House
Legislative
Analysis
Section

Olds Plaza Building, 10th Floor
Lansing, Michigan 48909
Phone: 517/373-6466

# MEDICAL MALPRACTICE LIABILITY

**Senate Bill 270 (Substitute H-1)**
**Sponsor: Senator Dan L. DeGrow**

**House Bill 4403 (Substitute H-1)**
**Sponsor: Rep. Lynn Owen**

**House Bill 4404 (Substitute H-1)**
**Sponsor: Rep. Lynn Owen**

**First Analysis (4-1-93)**
**Senate Committee (SB 270): Judiciary**
**House Committee: Judiciary**



## *THE APPARENT PROBLEM:*

In 1986, the legislature enacted a series of reforms aimed at growing concerns about the effect of the medical liability system on the availability and affordability of health care in Michigan. Reforms that specifically addressed medical liability issues included limiting awards for noneconomic loss (that is, pain and suffering) to $225,000 (with exceptions), specifying qualifications for expert witnesses, constricting the statute of limitations for bringing a medical malpractice lawsuit, providing for the dismissal of a defendant upon an affidavit of noninvolvement, requiring mediation, and requiring each party either to provide security for costs or to file an affidavit of meritorious claim or defense.

Opinion is widespread in the medical community and elsewhere that these reforms have proved inadequate. Providers of medical care and malpractice insurance cite numerous statistics to support their case. For both doctors and hospitals, medical malpractice insurance costs much more in Michigan than elsewhere, and, while Detroit area hospitals pay the highest liability rates in the country, even smaller, outstate hospitals pay more than some urban hospitals elsewhere: the average liability cost per bed is $1,400 nationally, $4,600 for the state as a whole, and $6,900 in Detroit, while the $2,800 per bed average for rural Michigan is higher than figures cited for Chicago and Cleveland. A 1990 report of the U.S. Government Accounting Office (GAO) confirms that while rates declined in the nation and adjacent states since about 1988, Michigan rates have continued to increase, although at a slower rate since 1986.

Reports are that only 37 cents of each dollar spent on medical liability premiums goes to victims of malpractice, while roughly half of the money paid in premiums goes to legal fees (plaintiff and defense combined) and court costs. Payouts per claim are increasing; one hospital insurer reports a 173 percent increase--from $51,000 to $139,000--in its average payout per claim between 1986 and 1990. Lawsuits, too, are on the rise, threatening to widen the gap between Michigan and other states; nationally, about a half-dozen lawsuits are filed annually for every 100 physicians, but the figure for Michigan is closer to 20 lawsuits per 100 physicians.

Using survey results and anecdotal evidence, critics of the current system maintain that litigiousness and the high cost of insurance in Michigan drive out physicians, either literally out of the state, or out of practice through early retirement; many other physicians choose to remain in practice, but eliminate costly elements such as obstetrics that carry a comparatively high risk for lawsuits ($1 million per occurrence/$3 million aggregate obstetrical coverage in Detroit costs $134,000 annually; for $100,000/$300,000 coverage, the annual cost is $63,000). The medical liability climate thus is held partly responsible for problems that people in urban centers and rural areas have in obtaining medical care, as well as responsible for increasing health care costs by forcing physicians to practice "defensive medicine."

One thing that carries the potential to reduce the time and expense of malpractice lawsuits is the use of binding arbitration. However, existing arbitration

provisions, which date to 1975, are little used; lack of participation has been attributed to patients' distrust of the current makeup of arbitration panels (which must have a physician as one of the three members), physician reluctance to serve on panels, the unwieldy process, and a lack of incentives to participate.

To alleviate problems with the state's medical liability system and address widespread dissatisfaction with it, further reforms have been proposed.

