2009 HOUSE JUDICIARY

HB 1390

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1390

House Judiciary Committee

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Minutes:

Chairman DeKrey: We will open the hearing on HB 1390.

Rep. Wes Belter: Sponsor, support (attachments). I have a personal experience that has really made me aware of the impact that non-economic damages can have on an individual. I believe we should remove the cap completely. That will enable the parties to reach a settlement award by negotiation or by the court without bumping up against the cap. Think about the victim, they need our protection.

Rep. Delmore: Are other states looking at this same statute, especially in the surrounding states.

Rep. Wes Belter: I don't know, but Minnesota doesn't have caps at all.

Rep. Zaiser: Having gone through your experience, do you think you are more aware now because of your personal experience.

Rep. Wes Belter: It did make me more aware. In 1995 medical health care costs were out of control and we put in this cap at that time.

Chairman DeKrey: Thank you. Further testimony in support.

Sen. Tony Grindberg: Sponsor, support. There are three reasons to bring suit against someone: 1) anger; 2) money; or 3) to make a difference. This cap restricts a lot of people that don't have a voice.

Chairman DeKrey: Thank you. Further testimony in support.

Rep. Wes Belter: This bill is not about me. My case was settled, but it is about just compensation to those who will be injured in the future.

Chairman DeKrey: Thank you. Further testimony in support.

Rod Pagel, Attorney: Support (2 attachments).

Rep. Delmore: Your statistics are very interesting. Can you give us any possible reasons why those differences exist because of the cap.

Rod Pagel: I think that the caps do encourage litigation. I tell my potential clients to think long and hard about going forward in a medical malpractice suit because of the time and money involved. You can't find a ND doctor to usually testify against another ND doctor. You have to bring in outside experts to testify.

Rep. Delmore: What is the cost of an expert witness from another state in an average malpractice case.

Rod Pagel: It can cost between $2500-5000 to retain the doctor and for the whole case about $20,000-25,000, especially if they have to testify at trial.

Rep. Delmore: Do you have any statistics on whether since 1995 the number of lawsuits has gone up in the state or down.

Rod Pagel: I don't have any information of that nature. Frankly, it would surprise me if it had gone up.

Rep. Klemin: The issue we're talking about is a cap on non-economic damages. There isn't a cap on economic damages. Please explain the difference between economic and non-economic damages.

Rod Pagel: In any negligent case, there are economic damages, which are a loss of income, medical bills, hire a home care worker, etc. Non-economic damages are the pain, suffering, emotional trauma, loss of quality of life, etc. things of that nature. Those are hard to prove.

Rep. Klemin: In regard to the cost of the expert medical witness, unless you settle the case, if you go to trial and prevail, aren't those recoverable costs, part of the judgment.

Rod Pagel: Yes, if my plaintiff goes to trial and prevails, I can petition the court to recover costs, and that medical witness would be included in those costs. But on the other hand, if we go to trial and don't prevail, the defense gets their costs recouped against the plaintiff and they have to pay.

Rep. Griffin: Is there an incentive for an attorney to bring a frivolous malpractice suit.

Rod Pagel: From my standpoint, no. I have a lot of expenses for time and costs that won't be recovered if it were a frivolous case. I have to have a doctor from somewhere in the nation to have looked over my plaintiff's case and come to testify at trial. These are all expenses that are paid by me because these cases are usually on a contingency basis. A jury would certainly be able to see through a frivolous case if we were to bring such a case.

Rep. Griffin: How many successful trials that have awarded for plaintiffs in medical malpractice cases in ND; have there been very many at all.

Rod Pagel: I don't know. There have been some successful plaintiffs' cases. Statistics will tell you that nationwide, roughly 90% of medical malpractice cases are defense cases. So that's 1 out of 10 are plaintiff's cases. From my standpoint , I want to make sure I have the best case I can before I go to trial. If not, that client is exposed to costs from the other side.

Rep. Dahl: Has there been a case that has even come close to the current cap in non-economic damages.

Rod Pagel: I believe that a vast majority do not reach the cap. But on those worst cases, it might have come close.

Rep. Dahl: Is the cap really an issue then, if in most cases, they are not bumping up against that ceiling, is there an issue then if most juries aren't probably going up against that amount.

Rod Pagel: I don't think many are up against that cap, the problem is that in those cases where it is an issue, they can't go any higher than the cap. I think it really affects the outcomes in those cases.

Rep. Zaiser: I know that doctors stick together, does the cap have a bearing on that, for the attorneys to take the case or not.

Rod Pagel: No, from my personal experience, I don't think the cap has a bearing on whether you take the case or not. I know how difficult it is to get one doctor to testify against another doctor, and I let my clients know that before we even begin a case. It is hard to prove legal malpractice as well as medical malpractice.

Rep. Zaiser: In what way would the cap prevent you from resolving the case.

