if such insurance is part of any employee benefit program and not a gratuity

•• any insurance premiums paid directly by the patient within the previous 5 year period

•• any other expenses paid directly by the patient to acquire the sources of payment within the previous 5 year period

• A maximum reduction under any circumstances of 50% of the present value of the settlement or award

• The reduction to be accomplished by the court after a full hearing as to the claimed offsets, exclusions, and credits

•• as part of any award made by the court acting without a jury

•• in a separate hearing held after any award by a jury or any settlement of the parties, at which hearing evidence shall be admissible for consideration on the question of whether any of the duplicate payments covered have been paid or are payable in the future, less any exemptions, plus any credits due the patient under the legislation, and taking into account the dollar limits involved

• Where public or private sources of medical benefits or income replacement coverage now permit the public or private source to place a lien on a professional liability award or permit subrogation against the professional liability tort feasor, the lien and subrogation rights must be superseded by the revised collateral source rule, e.g. no insurer or other collateral source of benefits may recover from the patient benefits paid by the doctor or his insurer, or assign any such rights of recovery, or have a lien for such a recovery

• Allowance, under court supervision, in the physician or liability insurer in offsetting the patient's future collateral source benefits (such as employer sponsored health insurance) against judgment amounts or settlement amounts awarded for future medical expenses, with

•• such collateral source benefits received in the future to be disclosed to the court, by affidavit or otherwise under oath

•• provision for such offset to be set forth in any judgment or settlement agreement between the parties

•• contingent upon the insurer or physician providing and maintaining the required health insurance policy for gaps in benefits set out below

• A requirement that the physician or liability insurer purchase or issue a health insurance policy which would provide coverage for gaps in benefits awarded by a court or agreed to in a settlement if collateral sources of those benefits are not actually available to the patient in the future, with

•• such collateral source benefits not received in the future to be disclosed to the court, by affidavit or otherwise under oath

•• provision for such coverage for gaps in benefits to be set forth in any judgment or settlement agreement between the parties

• The required filing with the court of a petition for approval of such settlement agreement, and the filing of the proposed settlement agreement, as to any settlement agreement which is covered by this legislation or the legislation concerning the award of attorney fees or the payment of damages in periodic payments

• The legislation applicable to claims upon which no lawsuit has been filed as of the effective date of the legislation. [1]

C. REASONS FOR SPECIFIC LEGISLATIVE PROPOSALS ON COLLATERAL SOURCES

The general objectives of legislation concerning duplicate payments to patients are:

• to reduce some of the amounts of duplicate payments which patients receive from third parties in addition to that which they receive in settlements and court awards, after giving credit for contributions made by the patients or their employers

• thus assuring that patients receive full compensation, but not more than full compensation in major cases, for economic damages

• thus to some degree shifting a portion of the economic losses in medical malpractice cases to the more efficient, high-volume accident and health insurers and away from the medical malpractice insurers

• thus further assuring the affordability and availability of medical malpractice insurance

D. BACKGROUND ON COLLATERAL SOURCES

1. GENERALLY.

[1] If the law is applicable to claims occurring on or after the effective date of the legislation, it will take two to three years longer to realize the full initial cost savings.

The "collateral source rule" is a rule of evidence in the courtroom which prohibits the introduction of evidence - i.e. prohibits disclosure to the jury - that the patient has already been reimbursed from other sources for certain expenses for which the patient is asking in the lawsuit.

For example, if a patient has been paid benefits under insurance policies for loss of earned income, that patient is entitled to claim it again -- and receive a double payment -- in court. Any such duplicate payments are not taken into account in computing a damage award.

The patient receives a double recovery - one from an insurer or employer and one from the doctor or the doctor's insurer, which -- because the doctor's insurance costs are passed on to the medical consumer -- is the same as saying that the patient receives a double recovery from the public. [2]

The policy which supports the collateral source rule is that the possibility of double recovery encourages the victim of malpractice to bring a lawsuit so that the doctor is punished and thereby others are deterred from doing the same thing.

The argument against double recovery is powerful: people would not voluntarily choose to buy two separate policies to cover the same event. In allowing such a double recovery in the court system, the people who receive medical care in general are in fact buying a second policy, because the premiums for those double recoveries are passed on to patients as doctors have the costs passed on to them in the form of higher premiums.

The idea of a windfall runs counter to the basic aim of the tort law, which is to make the plaintiff whole, not to overcompensate him. The notion of a wrongdoing defendant is increasingly anachronistic in this age of widespread malpractice insurance and growing sources of compensation for injured patients. In this content, the aim should be to assure the plaintiff fair compensation from available sources, but no more.

It is most unlikely, according to one authority, that anticipation of the abatement of damages by collateral source benefits would seriously weaken the deterrent effect of civil liability. [3]

Furthermore, the doctor does not pay damages out of his own pocket; rather they are paid from medical malpractice insurance; the deterrence effect is probably thus imaginary in the first place.

The argument for allowing the patient to retain collateral benefits and receive full tort compensation is strongest where the plaintiff has purchased an individual health insurance or disability policy. Even here, however, an argument for overcompensation is not persuasive, as one doesn't purchase accident insurance to obtain a double recovery. Rather, one is

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[2] The double recovery is not present where the insurer has a right of subrogation against any judgment - that is, the right to get its money back. This area of concern is covered below.

[3] Duke Law Journal, "State Legislative Responses", 1975, pp.1417, at 1447.

Ex. #3

payment for insurance which covers losses regardless of how they occur and regardless of whether one is likely to recover damages in a lawsuit.

In receiving payment from an accident or health insurer, the injured or ill person is receiving exactly what was bargained for. There is no social reason a defendant doctor - and hence the public which pays medical bills - should duplicate the patient's recovery from this source. Any recovery in a malpractice action should be the amount necessary to compensate the patient for his losses; those losses do not include the damages for which the patient has already been reimbursed through certain collateral source benefits.

Those who agree that collateral source evidence should be permitted feel that this will not only prevent double compensation, but it will free up insurance resources to cover other losses or will put the carriers in the position of cutting prices.

Opponents of revealing collateral sources argue that victims of malpractice should not be penalized because they have purchased insurance, that collateral sources are not designed to compensate for negligence, and that insurance companies may have subrogation rights. Finally, they feel this change in the rule may weaken its claimed deterrence effect.

While it can be argued that the doctor should not benefit from the patient's precaution to protect himself against expenses or lost wages or the largesse of the patient's employer, it is accepted that the patient should enjoy the benefits of the physician's precaution in procuring liability insurance which often far exceeds what would be available if the doctor were uninsured. The equitable solution is to allow a setoff where both parties have exercised good sense and provided for the payment of compensable obligations.

Most patients are compensated by many forms of public compensation available, such as Medicare, Social Security, Blue Cross, and other health plans that are largely public in nature or form part of employment or union benefit programs, and thus are no longer part of any prudent acts of the individuals in purchasing them.

The adverse side of reversal of the collateral source rule is that most minor claims, involving medical expense and short-term wage loss, which are extensively covered by private insurance, would not be worth filing. It has been suggested that this would seriously weaken the deterrent effect of the tort system for minor injuries.

One solution to this potential problem is to not have any reversal of the collateral source rule apply unless the claim in the case exceeded a specified amount. Another solution to the problem is to give credit to the patient for insurance premiums paid by the patient or his or her employer.

2. REPAYMENT TO THIRD PARTIES.

A tangential question is whether collateral insurers which have made payments to the patient should be entitled to recover them. Since accident and health insurers are generally more efficient than liability insurers i

making a higher percentage of premium dollars available to claimants, and since shifting losses from the former to the latter source costs money, there is a strong argument for denying subrogation. Denying subrogation would tend to make the more efficient, high-volume accident and health insurers the primary insurers for malpractice losses and the liability insurers the secondary or excess layer insurers.

There is no double recovery if the collateral source is allowed to recapture its payments to the patient. The net result where subrogation is successfully asserted under current law is that the doctor's carrier is liable for the full damage, the injured party is made whole, but not overcompensated, and the collateral source is returned to the position it would have occupied had there been no loss.

Where the collateral source is insurance or a private contract right for which the injured party has paid consideration, the argument is often made that to abolish the collateral source rule would in effect deprive the injured party of that which he has bought and paid for, give the doctor the benefit of the patient's prudence, and impair subrogation rights of third parties. This content is almost universally criticized on the ground that what the patient has intended to buy was protection from loss and not a right to double recovery.

It clearly would be indefensible to abolish the collateral source rule while still allowing subrogation. If collateral sources were limited to health or disability insurers which have and exercise subrogation rights, the present rules might appear justified.

Where the patient has received benefits gratuitously conferred, application of the collateral source rule will result in a windfall in all cases, since subrogation is unavailable to a mere volunteer.

3. THE POSITION OF COMPETENT AUTHORITIES.

The American Medical Association has suggested that there should be a mandatory offset of collateral source income, with insurance premiums paid being an offset against any deduction. [4]

The American Bar Association Report of the Commission On Medical Professional Liability recommended also that recovery of damages should be reduced by collateral source payments, and that subrogation should not be allowed to any collateral sources for medical benefits thus set off. [5]

The ABA Report concluded that the set-off of collateral source payments should be mandated as a matter of law rather than left to the jury's discretion and that legislation should require that the trial judge

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[4] American Medical Association. Professional Liability Report 3, 13. March, 1985. For the full text, see the Appendix to this Report.

[5] American Bar Association. 1977 Report of the Commission on Medical Professional Liability, 1977, pp. 146 -7. The Commission did not take a position on whether any forms of life insurance benefits should be set off or whether there should be any subrogation as to wage and disability payments. See the Appendix to this Report for further details.

deduct all collateral source payments from the jury's award before entering judgment. The jury would be instructed to resolve any dispute as to the amount of a collateral source payment under the ABA Committee proposal.