## *THE CONTENT OF THE BILLS:*

Senate Bill 270 would amend the Revised Judicature Act (MCL 600.1483 et al.) to do the following with regard to medical malpractice actions: revise limits on noneconomic damages and link them to compliance with proposed financial responsibility requirements, limit attorneys' contingency fees, require expert witnesses to be of the same board-certified specialty or health profession as the defendant, forbid certain discovery actions by counsel ascertaining whether a witness was qualified, bar a plaintiff from receiving payment for the loss of an opportunity to survive, require a plaintiff to notify a defendant 182 days before filing a suit, provide for the waiver of the physician-patient privilege when a malpractice suit is commenced, enact new provisions on voluntary binding arbitration, generally constrict the statute of limitations on suing for injuries done to minors, and eliminate the tolling (suspension) of the statute of limitations when a foreign object was left in the body.

The bill is tie-barred to House Bills 4403, 4404, and the "physician discipline" package (House Bills 4076, 4295, and companion bills); it also is tie-barred to House Bill 4033 (now in the House Committee on Mental Health), which under a proposed substitute would bring mental health professionals and facilities into the package. Generally speaking, provisions that are procedural in nature (such as those dealing with expert witnesses, arbitration, and the 182-day notice requirement) would apply to cases filed on or after October 1, 1993, while substantive provisions (such as those dealing with noneconomic loss limits and statutes of limitations) would apply to causes of action arising on or after October 1, 1993.

A more detailed explanation follows.

Noneconomic losses. The bill would replace the current $225,000 limit on noneconomic losses (which statutory adjustments for inflation have increased to a reported $280,000) and the exceptions to it with a two-tier limit. Generally, payment for noneconomic losses could not exceed $500,000. However, the limit would be $1 million if there had been a death, if there were a permanent disability due to an injury to the brain or spinal cord, if damage to a reproductive organ left a person unable to procreate, or if a medical record had been illegally destroyed or falsified. The award caps would be halved for a defendant who was in compliance with the financial responsibility requirements proposed by House Bill 4404. Caps would be annually adjusted for inflation.

Contingency fees. An attorney's contingency fee would be limited to 15 percent of the amount recovered if the claim was settled before mediation or arbitration, 25 percent if settled after mediation or arbitration but before trial, and 33-1/3 percent if the claim went to trial. (Court rules limit contingency fees to 33-1/3 percent.) The bill would prescribe the manner of computing the fee, require a contingency fee agreement to be in writing, and require an attorney to make certain disclosures regarding fees. An attorney whose contingency fee agreement provided for a contingency fee in excess of that allowed could not collect more than what would be received under his or her usual hourly rate of compensation, up to the amount provided by the applicable contingency fee limit.

Expert witnesses. At present, if the defendant physician or dentist is a specialist, an expert witness must be of the same or related specialty and at the time devoting a substantial portion of his or her professional time to either active clinical practice or medical or dental school instruction. Under the bill, each expert witness (not just those in cases involving specialists) would have to have spent a substantial portion of the preceding year in active clinical practice in the same health profession as the defendant or in the instruction of students. If a defendant was board-certified, the witness would have to be, and if the defendant was a general practitioner, the witness would have to either be a general practitioner or instructing students.

Neither the tax returns nor the personal diary or calendar of an expert witness could be sought or used by counsel to determine whether an expert

witness was qualified, and counsel would be forbidden from interviewing the witness's family members concerning the amount of time the witness spent engaged in his or her health profession.

Lost opportunity to survive. A plaintiff would be barred from recovering for a lost opportunity to survive.

Advance notice of suit. For the stated purposes of promoting settlement without the need for formal litigation, reducing the cost of medical malpractice litigation, and providing compensation for meritorious medical malpractice claims that would otherwise be precluded from recovery because of litigation costs, the bill would require a plaintiff planning to file suit to notify a defendant at least 182 days before commencing court action. The notice could be filed later if a statute of limitations was about to apply. Meeting the 182-day requirement for one defendant would cover meeting it for any future defendants added to the suit. The notice would have to contain certain minimum information about the case and its basis.

The claimant and the defendant would have to give each other access to each other's medical records within 91 days after the notice. A defendant's failure to allow timely access to records would be penalized under provisions regarding affidavits of merit and interest on judgments (see below). Within 126 days after the notice, the defendant would have to furnish the claimant with a written response with certain information about the defense; failure to provide the information on time would entitle the claimant to file suit immediately.