Rod Pagel: The affect of the cap is that I can't get the true value of that non-economic claim. If you have someone who has died, do I think the value of that person's life or trauma caused to someone, such as cerebral palsy, is worth in excess of $500,000, yes in a lot of situations I do. But I cannot get that in a settlement because the other side knows that is the highest and they don't ever go that high in the settlement.

Rep. Zaiser: To me a value of a life is way beyond $500,000. The limit of $500,000 would certainly make it hard to reach a fair settlement.

Rod Pagel: Yes and no. When I am negotiating a settlement, the other side goes as low as they can and of course, knows what the limit is, and I can't get anywhere close to that. Since there isn't a bottom cap on the non-economic damages, they go as low as possible.

Rep. Wolf: Do you know when it comes to medical malpractice, in other areas of litigation, such as a car accident, do you know their caps on economic or non-economic damages in any other part of our century code regarding lawsuits.

Rod Pagel: No, there are no caps on negligence cases in car insurance.

Rep. Klemin: This particular cap applies to more than just to physicians, correct. It applies to other kinds of health care providers.

Rod Pagel: This applies to all health care providers, such as doctors, nurses, healthcare facilities.

Rep. Klemin: How about dentists.

Rod Pagel: Yes.

Rep. Klemin: Optometrists.

Rod Pagel: Yes.

Rep. Klemin: Hospitals.

Rod Pagel: Yes. Any type of health care provider is covered.

Rep. Koppelman: Can you give me an idea of what percentage of a claim in malpractice suits is typically hard financial loss, factual loss vs. non-economic damages.

Rod Pagel: That's a difficult question to answer. If you have a child who will need lifelong medical care, then my typical suggestion would be that the economic side of that is probably a little easier to prove. Alternatively, in the situation where someone has passed away as a result of medical negligence case, then it is pretty flimsy as to the economic damages because you don't know what they would have been had they lived.

Rep. Koppelman: So this statute applies also to wrongful death claims or strictly medical malpractice.

Rod Pagel: Yes it applies to wrongful death if death is due to medical malpractice.

Rep. Koppelman: So if a 25 year old father of three children, who is a professional and has a reasonably good earning capacity and large economic dependency, and you can demonstrate that he died because of medical malpractice, I would think that you would be looking at the $ he would have earned.

Rod Pagel: Yes, you could use his earning capacity as economic damages.

Rep. Koppelman: And there isn't a limit on that.

Rod Pagel: No, there is not. Again you take that person and make him 18 or 21 and just starting his life, in college, has no demonstrated earning potential, but with a mother and three siblings, or a recently retired individual, what is the value of their economic losses.

Rep. Koppelman: So you're saying that the economic damages cannot be calculated for that type of person.

Rod Pagel: Yes. It is difficult to quantify such losses.

Rep. Koppelman: I remember a fairly high profile case of a doctor in Mississippi who came to ND because of their high malpractice rates there in MS, the higher propensity for higher award lawsuits in the non-economic area, which might have resulted in their high malpractice rates. I've heard of cases like that. Are there any places where attorneys are capped for the fees that they are entitled to.

Rod Pagel: The effect of the insurance situation, I think you will find in the data I supplied, shows that insurance premiums aren't based so much on caps for the legal fees, it's more so because of the cycle of the insurance industry. Is there a cap on attorney's fees in a contingency basis, no. In ND is there a cap, no. From a federal standpoint, there are some

caps in place. In federal cases, it is 25% of the total award, but no in state cases. I tell my prospective clients that I will do it on an hourly basis or on a contingency. I don't care which. That is a choice they make, no matter what. I have yet to have anyone choose an hourly basis. The problem with the hourly basis, is that I am going to get paid no matter what the result. On the contingency basis, I am only getting paid if I win the case.

Rep. Koppelman: How many states have caps.

Rod Pagel: I don't know the number of states. I believe there are more states that have caps of some nature, than the states that do not. I believe there are about 20 states that do not have caps.

Rep. Kretschmar: Has there been a court case where the cap was found to be unconstitutional and the court has ruled on that in ND or somewhere else in the country.

Rod Pagel: In ND I am not aware. I believe that the cap, in some other states, has been found to be unconstitutional. I can't stand here and tell you what exactly happened in those cases.

Rep. Kretschmar: Are you aware of any state that has taken the caps off that had them.

Rod Pagel: Frankly I'm not aware of what the states are doing. There was a push to put caps on, and I think that push has calmed down. Do I know of any states where they have removed caps, I don't know.

Rep. Zaiser: You mentioned that there are indices that are used for the cost of living. Does the cost of living have anything to do with the caps.

Rod Pagel: The caps range from $125,000 and up. I don't know what the highest amount is.

Chairman DeKrey: Thank you. Further testimony in support.

Mathew Schwarz, private citizen: Support (attachments).

Rep. Wolf: What is a hospitalist.

Mathew Schwarz: A hospitalist is someone who is hired by the hospital. I am not against the hospitalist program but we had requested that only her physician attend to her.