4. LEGISLATIVE ACTIVITY IN THE STATES.

Many states - some 19 - have statutorily reversed the collateral source rule. The changes have been upheld in five states, struck down in four states, and allowed to expire under Sunset legislation in another. [6]

The collateral source proviaions by state, including those states which have had the proposals overturned by the courts, are as follows:

State	Discretionary	Mandatory
Alaska		Yes
Arizona	Trier of Fact [7]	No
California	Trier of Fact	No
Delaware	Trier of Fact	No
Florida		Yes
Idaho [8]		Yes
Illinois [9]		Yes
Iowa		Yes
Kansas [10]	Jury	No
Nebraska	Court	No
New Hampshire [11]		Yes
New York	Trier of Fact	No
North Dakota [12]		Yes
Ohio		Yes
Pennsylvania [13]		Yes
Rhode Island	Court	No
South Dakota		Yes
Tennessee		Yes
Washington		Yes

Prepared by the Montana Medical Association, 2021-11th Ave., Helena, Montana 59601, G. Brian Zins, Executive Director, 406-443-4000. 2/86	LEGISLATIVE PROPOSALS - DUPLICATE BENEFITS

[6] Allow to expire in Idaho; overturned in Kansas, New Hampshire, North Dakota, and Pennsylvania.
[7] Jury, if there is one; otherwise Judge.
[8] Eliminated by Sunset provision.
[9] Reduced 100% but only to a maximum of 50% of the judgment.
[10] Found unconstitutional.
[11] Found unconstitutional.
[12] Found unconstitutional.
[13] Found unconstitutional.

LEGISLATIVE PROPOSALS OF THE MONTANA MEDICAL ASSOCIATION

PERIODIC PAYMENT OF FUTURE DAMAGES TO PATIENTS

A. SUMMARY - PERIODIC PAYMENTS LEGISLATION

The Montana Medical Association supports legislation which provides for the following in all medical malpractice cases against physicians or professional service corporations (such as Clinics) which are owned by physicians:

- PERIODIC PAYMENT OF FUTURE DAMAGES PAID BY ANNUITY. After a jury or judge verdict awarding in excess of $50,000 in future damages (such a medical treatment, loss of earnings, pain and suffering, etc.), the judge shall order that an inflation-indexed annuity be purchased by the physician or insurer for payment of the future damages in installments. Depending upon circumstances, the court can authorize the use of a trust fund and an appropriate bond.

- PAYABLE UNTIL DEATH OR TERMINATION OF DISABILITY UNLESS EXTENDED BY COURT. The periodic payments would be payable until the patient's death, even if beyond the anticipated life expectancy, if an annuity be used, or upon termination of the disability involved if that be part of the court's order, whichever first occurs. If an annuity is not involved, the patient, upon expiration of the normal life expectancy, may apply to the court for additional payments of economic damages arising out of the injury. The court can authorize that payments continue if persons are dependent upon the support of a deceased.

B. SPECIFIC LEGISLATIVE PROPOSAL - PERIODIC PAYMENTS

- In all medical malpractice cases against physicians or professional service corporations (such as Clinics) which are owned by physicians

- The trial court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for any future damages of the patient

  - be paid in whole or in part by periodic payments rather than lump sum payments, by the use of inflation-indexed annuities purchased by the party responsible for payment and payable until the death of the patient even if beyond normal life expectancy, unless the court orders that the circumstances warrant the use of periodic payments direct from a financially responsible insurance carrier or by the use of a trust fund if no carrier be involved

  - as to all verdicts in excess of $50,000 in future damages

Ex. #3

•• upon specific findings by the court as to amounts, recipients, intervals between payments, and number of payments, modifiable only upon the death of the patient or termination of the particular disability warranting the future damages by payment of the future damages for the same, whichever shall first occur, and then only to the extent that monies are separate and apart from that needed to support persons lawfully dependent upon the patient for support, as determined by the court, unless the court otherwise orders payment of economic damages on behalf of a patient outliving his normal life expectancy

•• conditioned upon an appropriate bond to assure performance of the obligation if the party paying is other than an admitted insurance carrier and if an inflation-indexed annuity is not then available or not used by the court

• Failure to timely pay said amounts shall be a basis for a finding of contempt of court and damages assessable against the offender, plus costs and attorney fees, in addition to the required payments

• Claimant's attorney fees shall be paid periodically in the same fashion as the award, and under the same statutory way as in separate attorney fee legislation which is recommended in conjunction with this legislation

• Account shall be taken of separate collateral source legislation which is recommended in conjunction with this legislation.

• Following the expiration of all obligations specified in the periodic payment judgment, any obligation of the party responsible for paying shall cease, except that if

•• an inflation-indexed annuity is not used

•• and the patient lives beyond the date of the final payment by the person responsible for paying,

the patient may apply to the court for additional payments for economic damages arising out of the injury. Any added payments will be calculated at the same annual rate at which the damages were originally calculated if an annuity not be used.

C. REASONS FOR SPECIFIC LEGISLATIVE PROPOSALS ON PERIODIC PAYMENTS

The general objectives of legislation concerning periodic payments to patients are:

• provide a guaranteed method of payment of future damages that is reflective of what will actually occur in the patient's life, rather than on a speculative basis at an earlier time, on a basis that resembles disability plus life insurance

• allow the carrier to not have to maintain as much reserves and to reduce the amount necessary for reinsurance, thus further assuring the affordability and availability of medical malpractice insurance

• eliminate, by use of the inflation-indexed annuity, numerous complex matters that are typically presented to a jury, which then makes a speculative decision as to interest rates and life expectancy, and in the process reducing significantly the cost of attorney fees and expert witness fees at the trial stage

D. BACKGROUND ON PERIODIC PAYMENTS

1. GENERALLY.

In states without "periodic payment" or "structured settlement" of damage legislation, unless otherwise agreed upon by the parties or ordered by the court, judgments can only be rendered as a lump-sum award. This type of payment mechanism is ill-suited to many medical malpractice cases, because awards in such cases often include payment for anticipated future medical care, lost earnings, and pain and suffering.

One reason malpractice premiums are unnecessarily high is the practice of awarding claims on a lump sum payment basis, which often leads to overpayments not intended by the judge or jury. The premature death of the plaintiff may create a windfall.

Periodic payments allow damages to be paid in installment amounts, the size of which can be specified by statute, negotiated by the parties, or determined by the trial judge, depending upon the type of statute.

Periodic payments may be limited to the disability period or lifetime of the patient only or they may be limited to the patient's lifetime plus the support of persons whom the patient was legally obliged to support.

The structured payout offers protection to the injured person by preventing injudicious use of lump sum settlements by guardians or persons ill-equipped to handle large sums of money.

Opponents argue that periodic payments involve higher administrative and court costs and that malpractice victims should get the use of and interest from settlements; the victim, not those liable or the court, should benefit from control of settlement amounts.

But juries are now presented with long and highly technical arguments with respect to average life expectancy and the range of possible interest rates by which a lump sum award should be discounted in order to determine how much money need be paid now in order to provide a given amount over future years.

These interest rates must be balanced against another dizzying range of possible guesses about what the purchasing power of the dollar will be in the interim.

Future damages usually cover the cost of medical care and rehabilitation, loss of income or the obligation of support, and general damages for pain and suffering. Any determination by the jury has no necessary relationship to what actually will occur, and experience indicates that that is one of the major factors in large verdicts, which in turn are often routinely approved by appellate courts.

And this business of inflation adjustment, discounting the present value, and life expectancies are major components -- not only in the large awards -- but the significant dollars which must be spent on expert witnesses and lawyers in preparing the case.

Periodic payments are less expensive to finance for the insurer than the equivalent lump-sum payment. Periodic payments allow savings to be passed on to the insured in at least a reduced rate of increase in premiums and they assure that financial resources will be available to an injured person over time as needed.

The use of periodic payments allows the insurer to not have to maintain large reserves to pay lump sum awards and reduces the cost of reinsurance or at least spreads it out over a longer period of time.

The installment approach leaves the cash involved in the judgment in position to earn interest for the insurer during the period between the date of the judgment and the date of payment.

To the degree that this interest rate is higher than that which would have been assumed by the jury in discounting the award to its present value, the interest income offsets the effect of the judgment on the companies' assets.

Interest rate differentials can add up fast. A series of payments which would cost $4 million in present value if discounted at 8% would cost only $2.7 million if discounted at 5%. This is roughly a one-third reduction in the amount that would have to be paid out, but under both circumstances, the patient still receives his due.

Also, if the jury has based its judgment on a longer life expectancy than actually occurs, there is at least the freeing of the portion of assets encumbered by the defendant's need to prove responsibility. And predicting life-expectancy by a jury is error-prone.

The patient can fall far short of living out his normal life expectancy, either because of an inaccurate estimate of his natural life or as a result of unexpected accidents or illness unassociated with the claim the patient has made. The consequence is an inequitable cost to those paying for malpractice premiums -- the public -- and an unjustified windfall to the patient's heirs if they are not dependent upon the patient for their support.

Under the annuity approach, the insurance carrier buys an annuity; if the patient outlives his normal life expectancy, he would receive payments for his entire life. If all patients were covered by such annuities, any

such imbalances would work themselves out over a period of time, since some patients would die before and some after their life expectancy.

Use of the annuity makes it immaterial in severe cases whether at trial or in settlement the claimant's contentions about life expectancy are exaggerated. And convoluted jury instructions on reduction to present value would no longer be necessary, as the insurer would invest the funds as it saw fit, and pay the patient what the patient is entitled to.