Affidavits of merit. Existing law requires plaintiffs and defendants either to post a $2,000 bond or other financial security for payment of costs, or to file an affidavit of meritorious claim or defense. The bill would delete provisions allowing security for costs to be filed in lieu of an affidavit. Affidavits would have to contain information on the basis and allegations of the case, as prescribed by the bill (this information would parallel that to be exchanged under the 182-day notice provisions). If the defendant failed to allow access to medical records as required by the 182-day notice provisions, a plaintiff's affidavit could be filed 91 days after the complaint.

Professional privilege. Someone claiming malpractice would be considered to have waived the physician-patient privilege or similar privilege with respect to a person or entity who was involved, whether or not that person was a party to the claim or action. A defendant could communicate with other health facilities or professionals to obtain relevant information and prepare a defense; disclosure of that information to the defendant would not constitute a violation of the physician-patient privilege.

Arbitration. The bill would repeal Chapter 50a of the act, which provides for arbitration of medical malpractice lawsuits, and replace it with provisions for voluntary binding arbitration that would apply to cases where damages claimed amounted to $75,000 or less, including interest and costs. The bill's arbitration procedures would be available during the 182-day notice period (that is, after notice was given but before a case was filed). Unlike current law, which calls for an arbitration panel consisting of a doctor, a lawyer, and someone who is neither, under the bill the parties would agree to a process for the selection of a single arbitrator. The arbitration agreement would also apportion the costs of the arbitration and contain waivers of the right to trial and appeal; defendants would waive the question of liability. The parties could agree to a total amount of damages greater than $75,000.

There would be no live testimony, and court rules on discovery would not apply, although certain information would have to be exchanged upon request under deadlines established by the arbitrator. The arbitrator could issue the decision with or without holding a formal hearing, although he or she would have to conduct at least one telephone conference call or meeting with the parties. If there was a hearing, it would have to be limited to presentation of oral arguments. The arbitrator would issue a written decision stating the factual basis for it and the amount of any award. There would be no right to appeal the award.

Settlements. If a case was settled (with or without court supervision), the parties would have to file a copy of the settlement agreement with the appropriate bureau of the Department of Commerce. The information would be confidential except for use by the department in an investigation; it would not be subject to the Freedom of Information Act.

Mediation. Current law provides for mediation of medical malpractice suits. Under the bill, if a

defendant rejected a mediation panel's evaluation, but the plaintiff did not, and the case went to trial, the defendant's insurer would be liable for the plaintiff's costs unless the verdict was more favorable to the defendant than the mediation evaluation.

Statute of limitations--general. Generally, a medical malpractice action must be commenced within two years after the injury was caused, or six months after it was or should have been discovered, whichever was later; however, in no event may it be commenced more than six years after the injury was caused. However, for certain injuries, this six-year statute of repose does not apply; the bill would eliminate an exception for situations where a foreign object was wrongfully left in the patient's body, and limit an exception for reproductive injuries to those where there was a loss of the ability to procreate in someone under 35 years old. An exception for fraudulent conduct of a health care provider would be retained. Giving 182-day notice as required by the bill would toll (suspend the running of) the statute of limitations.

Statute of limitations--minors. The running of the statute of limitations is suspended until someone reaches age 13. For injuries to a child that occur before age thirteen, action must be commenced by the time the child reaches age 15; after age 13 the regular medical malpractice statute of limitations applies. Under the bill, the running of the statute of limitations would be suspended until a child reached age 10, and an action for a child under that age would have to be commenced before the child's twelfth birthday, or within the regular medical malpractice period of limitations, whichever was later (the six-year statute of repose would not apply).

However, if an injury to the reproductive system of someone under age 13 was claimed, the claim would have to be brought before his or her fifteenth birthday or before the regular medical malpractice statute of limitations would apply, whichever was later (the six-year statute of repose would not apply).