Ch. DeKrey: Thank you. Further testimony in support.

John Risch, Legislative Director of the United Transportation Union in ND: Support (2 attachments). We ask that you remove the caps, there are no runaway juries in this state.

David Peterson, former lawyer: Support, I have 20 years experience as a plaintiff's attorney in medical malpractice cases, and have also defended cases as an Assistant US Attorney. Doctors in ND wouldn't even review the case. I had to go out of state for the plaintiff cases which was very expensive. The ND doctors were always ready to lend a helping hand for the defendants' cases. In my 40 years of experience, I have tried over 200 cases to juries. Approximately 85 of those cases were civil cases and 115 were criminal cases, including murder, drug cases, etc. and we allowed the juries to make decisions in those cases. Why would we not allow our jury to make decisions in these types of cases. I believe we can leave these decisions for the juries to decide what an appropriate level of compensation is. For someone who has lost his wife or someone been rendered a paraplegic as a result of the negligence of some doctor. If you drive down the street, and you have an accident and cause the types of injuries, you are going to be responsible for all of the economic and non-economic damages. If you're the administrator of the local hospital and you are, unfortunately involved in a medical malpractice incident where you have a very large salary and you're unable to work for the rest of your life, you are going to recover if there is viable medical malpractice action for a considerable amount of money. But suppose you are a minimum wage employee at McDonalds and you're 25 years old and you're rendered a para- or quadriplegic because of a medical error, and your economic loss is not going to be very high; but what it is worth to spend the rest of your life in a wheelchair with someone feeding you. (related a couple of

examples of what could happen). Our ND juries are very practical people. Over 200 times I have taken a case to the jury, civil and criminal and I can't think of more than three or four where I disagreed with the verdict they came back with. I may not have liked the verdict that they came back with, but I did not disagree with their ultimate decision-making. You have all of these practical people in ND, they go to a jury room, give them all the facts, and let them make the decision. Justice can't be done in medical malpractice cases with this cap. It simply should be removed and left to the jury to do justice.

Chairman DeKrey: Thank you. Further testimony in support. Testimony in opposition.

Bruce Levi, Executive Director, North Dakota Medical Association: Opposed (2 attachments). A new environment is emerging in terms of how we address medical errors, known as the Patient Safety Act, and we are seeing stabilization in the field. Thirty (30) other states have caps on non-economic damages.

Rep. Delmore: How many cases with non-economic damages are filed for suit in ND.

Bruce Levi: I have data available which is about 5 years old over a 10 year period, and also have some numbers on claims and settlements that have been reported directly to the Insurance Department, but I don't think they break out the amounts.

Rep. Delmore: How many of those cases were won and what the damage award was. I think we have heard some pretty clear instances where the damage may not be met by $500,000. Would you concur that there may be cases where that is going come into play.

Bruce Levi: I don't know. I think there are others that will have that information.

Rep. Zaiser: Do you know how many lawsuits were brought forward that were frivolous.

Bruce Levi: I don't know because there is a screening process in place in ND, where there has to be a medical expert before they can go forward.

Rep. Zaiser: Saying that there is a broken legal system a little ironic, considering the state of the medical system.

Bruce Levi: I would agree. In the medical world we are calling for reform in the health care system.

Rep. Zaiser: Wouldn't you say that the biggest problem is access and affordability in the medical field.

Bruce Levi: Yes, I agree. I think this issue relates directly to the issue in terms of the need for a stable medical liability environment.

Rep. Zaiser: I know that medical doctors take the Hippocratic oath. If someone is limited to a $500,000 malpractice claim if they were injured in a major way, I don't think that person's whole, so I'm wondering if that is a violation of the Hippocratic oath.

Bruce Levi: I don't believe it is. I think initially the comment to be made is that the patient is entitled to unlimited economic damages and the only limited damages are the non-economic damages. There is a crisis going on around the country in regard to access to care. No one wants to see incompetency in the medical community.

Rep. Griffin: There are punitive damages caps in other areas. Do you know what areas those are in.

Bruce Levi: I think we have a cap on punitive damages generally in civil actions.

Rep. Griffin: What are those caps?

Bruce Levi: I think it is $250,000.

Rep. Griffin: You're saying that your position against it is because of the possible increase in malpractice insurance premiums.

Bruce Levi: I think it goes beyond that. It is the environment in which health professionals practice in ND. If the environment is unstable, it makes it impossible or very difficult for people

to practice here. If it impacts our ability to retain physicians or recruiting someone to come to ND. I think that's the problem without flexibility. This has shown to have worked, to be working right now. It has worked across the country. We would like to see an alternative to the legal system, we would like to see more work on Patient Safety and improve the care and quality of care. But right now, looking at removing the cap could be devastating to our liability insurance rates in ND. We don't really know what the consequences will be.