If the award is specified as an annuity, to be indexed to a publicly available price index such as the consumer price index, the issue of inflation and discounting is removed from the jury. Under this approach, the patient is assured the intended real future purchasing power with no windfall losses or gains.

The existence of periodic payments by statute as to all awards will induce such periodic payments in settlements.

One argument in favor of periodic payments is that plaintiffs spend lump sum awards frivously and then become wards of the state. This position implies a degree of paternaliam and restriction of freedom of choice of the tort victim that is hard to defend, although that may be the motive of many states in their lotteries in requiring payments to be made over a period of time.

A better argument for periodic payments is that the approach resembles the form of disability plus life insurance policy that people choose to buy when insurance is voluntary, and thus it reduces the cost of providing malpractice insurance. This ultimately reduces the cost to the public, who pays for the malpractice premiums.

The use of periodic payments of future damages greatly facilitates the integration with other sources of compensation to prevent double recovery. For example, it becomes a simple matter to reduce collateral source payments by the amount of payments from the annuity.

2. THE POSITION OF COMPETENT AUTHORITIES.

In addition to the American Medical Association support of the use of periodic payments, the American Bar Association Commission on Medical Professional Liability recommended that legislation should be enacted in all states to permit the payment of future damages in periodic installments. [1] They concluded that periodic payment judgments constitute a generally sensible and flexible way of compensating those whose disabilities are long-term and substantial.

3. LEGISLATIVE ACTIVITY IN THE STATES.

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[1] American Bar Association. 1977 Report of the Commission On Medical Professional Liability, Appendix F. See the Appendix to this Report for a full report of the reasons advanced by the Commission.

Twenty-one states have passed statutes permitting or requiring periodic payments of damages over the lifetime of the plaintiff. The statutes have been upheld in two states and overturned in two states.

In some of these states which have periodic payment statutes in effect, annuities may be used to fund installment payments. Other states provide that sums from patient compensation funds can be paid in installments, except for those portions of the award paid by insurers.

A summary of the states which have periodic payments statutes are as follows, including those which have had them overturned:

State	Mandatory	Discretionary
Alabama		Court awards over $100,000
Alaska	Future damages only	
Arkansas		Court awards over $100,000
California [2]	Over $50,000	
Delaware	Future damages only	
Florida	Over $500,000	
Illinois	$250,000	
Indiana	$50,000	
Kansas		Court
Maryland		Arbitration
Michigan		Arbitration
New Hampshire [3]	$50,000	
New Mexico		Parties & Insur Comm.
New York	Future over $250,000	
North Dakota [4]		$100,000
Oregon		Court & Insur Comm.
Pennsylvania	----	-----
South Carolina		Court & Fund Comm. [5]
Washington		Arbitration with Court Approval
Wisconsin [6]	Lump to $300,000 $25,000 increments for balance over $300,000	
Wyoming	----	----

Prepared by the Montana Medical Association, 2021-11th Ave., Helena, Montana 59601, G. Brian Zins, Executive Director, 406-443-4000. 2/86	LEGISLATIVE PROPOSALS - PERIODIC PAYMENTS

[2] Constitutionality upheld.
[3] Held unconstitutional.
[4] Provision not severable from act found unconstitutional, although provision not specifically reviewed by the court.
[5] When the award is from the patient compensation fund, the payments may be periodic at the discretion of the court and the fund committee.
[6] Constitutionality upheld.

LEGISLATIVE PROPOSALS OF THE MONTANA MEDICAL ASSOCIATION

PATIENT ASSURED COMPENSATION ACT

A. SUMMARY - PATIENT ASSURED COMPENSATION ACT LEGISLATION

The Montana Medical Association supports legislation which provides for the following in all medical malpractice cases against physicians or professional service corporations (such as Clinics) which are owned by physicians:

- ESTABLISHMENT OF PATIENT ASSURED COMPENSATION ACT. Creation of an actuarially sound fund for the purpose of payment to patients of all allowable damages in excess of required insurance coverage for participating physicians.

- VOLUNTARY PARTICIPATION. Voluntary participation by patients and physicians, provided the patient makes certain timely requests and provided the physician has sufficient levels of insurance or is otherwise financially responsible

- REQUEST FOR PAYMENT OF ECONOMIC DAMAGES AND ADMISSION OF RESPONSIBILITY. The legislation would be triggered by the patient's request that the physician timely pay for and provide an inflation-indexed annuity for the economic damages incurred by the patient, pursuant to a schedule for such damages. The physician would also be requested to allow entry of judgment against him or her on the question of fault. If the physician had a pattern of adverse claims over a period of time, there must be a hearing by the Board of Medical Examiners to determine if action should be taken against the physician

- PAYMENT OF ECONOMIC DAMAGES OR A COURT DETERMINATION OF THE SAME. Upon proper compliance by the physician, the case would be at an end; if the physician still wished to participate, but disagreed as to the amount to the paid, the patient could then file a lawsuit before a judge sitting without a jury to determine the economic and non-economic damages to which the patient might be entitled.

- COURT DAMAGES AVAILABLE. Economic damages, pursuant to an appropriate schedule designed for such purposes, would be available to the patient. Additionally, non-economic damages would be available upon a court determination that a serious injury exists which warrants such a damage, and then only based upon the age and life expectancy of the person, the severity of injury, and the usefulness of additional funds in maintaining a reasonable quality of life, pursuant to an established schedule where possible, with a maximum award in any event of $100,000 for such damages. No punitive damages would be available, and the damages would be subject to other statutes concerning collateral sources and periodic payments.

• ADVANCE AND FULL PAYMENT OF PATIENT'S ATTORNEY FEES. The provision for automatic advance attorney fee retainers paid on behalf of patients electing to proceed under a proposed Medical Patients Assured Compensation Act, and the full payment of such patient's attorney fees under such Act where the patient is successful in the case in an amount in excess of a required offer of settlement by the physician

• USE OF SURPLUS FUNDS TO FUND MEDICAID. Surplus funds in the account of the Patient Act, over and above certain levels to maintain actuarial soundness and to provide some reductions in premiums (which can be passed on in the form of lower health care costs), will be directed towards additional funding of Medicaid.

• EVENTS MAKING PATIENT ASSURED COMPENSATION ACT MANDATORY. If, in the determination of the Commissioner of Insurance, adequately funded and staffed for such purposes by separate legislative authorization, after due hearing and investigation,

•• cannot be made available for any specialty or group of physicians, or that its economic cost is such that its economic unavailability has created or is likely to create a public health emergency, or that a significant segment of the physician population will be adversely affected by the unavailability of the insurance

•• then within a specified time, there shall be mandatory participation in the Act by all physicians, and as to that specialty of physicians for which insurance is not available, and as to all patients with a claim against such physicians, during such period of time that the order of the Commissioner remains in effect.

B. SPECIFIC LEGISLATIVE PROPOSAL - PATIENT ASSURED COMPENSATION ACT

• In all medical malpractice cases against physicians or professional service corporations (such as Clinics) which are owned by physicians

• Creation of a legislative Patient Assured Compensation Act, whose purpose will be the payment of all allowable damages in excess of available required insurance coverage for participating physicians, including the attorney fees of the patient.

• Voluntary participation in the Patient Assured Compensation Act by patients with a claim against physicians by patients including such a request for participation

•• in their application before the Montana Medical Legal Panel,

•• or, if the claim has been ruled on by the Panel, including such a request in writing to the physician within 3 months of the Panel decision,

•• or alternatively, as part of and in any lawsuit filed against the physician

••• Part of the request by the patient shall include a demand, in proper form, for the physician to pay all economic damages of the patient, in a stated, itemized amount, pursuant to a schedule published for such purposes

••• During the period of time for response for a potentially -participating physician, the patient shall file no lawsuit against the physician, and all relevant statutes of limitation shall be tolled.

• Voluntary participation on the part of the physician, but for the physician to qualify for participation in the Patient Assured Compensation Act as that particular patient, the physician must, prior to any claim being made against the physician at the Panel level, or thereafter:

•• Maintain a minimum level of insurance as required by the legislation, or otherwise meet the minimum financial responsibility requirements of the legislation

•• Respond to the patient, in writing, in an approved form, within 30 days of receipt of the required notification of the patient's election to proceed with the Patient Assured Compensation Act, that the physician:

••• Has specified insurance coverage, in amounts on the order of $200,000/$600,000 or is financially responsible in at least the amount and as required by the Act

••• Will allow entry of judgment against the physician on the question of liability, for all purposes

••• Agreeing in writing to provide within 60 days thereafter, an inflation-indexed annuity providing for payment of the demanded economic damages, even if beyond the limits of insurance, or in the alternative, requesting the patient file suit for the sole purpose of a court determination of the damages to which the patient is entitled, at which point the patient is so authorized to file such a suit.