Interest on judgments. The law now provides for the calculation and payment of interest on judgments. Under the bill, if a medical malpractice defendant failed to allow access to records as required by the 182-day notice provisions, the court would order that interest be calculated from the date notice was given to the date of satisfaction of the judgment. The injured party, and not his or her attorney, would receive the interest accruing on the portion of a judgment represented by the attorney's fee.

House Bill 4403 would amend the Insurance Code (MCL 500.2204) to require an commercial liability insurer to pay the plaintiff's attorney fees and court costs when an insured defendant had rejected a mediation evaluation under the Revised Judicature Act, the plaintiff had not rejected it, and the case went to trial. However, the payment requirement would not apply if the verdict was more favorable to the defendant than the mediation evaluation. The bill could not take effect unless Senate Bill 270 was enacted.

House Bill 4404 would amend the Public Health Code (MCL 333.16280 and 333.21517) to require each physician, dentist, psychologist, chiropractor, and podiatrist to maintain financial responsibility for medical malpractice actions. The financial responsibility would have to be one of the following: a $200,000 surety bond or irrevocable letter of credit; an escrow account containing at least $200,000 in cash or unencumbered securities; or professional liability insurance coverage with limits of at least $200,000 per claim and $600,000 in the aggregate.

Someone licensed on or before October 1, 1993 would have to file proof of financial responsibility with his or her licensing board by January 1, 1994. Others would have to file proof within 90 days after the issuance of a license. After the initial filing, proof would have to be filed annually.

Financial responsibility requirements would not apply to someone with a hospital affiliation, if the hospital provided the equivalent amount of financial responsibility. However, if the person practiced outside of the hospital, he or she would have to maintain financial responsibility for that portion of his or her practice performed outside the hospital.

Financial responsibility requirements would not apply to someone whose practice outside of a hospital consisted of at least 25 percent uninsured and Medicaid patients, based on the total number of patients treated annually by the person. Proof of such a practice would have to be filed with the person's board.

A hospital would be prohibited from granting privileges to a physician unless financial responsibility requirements were met. Compliance with the bill would not be a condition of licensure for a physician or other person required to maintain financial responsibility.

The bill could not take effect unless Senate Bill 270 was enacted.

## *FISCAL IMPLICATIONS:*

Fiscal information is not available at present.

## *ARGUMENTS:*

### *For:*

The bills would go far to discourage unjustified medical malpractice lawsuits and reduce the costs of the medical malpractice liability system, thus helping to contain spiraling health care costs, stem the flight of physicians out of Michigan, and assure the citizens of this state access to affordable health care. Stricter limits on pain and suffering awards, limits on contingency fees, early notice requirements, and new arbitration provisions would reduce litigation costs by encouraging arbitration and early settlement and curbing excessive awards.

New limits on pain and suffering awards and the medical malpractice statute of limitations would help to further reduce insurance costs by addressing the uncertainties and long period of exposure in this highly volatile area of insurance. Without such measures and controls on the costs of litigation, there is little to be done to reduce premiums, for neither they nor profits are inflated: the major malpractice insurers are customer-owned (that is owned by physicians or hospitals), and the insurance bureau reports a healthy degree of competition in the marketplace.

Victims of medical malpractice would not be ignored, however: requirements for physicians to maintain financial responsibility, provisions on payment of judgment interest, and incentives to arbitrate small suits that might otherwise go begging for legal representation all would help to put money in injured patients' pockets. Links to the physician discipline package would recognize the need to also protect patients by reducing the incidence of malpractice. And, eventually, the bills would help patients by holding back health care costs, and not only through effects on premiums; far greater savings are likely through easing physicians' litigation fears, thus reducing the need to practice "defensive medicine" which drives up the cost of health care through the use of high technology and second opinions.

The bills offer a balanced compromise that should streamline the system to the ultimate benefit of both patients and health care providers.

### *Against:*

Many dispute whether there is really any sort of malpractice "crisis" that demands resolution, and certainly not resolution by restricting legal recourse for victims of malpractice. If malpractice litigation appears to be a problem in Michigan, it is because Michigan ranks low in its effectiveness in getting bad doctors out of business, and because insufficient attention has been devoted to risk management in hospitals, where the vast majority of malpractice claims arise. If insurance costs too much, it is because insurers are charging too much; profits are up in recent years, but premiums continue to rise. More carriers are writing malpractice insurance in Michigan, and availability problems have decreased.