Rep. Griffin: We went from a situation where we had no cap, to a situation where we have a cap. So instead of looking around the country, let's look in ND. Is there evidence that putting this cap in place in ND that medical malpractice premiums actually went down. Did it work.

Bruce Levi: I have the numbers here, the premium rates in 1995 for ND, from one carrier. I have the numbers from 1997-2003 for internal med, general surgery and OB/Gyn. I see different levels that started out at 0%, 5%, etc.

Rep. Griffin: Can you provide the premium rates before and after the cap on the insurance premiums.

Bruce Levi: I should be able to find the figures.

Rep. Griffin: You said that ND currently has some of the lowest medical malpractice insurance rates in the country. Didn't we also have one of the lowest before the caps went into place.

Bruce Levi: I would have to find that out. I don't know. I am assuming that they were low.

Rep. Wolf: Has our Supreme Court ever been challenged on the constitutionality of the caps.

Bruce Levi: The current cap has not been challenged.

Rep. Wolf: Do you know what any of the capped damages awarded have been in our state, are they any astronomical awards in ND.

Bruce Levi: I do have data from the Insurance Department. I can look at the settlement numbers that are on here, they range from some large ones of $1.2 million, etc. to much lower settlements.

Rep. Wolf: Do you know if doctors pay their own liability insurance.

Bruce Levi: About 75% of our physicians are employed by hospitals and come under their health systems. Some of the other 25% are either self-funded or they're in a group setting where it can be negotiated with their salary.

Rep. Koppelman: You said that there is a $250,000 cap on punitive damages, $500,000 on non-economic damages and no cap on economic damages (what you can prove you are damaged).

Bruce Levi: Yes.

Rep. Koppelman: It appears that there are 10 states that have no caps, and 40 states do have some cap system in place. How do we stack up against the states with caps, are we in a good range.

Bruce Levi: That's correct – we're okay. The courts have overturned caps in 11 states.

Rep. Koppelman: We seem to be on the high side of the caps, this is workable in ND.

Bruce Levi: I would agree that our cap has shown, at least from our standpoint, to be a workable cap in ND. It is not the lowest, nor is it the highest cap in the country. We ask that it be left alone.

Rep. Klemin: I was just going to mention that you were asked to provide some information on pre-1995 and post-1995 rates, I think you have to make sure that those are in constant dollars so that the dollar amounts aren't affected by such things as inflation, etc.

Rep. Zaiser: You talked about the egregious settlements, or high settlements. What types of cases were they, did they involve death?

Bruce Levi: There is an explanation of a major claim.

Rep. Zaiser: You said that doctors were moving out of MS because of the liability situation. Isn't MS one of the least progressive states in the Union.

Bruce Levi: Actually MS adopted the ND model of caps and addressed a lot of serious issues that were facing their state in terms of the medical climate.

Rep. Zaiser: How do you put a limitation on $$ for pain and suffering for patients.

Bruce Levi: There are always different sides to the issue. It is an imperfect situation. The system creates delays. If we go back to no caps, we will go back to defensive medicine, instead of offensive. If doctors are afraid of being sued, they will perform unnecessary tests to make sure that there isn't a cause of action. This will create more costs for the patient. This defensive medicine involves a loss of time for the doctors and patients. We will lose good doctors, health professionals because of the issue with medical liability, with not only doctors, but nurses, etc.

Chairman DeKrey: Thank you. Further testimony in opposition.

Tracy Kolb, Attorney: Opposed. I have represented hospitals, doctors, etc. since 1995. In 1995, this statute was part of a comprehensive health care reform act. This is only a small part of the whole reform act. In cases that I've handled, we've never even come close to the cap of $500,000. I believe that the cap is a tool that helps to settle the case instead of having to go to trial. Non-economic damages are unquantifiable. There is no way to quantify those losses. There is always going to be an arbitrary number for pain and suffering, emotional distress, inconvenience. Those are unquantifiable, as opposed to economic damages, which are more clearly defined and quantifiable. There is no limit on those damages. You have to prove those losses. There are also fewer insurance carriers in ND that are even licensed to sell the malpractice insurance. A lot of our hospitals are self-insured. They don't even carry the

liability insurance through an insurance agency. They usually carry an amount of $1 million in their self-insured account. There is no shortage of expert witnesses, you just may have to go out of state. The cap has not been challenged in ND because it is working. There are other caps in place in ND such as for punitive damages, etc.

Rep. Delmore: I would rather not have the lawyer have to find a doctor via the internet. I don't think they were saying that they couldn't find a doctor; just that it would be handier for somebody in ND to testify for them. Wouldn't you agree that would add credence in a jury trial if the expert was from ND.

Tracy Kolb: I don't really think so. There are expert witness services all over this country that offer that offer that service. I think the standard of care is pretty standard across the country. Is it nicer to find a doctor in ND, yes. If you can't find a doctor to back up your claim, you probably don't have a claim to begin with.