•••• The failure to timely respond on the part of the physician shall be presumed to be a request to the patient to file suit for purposes of damage determination, at which point the patient is so authorized to file suit

••• So providing such annuity within 60 days thereafter, unless the physician wishes a court to determine the amount of damages

••• Permitting disclosure from the appropriate sources, of the number of claims made against the physician with a previous

specified period of time, and if each of those claims resulted in a settlement or verdict against the physician and in favor of the patient, requesting a review by the Board of Medical Examiners to determine whether there is any basis for disciplin or any other action by the Board against the physician, which review must be undertaken by the Board

• A patient's demand for, and court determination of, damages shall correspond to and include under the Patient Assured Compensation Act the following damages only, pursuant to a schedule of such damages established for purposes of the court's determination

•• Compensation for medical expenses and for support services which are essential to maintaining a reasonable quality of life

•• Compensation for wage loss up to 70 percent of pre-tax, pre-disability earnings, i.e. full replacement of after-tax earnings

•• Compensation for potential earnings or replacement of home services performed by persons not in the labor force

•• Specified standards for determining inflation, interest rates, and wage growth parameters to be used in setting the schedule, in conjunction with the requirements of periodic payment of such damage

•• Such other specified, definable economic damages which it is in the interest of all that injured patients receive

•• Non-economic damages as indicated below

• The Patient Assured Compensation Act shall additionally include, as to any court determination of damages available to the patient

•• The inclusion of all restrictions on attorney fees, as provided in separate legislation in another portion of these recommendations, plus the allowability of attorney fees as provided by the Patient Assured Compensation Act, as set out below

•• A ban on all punitive damages against the physician

•• Periodic payment of damages legislation recommended in another portion of these recommendations

•• Modification of the collateral source rule, as recommend in another portion of these recommendations

•• Elimination of non-economic damages except upon a court determination that a serious injury exists which warrants such a damage, and then only based upon the age and life expectancy of the person, the severity of injury, and the usefulness of additional funds in maintaining a reasonable quality of life, pursuant to an established schedule where possible, with a maximum award in any event of $100,000 for such damages

• A requirement that the reasonable attorney fees of a patient be paid, over and above any award given the patient, after crediting any advance retainer paid

  •• if the lawsuit is instituted under the provisions of the separately-proposed Medical Patient Assured Compensation Act, which would prohibit the use of contingency fee contracts

  •• if the patient prevails in the lawsuit in an amount in excess of the larger of the offer of settlement required by the legislation to be made by a physician to qualify under the Act (an offer of payment of economic damages) or any offer of settlement made by the physician in the form of a formal offer of judgment allowed and pursuant to the Montana Rules of Civil Procedure, and not timely accepted by the patient

  •• with a specified advance retainer amount of attorney fees payable to the patient's attorney upon the filing of such a claim in court, to be credited against any subsequent award of attorney fees, and not to be repaid if the client is unsuccessful at trial, unless the court determines that the patient did not have a reasonable chance of recovery, in which case the amount is to be repaid by the patient's attorney, pursuant to an appropriate bond given by the attorney for such purposes

• Disclosure to the jury of the availability of attorney fees and the circumstances thereof

• The reasonableness of the award to be determined as with all other attorney fees pursuant to proposed legislation

• The fund established under the Patient Assured Compensation Act shall pay all amounts in excess of the limits of insurance maintained by participating physicians, as determined by the final decree of the court assessing the amount of damages, amounts covered by the physician or the physician's insurance to be paid by the physician or insurance carrier

• The fund would be required to be actuarially sound, as determined by the Commissioner of Insurance, with a required minimum balance maintained after payment of expenses and claims and after inclusion of reserves, and incurred but not reported set-asides.

• Financing of the Act will be either by legislative appropriation or assessments levied against Montana physicians, as a surcharge to their medical liability insurance (as determined by the Commissioner of Insurance) or an amount equivalent thereto if insured, plus amounts received from investment income earned by the fund, with the fund to be administered by

  •• The office of the Commissioner of Insurance, if public monies are used for funding the Act,

•• The Montana Medical Legal panel, if the Act is funded by assessments on physicians, with funds held in trust and all personnel bonded in connection therewith

• To the extent that the fund would be exhausted by payment in full within a six month period of all claims becoming final, then -- except as to payments for medical care and related benefits -- amounts would be prorated, until such time as the Commissioner of Insurance caused replenishment of the fund by assessments on physicians, whether legislative appropriations are made or not.

• Any patient making a claim in medical malpractice must, by their attorney if represented, or by the Montana Medical Legal Panel, be advised in writing in an approved form,

•• of the options available under the Patient Assured Compensation Act,

•• and be advised that participation in the plan involves a waiver of a jury trial on the question of damages, including limits on available damages pursuant to a schedule of the same made available to the patient

• If the patient's request to participate in the Act is included in an application before the Montana Medical Legal Panel, and if the physician timely responds thereto with a request that a court determine the amount of damages, the Panel sitting on the claim shall, in addition to its current responsibilities, prepare an appropriate report, based upon the available evidence presented, as to its recommendation of awardable damages under the Act.

• Upon a suit being filed to determine the available damages to the patient, the District Court appoint the same Panel as a special master or fact-finder in the case to make non-binding recommendations to the court on the question of damages, accepting the initial report of the Panel, in addition to any further charges it shall make to the same Panel, on its own initiative or on the initiative of the parties, for purposes of such additional fact-finding as may be necessary.

• If the patient's request for participation is made subsequent to the application to the Panel, the District Court shall order the Montana Medical Legal Panel to select a new Panel for purposes of its appointment as a special master, under the same circumstances as presented above.

• Otherwise, the District Court proceeding to be the same as in any other civil proceeding.

• If, in the determination of the Commissioner of Insurance, adequately funded and staffed for such purposes by separate legislative authorization after due hearing and investigation, cannot be made available for any specialty or group of physicians, or that its economic cost is such that its economic unavailability has created or is likely to create a public health emergency, then within a specified time, there shall be

mandatory participation in the Act by all physicians, and as to that specialty of physicians for which insurance is not available, and as to all patients with a claim against such physicians, during such period of time that the order of the Commissioner remains in effect.

• Any such determination by the Commissioner of Insurance shall include determinations by actuarial computation from competent actuaries hired by the Commissioner of Insurance.

• Surplus funds in the account of the Patient Act, over and above certain levels to maintain actuarial soundness and to provide some reductions in premiums (which can be passed on in the form of lower health care costs), will be directed towards additional funding of Medicaid, to enable their payments to physicians for care rendered; current procedures do not compensate physicians for the actual costs involved in many procedures.

C. REASONS FOR SPECIFIC LEGISLATIVE PROPOSALS ON PATIENT ASSURED COMPENSATION ACT

The general objectives of legislation concerning the Patient Assured Compensation Act are, on a voluntary basis:

- to provide a system of damages for the patient not unlike other forms of insurance

- to provide a system of assured and prompt economic damage payments for patients without the necessity of lengthy trials and costly expert witnesses and eliminating the cost of attorney fees to the patient, or, if there is a trial, to have such determination limited to the question of economic damages pursuant to a schedule for such purposes, after an admission of liability by the physician

- to provide a system of non-economic damages in cases where they are warranted, within reasonable limits

- thus further assuring the affordability and availability of medical malpractice insurance

D. BACKGROUND ON PATIENT ASSURED COMPENSATION ACT

1. Generally.

A. Compensation Funds.

A patient compensation fund is typically a governmentally operated mechanism which is established to pay that portion of any judgment or settlement against a health care provider in excess of a statutorily designated amount.

The fund may pay the remainder of the award or it may have a statutory maximum. If the fund has a statutorily designated maximum, the health care

provider is liable for any damages beyond the fund maximum unless there is a corresponding limit on liability.

Compensation funds are generally funded through an annual surcharge assessed against health care providers, with such surcharge often being a specified percentage of the provider's annual liability insurance premium. The statutes which set up these funds typically specify that the amounts received are to be held in trust and are to be invested by the insurance commissioner.

States which have established patient compensation funds require that participants in the fund either maintain medical liability insurance in an amount not less than the amount at which the fund becomes operational, or otherwise demonstrate financial responsibility in such amount.

Failure to maintain such liability insurance or otherwise demonstrate financial responsibility results in the provider not receiving the protection of the legislation.

The statutes differ as to procedures for claims handling if the fund is unable to satisfy its outstanding obligations.

Louisiana provides that if the fund would be exhausted by payment in full of all claims becoming final within a six month period, then the amount paid to each claimant shall be prorated. Any amount due and unpai at the end of a six month period must be paid in the following six month period.

In South Carolina, if the fund does not have enough money to pay all of the claims, claims received after the funds are exhausted are immediately payable the following year in the order in which they were received.

In New Mexico, if the fund is exhausted by payment of all claims allowed during a calendar year, then the amounts paid are prorated with an amounts due and unpaid as a result of such proration to be paid in the following calendar years, however, payments for medical care and related benefits are to be made before any other payments.

The manner of payment from the fund also differs from state to state. In Kansas, the fund is to pay in full claims of less than $300,000. Claim of $300,000 or more are to be paid by installment payments of $300,000 or 10% of the amount of judgment, whichever is greater.

Wisconsin provides that if there is fund liabilities to any one perso in excess of $1 million in any one year, then the fund may not pay more than $500,000 per year until the claim is satisfied.

The statutes in Kansas, Oregon, and North Carolina explicitly provide that the funds in those states shall not be liable for punitive damages.

The funds allow risk spreading over statutorily specified health care providers and thus help ensure that professional liability insurance remains available and affordable.

In Oregon, in the discretion of the insurance commissioner and with the approval of the court, payment from the state's patient compensation fund may be made by installments or annuities.

B. The Tie-In With Limits On Damages.

Some states limit a health care provider's liability if the provider qualifies for the protection. These limits usually tie into the compensation fund the state provides to help qualified providers meet their liability.

A second approach is to limit recovery by placing an absolute limit on the amount recoverable against a physician and any excess amounts of a judgment are paid from a patient compensation fund.

Some states limit the amount that can be paid out of the fund so the judgment may not exceed the amount payable by the provider and the fund combined. Six states have enacted these types of statutes: Louisiana, New Mexico, Nebraska, Oregon, South Carolina, Wisconsin.

A third approach is to limit recovery to a specified amount of certain types of damages. For example, a statute might place a $250,000 limit on recovery of pain and suffering damage or exclude medical expenses from the absolute limit: California, Louisiana, New Mexico, South Dakota, Texas.