The numbers of physicians are up, not down, thus countering assertions that Michigan's malpractice climate has led to problems in obtaining care. Moreover, it is unreasonable to hold the medical malpractice system responsible for the lack of health care for residents of poor urban and rural areas of Michigan; recruiting doctors to such places is a problem across the country, and has long been so.

If rising costs of health care are a real concern, then attacking the medical liability system would have little effect: insurance premiums represent only one or two percent of total health care costs, and "defensive medicine" habits are unlikely to be affected (nor should they, say some, as the caution and thoroughness that characterize "defensive" medicine also characterize good medicine).

Virtually every assertion made by the proponents of medical liability reform has been challenged with conflicting data. Many believe the picture is not as clear as some present it, and urge restraint before prematurely assuming the reforms of 1986 need strengthening. Rather than again taking aim at the victims of malpractice, reformers should first look to the defects of the insurance and physician discipline systems.

*Against:*
While the reforms are a step in the right direction, they do not go far enough. Overly broad exceptions to caps on noneconomic awards would continue to allow half or more of major cases to get out from under the limits, as the language could be stretched to allow the exemption of many relatively minor injuries. A permanent limp, for example, could be argued to meet the exception for permanent disability.

Contingency fee provisions also are inadequate: without firm limits on attorneys' financial incentives to seek windfall awards in marginal cases, case filings are unlikely to decline. Worse, the proposed sliding scale would give attorneys an incentive to push for trial by giving them a bigger take than if they settled out of court or accepted arbitration.

Finally, Senate Bill 270 would do nothing to rid the system of professional witnesses. By allowing expert witnesses to qualify if they spent a "substantial portion" of their time in the necessary fields, the bill would continue to allow justice to be subverted by traveling "guns for hire."

*Against:*
Limits on contingency fees raise a number of constitutional issues. Being a matter of practice and procedure, contingency fees are properly within the constitutionally-determined purview of the supreme court, and are at present set by supreme court rule. To attempt to regulate contingency fees in statute would conflict with the court's constitutional rule-making authority and the doctrine of separation of powers. Statutory limits on plaintiffs' attorney fees may also violate constitutional provisions for equal protection, if defendants' fees are not also regulated. Finally, by inserting itself into a matter that is between attorney and client, Senate Bill 270 may intrude on the right to contract.

*Against:*
A major problem with the current state of affairs is the heavy financial burdens that a physician must assume if he or she practices in Michigan. Rather than ease those burdens, the legislation would add to them by requiring physicians to maintain a specified form of financial responsibility or lose hospital privileges. The financial responsibility requirements would tend to exacerbate problems with physicians leaving practice in Michigan.

*POSITIONS:*

The State Bar of Michigan opposed Senate Bill 270 as passed by the Senate, has concerns about the constitutionality of provisions on contingency fees, and is supportive of portions of the House substitute. (3-30-93)

The Michigan Trial Lawyers Association does not support the package. (3-30-93)

The Advocacy Organization for Patients and Providers does not believe the package will resolve the problem, in part because it is not linked to insurance reform. (3-30-93)

Physicians Insurance Company of Michigan (PICOM) opposes the package, but could support it with amendments. (3-30-93)

The Michigan Medical Liability Reform Coalition opposes the bills. (3-30-93) Organizations in the 75-member coalition include the following:

Greater Detroit Chamber of Commerce
Michigan Association for Local Public Health
Michigan Association of Osteopathic Physicians and Surgeons
Michigan Dental Association
Michigan Farm Bureau
Michigan Hospital Association
Michigan Hospital Association Mutual Insurance Company
Michigan Insurance Federation
Michigan Manufacturers Association
Michigan Physicians Mutual Liability Company
Michigan State Medical Society
Physicians Insurance Company of Michigan