Rep. Delmore: What is the number of cases that have been settled and for what amounts. You've been very clear that they're not even close to the $500,000.

Tracy Kolb: In jury trials.

Rep. Delmore: So it makes me wonder why we're so afraid of not having the cap. You've made the comment that the court has tried to put a value on these things. I understand that, but at the same time, aren't we doing that when we put a cap on it.

Tracy Kolb: I don't understand what the rationale for that is. The verdicts for non-economic damages aren't standard, it is hard to say what each part of the country will do in the same situation. That is the rationale for capping. You just can't explain why some juries reach the decisions that they do.

Rep. Delmore: I understand the difference between the two kinds of damages. But we are saying, that anyone, regardless of the circumstances, the most you will ever receive is

$500,000 and it really doesn't matter what those losses may be for any individual. There isn't any question that is what they get.

Tracy Kolb: I can envision scenarios where they are not limited to $500,000. If you sue more than one defendant, are you limited to $500,000 total or $500,000 from each defendant. We can argue about it, it has not been tested in our courts. We've had it involved in several cases.

Rep. Delmore: If the current statute says it doesn't matter how many people there are in the other side, you get one settlement, right. If I am reading the code correctly, I can sue five doctors for the baby that died, but I am going to get one settlement if I'm looking at this particular non-economic damage.

Tracy Kolb: That pre-supposes that you settled with all five defendants. Were you to settle with one and go to trial against four, you are not going to be limited to the $500,000 cap. That's my point I guess.

Rep. Griffin: Is it possible for a plaintiff to recover up to $500,000 for non-economic and $250,000 in punitive plus economic damages.

Tracy Kolb: Is it possible for that to happen in a jury trial. Yes, it is. You can't start off with a suit asking for punitive damages. You have to move to amend the complaint and establish that. Once you get permission to amend the complaint, and you establish your case, on the jury verdict form there is a question that says if you find the defendant guilty, how much should you get for that. They are asked that for all questions, non-economic, economic, and punitive.

Rep. Griffin: Under the statute, punitive damages aren't counted as non-economic damages.

Tracy Kolb: No, I've never heard that, punitive damages are not compensatory damages. Punitive damages are intended to punish the defendant for actions that transpired.

Rep. Griffin: You said we're not reaching past these caps in jury trials, and it's been insinuated that this might not have much of an impact on medical malpractice insurance premiums with the cap, what the purpose of that would be.

Tracy Kolb: Well, from my perspective the rationale that was presented in 1995, was that it was a practical to facilitate settlements. If we are able to settle versus going to trial would save time and money. Most states have them and that's not going to change.

Rep. Koppelman: There has been a lot of talk about medical care reform and talk about universal health care/social medicine. Some seem pretty excited about it. If that were to happen, and we remove this cap, since we don't have sovereign immunity in ND any more, would we be saying that there is an unlimited damage recovery from the state as the provider in these kinds of cases.

Tracy Kolb: I don't know.

Rep. Zaiser: What is "effective" resolution of a case, for whom? For the defendant or the plaintiff. Clearly, in terms of predictability, if we have $500,000 as a cap, that's going to lower the bar and make the range of settlement much tighter and therefore, the settlement will be much lower than what might be given had the range been higher to start with. That's why you can't ever reach the $500,000 level.

Tracy Kolb: You asked who it is effective for. It is an effective tool for both plaintiffs and defendants. Most medical cases aren't won, they are settled. They try to go to mediation first, instead of trial, and if they go to trial, most plaintiffs lose their case.

Rep. Zaiser: I know that plaintiff's often lose, because it is a difficult process. It is hard to find a doctor in ND to testify against another ND doctor.

Tracy Kolb: I don't know about that. I have been able to find experts for the defendant's case. I have heard that plaintiff's attorney have had a hard time trying to find an expert from inside ND.

Rep. Kretschmar: When the malpractice case goes to the jury, does the judge instruct the jury as to what non-economic damages are, and instruct them that they can't award more than $500,000.

Tracy Kolb: No, they can't. The statute specifically said that the jury cannot be told that there's a cap. So what would happen is that the jury would be instructed as to the kinds of damages that are being sought, which most likely would include non-economic; then on the verdict form they would be asked to award non-economic damages and the amount. They would fill in the blank and if that amount is more than $500,000 they would just be awarded the $500,000.

Rep. Zaiser: Is that public knowledge.

Tracy Kolb: I don't know.

Rep. Zaiser: Is information available to the public, that the award was more than what the statute would allow and that it was reduced by statute to the $500,000.

Tracy Kolb: I don't know. It probably would be reported to the National Practicing Database, the Supreme Court tracks cases.

Chairman DeKrey: Thank you. Further testimony in opposition.

Beverly Adams, Executive Director of the Health Policy Consortium: Opposed (attachment).

Rep. Delmore: On page 3, the last full paragraph, you have some statistics used there that refer to data in ND with the caps. Can you please explain what you mean and what the variables are.