Some statutes also limit the amount that can be paid out of the fund so the judgment may not exceed the amount payable by the provider and the fund combined. Six states have enacted these types of statutes: Louisiana, New Mexico, Nebraska, Oregon, South Carolina, Wisconsin.

Ten states have both a limit on physician liability and patient compensation funds.

As some commentators have indicated, the cap on awards plays an instrumental part in the success of Indiana:

> "...Indiana...where claims and rates have been stabilized. There, a legislative package combines a cap on awards with a state-run, actuarially sound, patient compensation fund that pays out on the high end of severe awards, reducing the liability company's needs for expensive reinsurance. The fund can remain actuarially sound because, with the award caps in place, it has a better idea of what it can expect to pay out and therefore can assess its rates more accurately." [1]

> "All but three of 30 established physician-owned companies polled by the American Medical Assurance Co. (AMACO) raised premiums [during the last 12

[1] American Medical News, June 7, 1985, page 25, "MD Insurers See Hope In Liability Crisis".

months]...Only Indiana's physician-owned company did not raise rates and said it had no plans for increases in 1985. In that state, there is a $100,000 limit on physician's liability with a Patient Compensation Fund picking up awards over that amount." [2]

"The frequency of claims and level of awards decreased in Indiana after the legislature passed a comprehensive malpractice reform act in 1975, which established a two-year statute of limitations starting from the time of occurrence, a ban on naming a dollar amount in the suit, pretrial screening panels, a $500,000 cap on awards, mandatory risk-management programs, and fact-finding panels." [3]

The no-cap on damages can be used as a contrast, as reflected in the following:

"The state legislature [in Florida] set up the Patient's Compensation Fund as a reinsurance program to provide unlimited professional liability coverage for judgments in excess of $100,000. This fund was financed by premiums paid by...insured.. physicians...and hospitals...just in case the fund lost money, the insured members were made assessable retroactively. The fund did lose money, some $12-million in its first six years..."

"Hawaii also has a Patient Compensation Fund, which provides malpractice coverage for awards greater than $100,000 and is funded by a surcharge on all health-care providers in the state. This fund is also said to be in financial difficulty due to unexpectedly large losses." [4]

A further comparison of the statutes of the states having patient compensation funds shows that many do not have provisions for the periodic payment of damages and many do not have legislation modifying the collateral source rule. The addition of these measures, plus measures to restrict attorney fees, undoubtedly will create a more favorable situation for such funds.

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[2] American Medical News, March 8, 1985, page 32, "Significant Boosts in Liability Premiums Reported".

[3] American College of Surgeons Bulletin, February, 1983, pp. 3-4, "The National Perspective: A Crisis May Be In The Wings".

[4] American College of Surgeons Bulletin, February, 1983, pp. 5-6, "The National Perspective: A Crisis May Be In The Wings".

2. States With Compensation Fund Statutes.

States with statutes providing for establishment of patient compensation funds are as follows:

Colorado	Kansas	Oregon
Florida	Kentucky	Pennsylvania
Hawaii	Nebraska	South Carolina
Illinois	Louisiana	Wisconsin
Indiana	New Mexico	Wyoming
North Carolina	North Dakota	

In Colorado, Illinois, and Wyoming, the provisions were enacted but the fund was never established.

3. Specific Funds.

Indiana

In Indiana, total damages recoverable by a plaintiff are $500,000. Qualified health care providers are liable for the first $100,000 of a judgment or settlement; the state patients' compensation fund pays the balance. [5]

To qualify, a provider must meet minimum insurance requirements and pay an annual fee. Health care providers qualify by showing part of $100,000 insurance coverage per incident and $300,000 annual aggregate. Hospitals must show $2 million or $ million annual aggregates, depending on their size; otherwise, responsibility can be negotiated with the state insurance commissioner. Additionally, health care providers must pay the surcharge.

The patient compensation fund assumes responsibility for the payment of claims under any one of three circumstances:

1. The limits of the primary coverage of the defendant or multiple defendants per occurrence ($100,000) are attained.

2. The defendant's primary coverage has been exhausted for the year ($300,000)

3. The defendant refused to pay a court-approved judgment, settlement, or award.

The fund's maximum liability for any one claim is $400,000 because Indiana has an absolute ceiling of $500,000 per claim for all medical liability damage. The fund has no role in the determination of liability but may object to the amount of damages.

The current surcharges are at 75% of the malpractice premiums.

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[5] Ind Code Ann sec 16-9.5-2.2 (West, 1983).

Ex. #3

Since the fund began operation, awards against the funds are higher than jury awards in many cases of questionable liability. Claims also tend to be slanted towards the ceiling so that in effect the ceiling really becomes a floor.

Structured settlements (periodic payments) are allowed against the total claim (which includes primary coverage and the fund monies.

The average value of claims paid in 1983 was $299,000. Attorney fees are limited to 15% of any award from the compensation fund.

The statutory provisions do not include changes in collateral source rules or in provision for periodic payments.

Although there has been some criticism that the fund system has produced larger awards than expected, insurance premiums in the state have remained moderate, despite a steady increase in the number of claims filed.

Kansas

The Kansas Health Stabilization Fund was created in 1976. The fund was created with an appropriated balance with the balance of amounts needed to be funded by surcharges on premiums for primary mandatory coverage of $200/$600,000. In 1984, the state of Kansas became liable for from $3 to $6 million per fiscal year to help support the fund.

State general fund support became necessary in addition to an increase in surcharge to 110 percent in 1985, as the fund was placed on an accrual basis from a modified cash-flow basis.

In a state without limits, the fund does little to affect the frequency of claims and very little to affect judgment sizes.

The average value of claims paid in 1984 was $308,825.

Louisiana

The Louisiana fund was created in 1975. There is a ceiling of $500,000 on general damages and economic loss. In 1984, the law was amended to allow payment for future medical expenses, prosthetic devices, rehabilitation services, and custodial care without limit.

The current surcharge rate is 24%, with physicians paying a surcharge based on classifications and hospitals paying a flat rate per bed.

Primary coverage requirements are $100/$300,000. Louisiana has a financial responsibility law permitting self-insurance.

The average value of claims paid in 1984 was $213,862.

New Mexico

New Mexico also limits the provider's liability to $100,000 and provides that the patients' compensation fund pay the balance. [6]

The New Mexico fund was created in 1976 and is financed by a 33% surcharge on the basic premium for primary coverage of $100/$300,000. New Mexico has a $500,000 limit on noneconomic damages and the fund's maximum exposure to such claims is $400,000. There is no limit on past medical expenses; future medical expenses are unlimited and may be paid by the fund as incurred.

Periodic payments are voluntary.

Pennsylvania

The Pennsylvania Medical Professional Liability Catastrophe Fund was established in 1976 as a state agency designed to provide coverage in excess of the basic medical malpractice insurance required of all providers ($200/$600,000 for physicians). Membership in the fund is mandatory for all physicians and surgeons and others covered. The fund's limits are $1 million per occurrence and $3 million in the aggregate for every provider member in any year.

The fund is financed by surcharges on premiums for basic coverage and investment income earned by the fund.

In 1984 the surcharge was 50% of the premium level for the insurance coverage. In 1984, the average value of claims paid was $295,474.

Wisconsin

The Patient's Compensation Fund and the Wisconsin Health Care Liability Insurance Plan were established in 1975. All claims over $200,000 are paid by the compensation fund, with the Plan being in essence a basic malpractice insurance carrier. All physicians, as a condition of licensure, must have malpractice liability insurance in the amount of $200/$600,000.

Health care providers who are able to meet Wisconsin's statutory requirements have their liability to claimants limited to $200,000 per incident and the greater of $600,000 or the insurance policy's limit for annual liability. [7]

There is no cap of any kind on liability in Wisconsin.

The fund is financed by surcharges and assessments by class. Membership in the fund is mandatory for physicians. The average value of the claims paid in 1984 was $ 604,629.

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6 NM Stat Ann sec 41-5-7(1982).

7 Wis Stat Ann sec 655.23 (West.

4. The Concept Of A Patient Compensation Fund With Scheduled Damages.

Since the early 1970's medical malpractice awards have been rising more rapidly than consumer prices or the cost of medical care. In response, some states have responded with dollar limits on awards in their legislation.

A major concern is the fact that awards for pain and suffering -- those amounts over and above actual economic loss -- are absorbing a very large and increasing amounts of total dollar payouts to patients.

One conservative estimate is that 30 to 40% of total indemnity paid on all medical malpractice claims in Florida in 1984 was for pain and suffering in excess of $100,000. [8]

Because the question of medical negligence involves insurance, and because the expectations of the patient are that the physician will have insurance, it is highly reasonable that -- given the state of affairs as to the availability and cost of malpractice insurance -- that the patient ask no more from the insurance than they would ordinarily purchase themselves for the risk involved.

The lawsuit system is a form of compulsory insurance which we all buy when we buy health care. When faced with the choice, most of us will not buy insurance for pain and suffering.

The economically optimal compensatory award in a medical malpractice case can be determined by looking at the type of insurance individuals purchase voluntarily.

A study of public and private insurance choices consistently indicate a willingness to pay for insurance to replace wage loss and medical expenses, subject to reasonable limits. [9] Private choices reveal an unwillingness to pay for unlimited medical care with insurance.

The only private disability insurance that is not a replacement of specific expenses -- thus bearing some resemblance to compensation for pain and suffering, is accidental death and dismemberment insurance, which typically pays a pre-specified sum in the event of a readily indentifiable physical injury. However, almost half of civilian wage earners do not

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[8] Florida Medical Association. Florida Medical Association Medical Malpractice Policy Guidebook, 1985, p. 170.