Beverly Adams: My information, regarding that paragraph, came from an article that was published by the Federal Agency for Healthcare Research and Quality. They have a reputation for being very reliable and they have economists who analyzed a lot of information because they just wanted to know what was going on, and they looked at 10 variables. This was done in 2006, and before that there was only one study done by Kessler and McClellan, and they did a study on two components of health care issues. They came up with the figures used in my testimony.

Rep. Griffin: In the state of ND, we didn't have caps and now we do. How are the malpractice premiums different. We should be able to see how they did or did not change.

Beverly Adams: I don't know. There isn't a direct correlation because there are a number of variables that need to be looked at when looking at caps and automatic lowering of premiums. If the caps are removed, the extra costs of medicine will have to be paid by someone. They will be passed on from the healthcare facilities, because they can't continue to absorb these increases.

Rep. Griffin: We've been told that in settlements where the jury hasn't been told that there was a cap still came under the $500,000 cap in non-economic damages, if that were raised to $1 million dollars in extreme cases – wouldn't that give a little more leniency for the case that really should be awarded the additional amount. How would that affect the premiums.

Beverly Adams: I don't know exactly how that would impact. But if you're going to increase the cap, in example 3, it shows how hard it is to get Ob/Gyn doctors and general surgeons. We don't know how that would affect insurance premiums. This would mean that the hospital or facility that self-insures would have to have increased reserves on hand. How that would affect their financials, I don't know.

Rep. Griffin: You talked about rural doctors being affected more by the increased cap why would that be.

Beverly Adams: In the study on example 3, even though there are two differences of opinion about whether no caps on non-economic damages actually increases malpractice premiums or not. Some found that it was actually cheaper on malpractice premiums in states without caps. I find that hard to believe. All the information I looked at, said it increased the premiums in states without caps. What the level of impact was, I don't know. Regardless of whether the premiums were increased or not, physicians perceived that states without caps were higher in premiums and was more of a problem; they would choose not to practice in states that had no caps or higher caps. The other thing that they would do, is simply not practice in areas that have high malpractice premiums like the general surgery or Ob/Gyn. We seen facilities in MN that can't get insurance and they had to self-insure for certain kinds of practice. Those facilities were scrambling trying to get malpractice coverage or they would have had to shut down the trauma center part of the hospital.

Rep. Klemin: The discussion in 1995 and the caps in the whole area of tort reform in general was that there were two aspects of it. One was the affordability of the insurance that relates to premium and the other was the one you just mentioned, the availability; because at that time, as I understood it, availability was a big issue and maybe it still is.

Beverly Adams: Absolutely. Accessibility and affordability are the two primary areas that are impacted when there are high caps or no caps at all on non-economic damages. As indicated in the report, there are going to be states that are put into the situation where malpractice premiums are so much higher, or that they just can't get coverage for certain specialties. In ND, we have to pay physicians in a lot of sub-specialty areas a lot more money than they would make in NY or FL, or CA, just to get them to practice in ND. This is not a destination

hot-spot. We don't want to waste medical resources. We don't tell Medicare and Medicaid what the charges are, they tell us what we will get reimbursed for the services we provide. So whenever we recruit new physicians, those are costs that are not reimbursed to us. That is a cost of doing business. We're competing on a national level for doctors to come here, and caps or no caps is driving up costs up and we need to figure out, financially how we are going to cover those expenses. If you do this, and take the cap off or increase the cap that is going to add just one more burden on the providing healthcare facility and will affect the accessibility and affordability. Recently NDMA took a general survey of individuals and asked them about the quality of healthcare and the affordability of their premiums. Everybody thought that ND's premiums were the highest in the nation, and that we paid higher healthcare premiums than anywhere else. It's exactly the opposite, people don't realize what the cost of healthcare premiums are in other states. The last thing we want to see is an increased cost of healthcare and try to add the additional burden on the healthcare facilities and physicians.

Rep. Zaiser: If there are too many variables to speculate how much the premiums would rise or fall, how can you say that the costs will go up if the cap is changed. Do you know what the differences are between the rates pre-1995 and post-1995.

Beverly Adams: There isn't any empirical data for ND but believe that the figures that were extrapolated would be correct.

Rep. Zaiser: You said that the prices would go up in ND; I heard earlier from both sides that there wouldn't be that many claims and most of them don't get to the threshold, that they didn't get that high. Given the number of doctors and claims that we've had, that can't be a lot of money even if the doctors paid out for every claim. Has anybody done that kind of extrapolation.

Beverly Adams: I don't know.

Rep. Zaiser: It just doesn't seem like it would be a very large impact.

Beverly Adams: I think it would.

Rep. Delmore: What is the average cost of malpractice premium now.

Beverly Adams: I don't know; it does depend on the practice of the physician.

Chairman DeKrey: Thank you. Further testimony in opposition.

Arnold Thomas, President, ND Healthcare Association: Opposed (attachment).