[9] Social Security Disability Insurance replaces 4=30% to 86% of predisability earnings, depending upon income and family status. All private long-term disability and pension plans limit coverage to 60% to 70% of predisability, pre-tax earnings, and include offset provisions against other coverages, such as Social Security Disability Insurance, to prevent total benefits from exceeding these limits. Since these replacement ratios refer to pre-tax earnings, coverage of after-tax earnings is virtually complete. Only 36% of the major medical plans have unlimited benefits. Private coverage of nursing home and other non-institutional long-term care is virtually nonexistent. Florida Medical Association. Florida Medical Association Medical Malpractice Policy Guidebook, 1985, pp. 171-172.

carry this type of insurance, and total contributions by employers and employees represent less than 1 percent of total contributions to health benefits. [10]

This is strongly indicative of a low willingness to pay for compensation beyond income replacement and medical expense. The current expectancy of those in support of the antiquated tort system of full coverage of economic damages plus pain and suffering far exceeds the coverage that people are prepared to pay for if given the choice.

If people are not willing to pay for it themselves voluntarily, and physicians form too small a base from which to afford such insurance, then one obvious solution is to either limit damages to that which the physician can afford or let juries pay for such awards directly from the taxpayer's pocket, i.e. without substantial limit but from a taxpayer supported fund for non-economic damages.

Not only is that approach one possible approach, but it has been suggested that general damages should be determined according to schedule, based on the age and life expectancy of the plaintiff, the severity of the injury, and the usefulness of additional funds in maintaining a reasonable quality of life.

Such a schedule is superior to a single uniform cap on all damages, economic or otherwise, which tends to hit hardest the young claimant with long life expectancy, who may have greater need of special provision because of less adequate coverage of health and disability insurance from other sources.

The tort system differs from other major compulsory insurance systems in attempting to compensate fully each individual victim, with loss measured after the occurrence of an injury, rather than using scheduled benefits as with other forms of insurance.

Those scheduled benefits can be used apart from or in conjunction with limits on non-economic damages, thus providing certainty as to the amount which will be received as compensation. This trade-off of certainty for uncertainty justifies some limitation on the non-economic side of damages in most instances.

An additional side effect would be a substantial reduction in the litigation needed to influence the outcome of a case, and an overall reduction in the uncertainty in pricing medical malpractice insurance, one factor in its high cost.

Such a schedule could (or perhaps should) provide for the following:

Compensation for

- medical expenses and for support services which are essential to maintaining a reasonable quality of life

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[10] Florida Medical Association. Florida Medical Association Medical Malpractice Policy Guidebook, 1985, p. 172.

- wage losses to the extent of full replacement of after-tax earnings

- potential earnings or replacement of home services performe by persons not in the labor force

- pain and suffering, in a modest amount only, for serious injuries only, based on the age and life expectancy of the person and the severity of the injury, and the usefulness of additional funds in maintaining a reasonable quality of life.

When combined with statutory standards for determining inflation, interest rates, and wage growth guidelines -- or the use of inflation-indexed annuities for future damages -- the whole matter of dispute resolution becomes much simpler.

Prepared by the Montana Medical Association, 2021-11th Ave., Helena, Montana 59601, G. Brian Zins, Executive Director, 406-443-4000. 2/86	LEGISLATIVE PROPOSALS - PATIENT ASSURED COMPENSATION

THE REPORT OF THE PROFESSIONAL LIABILITY COMMITTEE OF THE MONTANA MEDICAL ASSOCIATION ON PROPOSED LEGISLATION	FURTHER COMMENTS

THE LEGISLATION CONSIDERED

Legislation, especially in the short-run, is usually at best only a partial solution. But given that the legislative avenue needs to be fully considered, certain types of measures are regularly advanced as solutions to the medical liability problem.

This Committee has reviewed various legislative proposals, many of which have been enacted in some states, and some of which are original and presented here for the first time.

The available proposals are itemized in the separate Appendix to this Report, titled "SUPPORTING MATERIALS: LEGISLATIVE RECOMMENDATIONS OF THE COMMITTEE ON PROFESSIONAL LIABILITY", which Appendix also contains an in-depth background on the major areas of legislation considered and either accepted or rejected for purposes of these recommendations.

For sake of organization, all such proposals can be categorized into the following four categories:

1. Tort Law Reform

   (a) Changes In The Method Of Awarding Damages In The Traditional Lawsuit System

   (b) Changes In The Method Of Resolution Of Medical Malpractice Disputes

2. Insurance & Patient Compensation Availability Reform

3. Insurance Regulatory & Contractual Reform

4. Health Care Delivery System Reform

THE SELECTION CRITERIA FOR PROPOSED LEGISLATION

Each of these proposals was reviewed with the following tests in mind:

- Is there a reasonable basis to believe that the legislation will provide <u>some measure</u> immediate downward trend on insurance costs, and hence premiums and medical costs, if properly passed on by everybody?

- Is there a reasonable basis to believe that the legislation will provide a major long-term downward trend on insurance costs, and hence premiums and medical costs, if properly passed on by everybody?

- Is there a reasonable basis to believe that the legislation will lead to more stable insurance carriers in Montana or will reduce the likelihood of reduced availability of insurance or carriers in Montana?

- Is there a reasonable basis to believe that the legislation will reduce the number of injuries to patients, whether such injuries are the normal risks of medical procedure or actually the fault of physicians, or will improve the quality of medical care?

TORT REFORM LEGISLATION WHICH FITS THE TESTS IMPOSED

A significant number of proposals advanced involve changes in the tort or courtroom system of determining medical liability, apart from the other categories of legislation which might have some impact on the problem advanced.

The Committee, in its Report, recommends legislation causing reform of the current lawsuit, litigation, or tort system in the following major areas:

- Provision For Periodic Payments For Future Damages
- Changes In The Award Of Non-Economic Damages
- Changes In The Collateral Source Rule
- Changes In The Awarding Of And Allowance Of Attorney Fees
- Provision For A Medical Patient Assured Compensation Fund

Each of the above items finds support in independent scientific studies and received -- to varying degrees -- the support of the 1977 American Bar Association Report Of The Commission On Medical Professional Liability. [1]

With certain exceptions for stated reasons, all other tort reform legislation has been excluded from consideration because of:

- the lack of available evidence that such legislation will fit the tests imposed by the Committee in considering such legislation, or specific evidence that it will not.

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[1] 1977 Report Of the Commission On Medical Professional Liability. 1977, American Bar Association.

• legislation which is already in effect in Montana, or which even though in effect and even if somewhat defective, does not warrant substantial legislative efforts at this time. [2]

• other stated reasons [3]

The major reason that the recommended legislation has been limited to the above areas is that very few pieces of tort legislation have been shown, by independent scientific study, to have the effects desired under the tests imposed.

SCIENTIFIC STUDIES OR OTHER ANALYSIS SUPPORTING THE SELECTION

The results of such scientific studies and other independent analysis are summarized below, with in-depth materials presented in the supporting Appendix materials. [4]

At the outset and apart from any such studies, it is clear that a major problem of physicians is their small number in relation to the premium dollars they are expected to finance.

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[2] Examples of this type of legislation would be the Montana Medical Legal Panel and the legislation on the books in Montana which prohibits statement of the amount of damages (the ad damnum provision) in a claim in the complaint or initial pleading in a case.

[3] An example is found in the 1977 Report Of the Commission On Medical Professional Liability. 1977, American Bar Association, pp. 55, as to the statute of limitations:

> "Even as important a change as shortening the statute of limitations may have a small impact on costs. Most amendments give two or three years in which to act, and there is ample time for a person who is aware of a possible actionable injury to consult an attorney and bring suit...As the Commission put in its INTERIM REPORT, '...in view of the findings of recent studies that approximately 98 percent of disabilities are apparent within two years, and that 94% of all claims are reported within three years, even the most stringent statute which had been enacted (a two-year statute with no exceptions) would probably not have a significant effect on costs.' INTERIM REPORT, page 19, note 8]. Nonetheless, changes in the statute of limitations, especially those which limit the time for suits on behalf of minors and other legally disabled persons, will have a significant stabilizing effect on prices, since they will reduce the uncertainty with which actuaries must deal, and should therefore improve actuaries' predictions."

[4] See the Supporting Materials to this Report for a complete explanation of each of the studies reaching such findings, including other studies which have contrary findings as to some of the types of legislation.

Any legislation which causes the enlargement of the base of those paying premiums -- such as a state compensation fund which was financed to any degree by the taxpayers -- would have a significant affect on the amount physicians pay for their insurance.

That type of legislation, both in terms of taxpayer-financed terms and in physician-financed terms is considered here; as it involves each of the other recommended forms of tort reform, the scientific studies support such an approach, as does the general observation that increasing the base of those directly paying for the costs of the tort system will reduce the premiums charged to those carrying the insurance.

The following tort reform measures have been determined, by competent independent study, to have the effects desired in the degree indicated:

Type Tort Reform Legislation	Effect Of Implementation - Various Studies [5]
Periodic Payments	6% - 14% initial reduction in premium outlays
Limit On Damages	12% - 19% initial reduction in premium outlays
Collateral Source	8% - 50% initial reduction in premium outlays
Contingency Fees	9% initial reduction in premium outlays-reduced number of trials
Stat of Limit-Minors	Stabilizing effect on prices - statistically significant influence
Informed Consent	Statistically-significant influence
Ad Damnum	30% initial reduction in premium outlays - reduced claims costs
Mandatory Panels	Statistically-significant influence

The first four of these items are included in the recommendations of this Committee.

The topics of statutes of limitations of minor and informed consent were deferred for further study in the recommendations devoted to that are below.

Mandatory Panels and Ad Damnum legislation already exists in Montana, with recommendations as to ad damnum included in the material indicated fo future study. [6]

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[5] The combined impact of the measures is not the same as the sum of their individual impact, as the savings through the elements of some of the laws interact and reduce the opportunity for savings in other areas. For example, reduced recoveries through application of the collateral source offset reduces the percentage savings resulting from a revised contingency fee schedule, since the amount of savings depends on the size of the award Likewise, certain assumptions -- detailed in the recommendations in this Report -- are made as to the contents of the legislation and other factor which assumptions must be met for the indicated savings to likely occur.

[6] The proposed Patient Assured Compensation Act would involve minor changes in the Panel Act in Montana to make the two Acts consistent.

Without too much detail, some of those studies are summarized below, with additional details found in the appendix to this Report.

1. AMA GENERAL COUNSEL'S OFFICE SURVEY. [7]

The actuarial survey undertaken by and independent actuarial firm at the request of the American Medical Association with regard to specific tort reform proposals, indicated a total initial savings equal to 28% of premium costs to carriers from four specific proposals implemented together, with a likely range of from 23% to 33% depending upon the state and separately as follows:

- Periodic Payments For Future Damages in excess of $100,000: 6% Savings
- Limiting Non-Economic Damages to $250,000: 12%
- Eliminating The Collateral Source Rule: 8%
- Decreasing Sliding Scale For Attorneys' Contingency Fees: 9%

The analysis concluded that the reduction in claim severity trends (the dollar amounts claimed or awarded in claims made against the carriers) would

- in the typical state, approximate 4% per year, with most states realizing a trend savings ranging from 3% to 6%
- continue to increase since rising cost levels will increase the base of premiums paid and inflation will increase the potential for non-economic losses in excess of the $250,000 limit per claimant.

2. THE RAND STUDY. [8]

The RAND STUDY concluded that of the post-1975 tort reforms, caps on awards and mandatory offset of collateral compensation appear to have had the greatest effects.

Under that study:

- states that enacted a cap having a 19 percent lower average severity in awards and settlements within two years.
- in states that enacted a mandatory collateral offset, the severity of awards drops by 50%, on average, within two years time

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[7] November 22/29, 1985. American Medical News, p. 19. AMA General Counsel's Office commission of actuarial survey by Milliman & Robertson, Inc, New York. Survey: Actuarial Analysis of American Medical Association Tort Reform Proposals, September, 1985.

[8] Danson, P.M.: The Frequency and Severity of Medical Malpractice Claims. Santa Monica, Rand Institute for Civil Justice, 1983.

According to the AMA, the RAND CORPORATION study found as follows:

> "The Rand Corp.'s Institute for Civil Justice rates limitations or 'caps' on awards and changes in the collateral source rule as the most effective law changes in terms of reducing the size of jury verdicts and settlements. Also, changes in the laws that permit courts to order periodic payments of damages rather than lump-sum payments have been viewed as substantially reducing costs for insurance companies. A Pennsylvania study has estimated potential saving to be between 7% and 14% while a New York study suggests that potential savings might be approximately 5%...."

3. AMERICAN BAR ASSOCIATION. [10]

The Report of a special committee of the American Bar Association found as follows:

> "One tort change which is likely to have a measurable impact on premium costs is the repeal of the collateral source rule, so that costs now reflected in medical malpractice premiums would be shifted to first-party health and accident insurance and government health insurance programs. There would also be some overall savings due to the elimination of overlapping payments and the greater administrative efficiency of the collateral payers."

> "With the help of an experienced consultant, the Commission attempted to estimate the potential savings in malpractice awards in a 'typical' state which had broadly repealed the collateral source rule. While the conclusions necessarily reflect certain arbitrarily chosen assumptions, the Commission is reasonably confident that malpractice awards would be reduced by about 10 to 20 percent depending on the tendency of the fact-finder to ignore evidence of collateral sources."

> "*** Another tort law change which at least theoretically should have a downward impact on costs is a ceiling on recovery. However, as a practical matter, it is very doubtful whether the actual ceilings which have been enacted are low enough to be of any benefit from an actuarial point of view."

> "*** Finally, one other tort law change which could have noticeable impact on premiums, if used frequently in cases involving large future damages, is the periodic payment settlement or judgment."

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[9] p. 15, AMA Professional Liability Report 2.

[10] 1977 Report Of the Commission On Medical Professional Liability. 1977, American Bar Association, pp. 55 - 58.

4. OTHER STUDIES.

A. DANZON AND LILLARD. [11]

Danzon and Lillard tested, among other matters, the effect of modification of the collateral-source rule, limitation on awards, periodic payments, and contingency-fee limitations.

Their findings were as follows:

• States which sought to reduce awards by limiting plaintiff's ad damnum, by setting limits on award, or by instituting periodic payments did lower awards by 30% on average.

• Instituting a limit on lawyers fees reduced the percentage of cases dropped by five percentage points (i.e. lowered the plaintiff's asking price), reduced the fraction of cases litigated to verdict by 1.5 percentage points, and decreased settlement size by 9 percent.

B. DANZON. [12]

Danzon evaluated the impacts of post-1975 tort reforms and concluded, among other conclusions, that:

• States enacting a ceiling on awards had 19 percent lower awards by January, 1977.

• States requiring an offset of compensation from collateral sources experienced a drop of 50% in awards by January, 1977.

C. Minnesota Law Review. [13]

An article on elective no-fault insurance in the Minnesota Law Review reviewed studies available in the late 1970's, which concluded that other available sources of compensation such as Blue Cross, Blue Shield, accident and health coverage, and the like amount to at least 11% of the total tort recoveries, which amounted to 6% of the premium dollar.

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[11] Danzon, Patricia M. and Lee A. Lillard, "Settlement Out of Court: The Disposition of Medical Malpractice Claims," Journal of Legal Studies, Vol. XII, No. 2, June, 1983, pp. 345-77. According to the Florida Medical Association "Medical Malpractice Policy Guidebook", 1985, FMA, the study's "empirical results on tort reform effects should be viewed by policy analysts with caution. First, the time span was too short for assessing more than a very short-term effect. Second the authors considered only a limited number of reforms, and certain reforms were entered in some equations and excluded from others for reasons that are unclear." p. 95.

[12] Danzon, Patricia M. "The Frequency and Severity of Medical Malpractice Claims," Journal of Law and Economics, Vol. XXVII, No. 1, April, 1984, pp. 115-48.

[13] Minnesota Law Review, "Elective No-Fault", 1976, Vol. 60:501,504-505, at n. 11.

The writer of the article cited another study updating that of the first and including the overlapping of compensation that results from the fact that a claimant is excused from paying income tax on the compensation he receives for the amount of wages lost, on which he would have had to pay a tax if he had received that amount in wages. The writer concluded that figure of 8 cents on the premium dollar constituted a very conservative estimate of overlapping compensation.

OTHER LEGISLATION WHICH SHOULD BE GIVEN FURTHER STUDY

The following proposals for legislation should be given further study between now and the 1987 Legislative Session, to determine whether they should be included on the list of legislative objectives, it being the Committee's determination that such legislation may fit the tests imposed of legislation which should be presented to the legislature:

1. Ad Damnum Provision

A. RECOMMENDATIONS: The Committee recommends further study of whether additional legislative action is necessary to provide a penalty against the attorney for failure of the claimant in a malpractice action to adhere to the requirements of the law prohibiting a statement of damages in the initial pleading of a case. An alternative would be a proposal to the Montana Supreme Court that it provide such a penalty.

B. DISCUSSION.

Montana statutes, MCA 25-4-311, et. seq., prohibit damage amounts from being set out in the initial papers of a party seeking damages in a personal injury or wrongful death case. A procedure is set forth in the statute for a subsequent filing of such a damage statement.

The Montana Supreme Court, in Franz v Bednarek (Mont. S. Ct., March 14, 1984), 41 St. Rptr. 418, held that the remedy of a physician who has a suit filed against him or her stating a dollar amount is not the dismissal of the claim with prejudice (on a permanent basis), but rather: (1) the striking of the dollar amount from the complaint; (2) the allowance of the filing of an amended complaint without the damages in it. The Court did not rule on the question of whether the statute was or was not unconstitutional, even though such an issue was raised by the parties. [1]

It is unknown whether, in the face of this decision, the statute is being obeyed on a regular basis, thus eliminating the necessity of any further remedy or penalty.

The matter is of significance in that competent studies have concluded that a 30% reduction in premium outlays occurs from the existence of the legislation; to the extent that it is no longer effective, corrective measures should be taken.

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[1] Justice Shea dissented and claimed the statute was unconstitutional on its face because it infringes on the Court's rulemaking authority under the Montana Constitution. Such a result has been reached directly in White v Fisher, 689 P.2d 102 (Wyo S Ct., 1984).

2. Statute Of Limitations - Minors

A. RECOMMENDATIONS. The Committee recommends further study on the question of whether, given appropriate safeguards to assure that parents did not neglect a minor's interests, the current period of time of 19 years from the discovery of an incident to the required filing of a lawsuit on behalf of a minor should be shortened, to at least that allowed for an adult.

B. DISCUSSION.

The time in Montana within which a claim must be brought on behalf of a minor is one year past the age of majority. MCA 27-2-401. That would require suit by the 19th birthday.

For adults, the legal action in medical malpractice must be brought within 3 years after the date of the injury or discovery of the injury, whichever occurs last. MCA 27-2-205.

Twenty-one states have adopted special rules for minors, most typically providing that a child has until his sixth birthday before the statutory limits begin to apply. Texas overturned such a statute on the grounds that it was neither reasonable nor realistic for a child to be dependent upon parents bringing an action within the set time period.