Rep. Delmore: Who usually pays for the malpractice insurance, do the physicians pay or the hospital pay.

Arnold Thomas: It depends on the relationship between the physician and hospital. It's an integrated system. For example, at MedCenter One, the institution would be responsible as part of the employment agreement with the physician to pay all or some percentage of the insurance for that particular physician. It's become a very important to recruitment and retention tools for physicians, simply because of the additional cost to the physician. When the physician is employed with the hospital, that just becomes part of the compensation that the doctor gets.

Rep. Delmore: Do you have any numbers of what malpractice insurance premiums cost.

Arnold Thomas: I will try to get back to you later. What is the context of what you are asking for.

Chairman DeKrey: A context I would understand is my cousin and I are the same age. When she finished medical school and started her practice in Kansas City, MO in 1989 or 1990, her salary was $150,000 to start, and $75,000 of that was for malpractice insurance because she was an Ob/Gyn and the other $75,000 was salary.

Rep. Zaiser: You mentioned that one of your goals was to not have excessive claims. You also said that there haven't been that many claims that were over the $500,000. What is an excessive claim for loss of spouse or child.

Arnold Thomas: In terms of what we're talking about here with the cap in place since 1995, before that time it was too expensive to get malpractice insurance in the state, we couldn't find anyone to write the policies in ND. There is no compensation available to make the loss of a loved one seem okay. I believe that over time it has come to the heart of the matter, in which healthcare does business, that there are caps put into place to make sure that people, when brought to the table to discuss how to resolve this matter, they can bring about a resolution to that bad outcome.

Rep. Zaiser: I too would not want to speculate on the price of a life. What level is reasonable, what is excessive. The people this morning didn't feel that they were compensated adequately, and the principal reason was that they didn't feel it was a just compensation for the loss of their loved one. I know you can't put a value on that.

Arnold Thomas: I really don't have a number. All I can tell you that at the time, there was a lack of availability of malpractice insurance for medical malpractice coverage. This whole idea of constraining awards was part of the discussion that brought us to where we are in ND. There was discussion of $250,000; ND decided to go with $500,000. Some may say it was an arbitrary number, some may say that it showed that we understood exactly what you are talking about, the difficulty of putting a quantitative figure on the loss of life. We wanted to bring the parties to the table to settle the matter, instead of going to trial. There was never any undercurrent that said that even if you successfully resolve the financial consequences associated with a negative medical outcome, that that made you whole. Those kinds of consequences, unfortunately, I don't believe makes one whole.

Rep. Klemin: What about hospitals and the responsibility for the conduct of the hospital itself or the nurses, people other than doctors. It seems like we're only talking about doctors here, but what do your members do about medical malpractice insurance coverage for persons other than the doctors that work for you.

Arnold Thomas: We're responsible in most cases if there has been a negative outcome associated with the hospital, we're also a party to the suit. The court will go through and determines who is excluded from the suit, such as the employees who may have assisted.

Rep. Klemin: What is the status of insurance for the hospitals, we've heard that they self-insure somewhat.

Arnold Thomas: Back when this whole difficulty of medical malpractice, it was a challenge in ND and other things happened. We were instrumental in creating a captive, for our own facilities. A number of facilities took advantage of that. These are cooperatives that self-insure and manage claims. In that undertaking there was a significant amount of emphasis promoting best practices and claims management and how that should be accomplished. Over time, this captive was no longer necessary because the market place offers affordability in the premiums. The captive is still there. Currently most of the providers are self-insured or are using a commercial company simply because the market is suggesting that it is an affordable premium for the type of coverage that we need in ND. ND ranks very highly on quality measures, this helps with recruitment and retention. It is also a testimony to the seriousness with which we review the level of medicine that is being practiced in ND. ND ranks highly for care, with one of the most aggressive in the nation with respect to the Board of Medical Examiners and Board of Nursing. We are very committed in terms of what we do and do it well, and make it the best that we can. There is a bill on the Senate side that is coming where the hospitals also be allowed to go public, with a whole variety of performance measures and

how we prepare them, not only among ourselves, but equally so with hospitals in MN, relative to many aspects such as infections, etc. We want to afford all communities with accessibility and affordability of insurance. We are afraid if we remove the caps, that the doctors will revert back to their old ways of asking for tests that aren't needed, just to make sure that they have exhausted every avenue so as not to get sued for a negative outcome. These tests would be unnecessary, and the costs will increase and ultimately you and I will be paying for it; simply because the facility and the doctors do not get what they charge for the services, so they charge the services to someone else, and you and I will pay these unnecessary expenses.

Rep. Koppelman: Do we have a problem in ND where egregious substantiated claims are not covered because we have had a cap.

Arnold Thomas: There have been some cases where they were at the cap, but they aren't numerous. But those individuals, who perhaps were subject to the cap, the cap is a burden. For the remainder of the cases that were solved below the cap, I would say the cap has fulfilled its purpose, which is to bring the parties together to settle the issues.