Competent, independent studies have concluded that a reduction in the statute of limitations on behalf of minors would have a stabilizing effect on insurance prices and that such a change would have a statistically-significant influence on such prices.

3. Prejudgment Interest

A. RECOMMENDATION. The Committee recommends further study on the question of whether prejudgment interest should begin to run on an award from the date the claimant presents a written statement to the opposing party regarding the claim, or whether such interest should begin to run at a different time.

B. DISCUSSION.

The 1985 legislature passed a law, introduced by Senator Towe, that as to damages capable of calculation, interest begins to run at 10% on any amounts later awarded from a date 30 days after the claimant presents a written statement to the opposing party or his agent stating the claim and how the specific sum was calculated. [2]

Given that medical malpractice cases take a significant period of ti to reach trial, the mere statement of such a claim and the triggering of

[2] Senate Bill 322, passed into law and signed by the Governor, and encoded in Title 27.

such interest can be expected to have a significant impact on the dollar outlays of medical liability carriers at a time when there is great concern as to pricing stability. Delay in filing is costly to insurers because it lengthens the 'tail' of claims and makes the pricing of insurance more uncertain, particularly if plaintiffs delay filing.

Such a measure likewise introduced a very poor insurance climate for malpractice (and other) insurance carriers. Absent any changes in the very legal system which causes such delays, it may be unfair to cause interest to be paid when the causes of the delay may be attributable to the claimant's attorney. The legislation does not even require the claimant file the claim with the Panel or a Court after the Panel; the claimant can make his written demand and then sit back for up to three years, to await favorable developments in the law or just to accrue interest.

The act passed is further defective in that it makes no provision for whether the claimant's representation of the economic injuries is or is not realistic; the act only requires a written statement claiming some amount and allows interest on the amount awarded, whether or not the claimant was willing to settle the case or not.

A more satisfactory solution has been found in legislation which requires that interest be paid retroactively to the day the plaintiff makes a first settlement offer for such damages, if the defendant refuses the offer and the final judgment is higher. Even that solution has significant carrier costs associated with it. The California Hospital Association has estimated that this legislation in California will cost California hospitals as much as $20 million annually. [3]

An even better solution would be to make such interest run from the filing of a claim in court or the written statement as currently required, whichever occurs last, and then require that the written statement be made in the form of an offer of settlement, which if not accepted by the physician and where the patient recovers as much or more at trial, triggers the interest back to the latter of the written statement or filing of lawsuit.

The measure must also be viewed with a mind towards structured settlements or periodic payments. If this statute requires interest to be paid at the 10% rate on structured or periodic payment awards, that type of legislation would in effect be gutted.

4. Discoverability Of Peer Review Records

A. RECOMMENDATIONS: The Committee recommends further study to ensure that the proceedings and records of professional utilization, peer review, and professional standards review committees are not subject to discovery or introduction into evidence in any proceeding.

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[3] American College of Surgeons Bulletin, February, 1983, pp. 3-4, "The National Perspective: A Crisis May Be in the Wings.".

B. DISCUSSION:

Concern has been expressed concerning the ability of a claimant's attorney to obtain information divulged in peer review and other review committees, in light of apparent judicial decisions in the area.

Montana statutes provide that the proceedings and records of professional utilization, peer review, and professional standards review committees are "not subject to discovery or introduction into evidence in any proceeding" as follows:

> "*** (2) The proceedings and records of professional utilization, peer review, and professional standards review committees are not subject to discovery or introduction into evidence in any proceeding. However, information otherwise discoverable or admissible from an original source is not to be construed as immune from discovery or use in any proceeding merely because it was presented during proceedings before the committee, nor is a member of the committee or other person appearing before it to be prevented from testifying as to matters within his knowledge, but he cannot be questioned about his testimony or other proceedings before the committee or about opinions or other actions of the committee or any member thereof.***." [4]

5. Penalizing Malpractice & Physician Discipline

A. RECOMMENDATIONS:

1. The Committee recommends further study on how Montana statutes should be changed to further insure that medical disciplinary mechanisms are effective in dealing with any gross misconduct of physicians or patterns of negligence that persist over a period of time.

2. The Committee recommends adoption of a substantial number of the suggested potential changes as part and parcel of any legislation which provides for limits of any sort on non-economic damages of patients.

B. DISCUSSION:

Consideration should be given to strengthening the authority of the licensing board in the following regards:

> • impose specific, defined sanctions upon incompetent or unethical practitioners in addition to those currently included in the statutes, including the addition of provisions for imposition of fines and the requirement of restitution

[4] MCA 37-2-201(2).

• streamline the complaint process by requiring the Board to develop a system to prioritze complaints so that those which pose the most serious threat to the public welfare are promptly reviewed, with a requirement that the Board assume responsibility for how the system shall be established and a determination of the criteria for prioritizing the severity of complaints

• provide immunity from civil suits for board members when they are performing official duties unless they act in a grossly negligent fashion or exhibit deliberate and wanton misconduct

• clarify the relationship between courts and sanctions, by prohibiting any agency or court from ordering a stay of enforcement for a sanction imposed by the Board of Medical Examiners, prior to the final decision of the Board

• authority in the Board to require a licensed medical practitioner to undergo mental and medical examination when necessary to determine the practitioner's competency and fitness in any proceeding before the Board, limited to those situations where the Board has reasonable cause to believe a practitioner's ability to provide health care services is impaired by reason of a mental or physical condition

• require that license limitations or restrictions be displayed prominently in proximity to the original license

• correct what appear to be serious deficiencies in the record-keeping and data-processing capabilities of the Board of Medical Examiners, and make certain that sufficient funds are available to the Board of Medical Examiners for them to fulfill their functions, including but not limited to an increase in professional staff, investigator qualifications, and concomitant increases in salaries.

• require the review by the Board of Medical Examiners of any physician who loses or settles three malpractice claims of more than $10,000 each in any three-year period, with a requirement that the Board of Medical Examiners properly track and report on their findings in this regard

• otherwise require the Board to publicly report on the nature and extent of their activities with regard to the disciplinary action taken or not taken, by case, and including the length of times involved from initial complaints to final disposition

• provide for authority in the Board of Medical Examiners to enter into an agreement with the state medical society, its committees, or any component medical society and any of their committees whereby the Board may refer to such societies or committees for investigation and report, allegations of conduct which may constitute grounds for disciplinary action, with sufficient safeguards for such committees and the people who might be brought before such committees.

Ex. #3

- including in the definition of unprofessional conduct, the charging or collecting of an excessive fee

6. Punitive Damages & Physician Discipline

A. RECOMMENDATIONS: The Committee recommends further study of whether the following should be undertaken

1. Elimination of punitive damages against physicians in medical malpractice cases in conjunction with any measures to further insure that the medical disciplinary mechanisms are effective in dealing with any gross misconduct of physicians, especially including an increase in the level of medical discipline against physicians who have a pattern of conduct which warrants discipline, loss of license, or a loss of privileges.

2. Under circumstances where it is concluded that medical disciplinary mechanisms are not sufficiently effective, and under circumstances where no additional measures are taken to further insure that such mechanisms are effective, legislation which prohibits malpractice insurers from insuring against punitive damage awards against physicians and providing that punitive damages are the sole liability of the physician.

B. DISCUSSION.

"Punitive" damages or "exemplary" damages are those damages awarded by a jury at trial in addition to "compensatory" damages (economic and non-economic damages which fully compensate the person injured).

"Punitive damages" are those damages awarded by way of example and punishment: where the person being sued for the injury should suffer some additional penalty for wrongful conduct and where the punitive damages will serve as a warning to others and as a deterrent and punishment to the defendant.

By definition, punitive damages are in addition to full compensation. When awarded, punitive damages can be extremely large, even when actual damages are minimal. Such damages are impossible to accurately ascertain, can be manipulated by emotion, and are inevitably subject to speculation.

Such damages are difficult to build into the premium because they are impossible to accurately ascertain, can be manipulated by emotion, and are inevitably subject to speculation, and hence tend to be extremely large, even when actual damages are minimal.

They are particularly inappropriate in medical professional liability suits where state licensing boards, medical society and hospital peer review systems, and the criminal justice system provide adequate mechanis to discipline physicians.

STANDING COMMITTEE REPORT

March 27, 1986

MR. PRESIDENT

We, your committee on State Administration

having had under consideration SJR No. 1,

first reading copy (white color)

JT RESOLUTION FOR STUDY OF INSURANCE ISSUES: PUBLIC AND PRIVATE

Respectfully report as follows: That SJR No. 1,

be amended as follows:

1. Page 1, line 16.
Following: "WHEREAS,"
Strike: "recent turmoil"
Insert: "current circumstances"
Following: "industry"
Strike: "has"
Insert: "have"

2. Page 1, line 17.
Following: line 16
Strike: "placed"
Insert: "made"
Following: "protection"
Strike: "beyond the reach of"
Insert: "unavailable for"

3. Page 2, line 1.
Following: "WHEREAS,"
Strike: "certain"

4. Page 2, line 3.
Following: "are"
Strike: "extremely complex"
Insert: "not easily identified"

XXXXXXX
DO PASS

XXXXXXXXXX
DO NOT PASS

CONTINUED

Chairman.

March 27, 19 86

5. Page 2, lines 7 and 18.
Following: "tort reform"
Insert: "and constitutional amendment"

6. Page 2, line 13.
Following: "committee"
Insert: ", to which the full subpoena power of the Legislature and the Legislative Council is extended,"

7. Page 2, line 25.
Following: "arrangements,"
Insert: "attorney fees for defense counsel, reinsurance, a state reinsurance fund, insurance marketing assistance, wrongful discharge,"

And, as amended, DO PASS

Senator Jack Haffey, Chairman