Rep. Koppelman: Do you know how many cases were like that.

Arnold Thomas: I believe that Mr. Levi will get that to you.

Rep. Koppelman: The legislation that we passed in 1995, that was unanimously passed in the House at least, was a pretty comprehensive tort reform bill with regard to medical malpractice for the reasons that have been discussed in the hearing. Did it work for ND, are you concerned about the issues you raised about access and affordability, are we better off now than we were before, and if we removed the cap, would it get us back to pre-1995.

Arnold Thomas: My comment is that the policy position that was adopted by the Legislature was relevant then and it's still relevant now.

Rep. Griffin: We heard testimony today that most of the jury settlements, where they don't know what the cap is, have come in under the cap. If that's the case, if we moved it to $1 million dollars, and in a rare circumstance we had a case fall between the new levels of the $500,000-$1 million, do you think that would really increase medical malpractice premiums.

Arnold Thomas: I think it will increase the amount of settlement talks. I could ask what would happen if we decreased the amount to $250,000 and what would happen. How big of a conversational framework do you want to have with discussion on this particular aspect of malpractice premiums.

Rep. Griffin: The juries have no clue what the amount of the cap is, but a related question would be that it's been 13 years since we put the cap in place. Should the cap be adjusted for inflation.

Arnold Thomas: I don't have a position on that, I believe that if the cap needs to be raised, that question should be brought to you, and then you should decide. If you think it needs to be adjusted for whatever reason they bring that in to the committee for discussion, I think that should be adequate way to handle that.

Rep. Delmore: Do you know how many claims were settled out of court.

Arnold Thomas: I will report back with that information.

Chairman DeKrey: Thank you. Further testimony in opposition.

Bev Adams: The medical malpractice premiums range from as low as $10,000 to $120,000, and it varies by region, the history of claims, and the area of practice that the physician is in.

Rep. Delmore: Do you know how many doctors pay the insurance themselves or that the hospital pays it, is that something that is negotiated when they are hired.

Bev Adams: At MeritCare, there are 450 employees covered by the hospital and another 50-75 physicians that have hospital privileges at MeritCare that have their own malpractice

insurance and some physicians who are employed also may have privileges at another hospital, which they would cover themselves.

Rep. Wolf: What are the salaries for the doctors, the range.

Bev Adams: They range from $120,000-500,000 depending on area of practice.

Rep. Zaiser: Do you know how many claims that were covered, and what the average claim costs?

Bev Adams: I don't know.

Chairman DeKrey: Thank you. Further testimony in opposition.

Jeb Oehlke, ND Chamber of Commerce: Opposed (attachment).

Rep. Delmore: Among the business people in the State, who decides whether to back a bill or not.

Jeb Oehlke: There is a legislative committee, which has members that create a policy statement.

Rep. Delmore: Like a platform.

Jeb Oehlke: Yes.

Rep. Wolf: Which specific platform is it.

Jeb Oehlke: The Health Care or Insurance section.

Rep. Griffin: It's been said that we have some of the lowest premiums in the country for medical malpractice, because of the caps. Is there data that shows pre-1995 when we had no caps and post-1995 since there have been caps in place.

Jeb Oehlke: I believe that Ms. Adams addressed that matter.

Rep. Griffin: I am looking for ND statistics, no has really addressed that matter.

Jeb Oehlke: I don't have that information with me but would be happy to find it.

Chairman DeKrey: Thank you. Further testimony in opposition. Testimony neutral.

Larry Maslowski, ND Insurance Department: I am here only for information, neutral. We will try to put together a report with as much information as we have in regard to claims and settlements. Mr. Levi asked us to prepare a report for him and will try to get that to you as soon as possible. There are a number of areas that we don't keep track of and so no data will be available.

Rep. Klemin: When you say settlements, are you including in that the cases that weren't settled out of court, but went to trial and had a verdict.

Larry Maslowski: I believe that should be in there.

Rep. Klemin: So it's just not settlements, also includes other resolutions.

Rep. Delmore: Is there a reason why this is not broken down into categories, what part was punitive, non-economic, economic, etc.

Larry Maslowski: I don't know.

Rep. Delmore: Do you have the pre-1995 number of cases that had been settled or what the outcomes was. I don't care about other states. I think we need to look at what happened here.

Larry Maslowski: I don't know if we do or not. I don't believe we have any accurate information that old, but I will look into it.

Rep. Klemin: I would suggest that maybe that requirement started in 1995.

Rep. Delmore: Somebody must know what happened, obviously lawsuits were happening pre-1995, which led to why the bill was needed. There had to be some statistics somewhere that showed that there was a need to put that cap on in the first place.

Rep. Klemin: Perhaps we could have the LC library pull the legislative history of the 1995 statute.

Rep. Zaiser: Could the Insurance Dept. begin to do that breakdown of settlements now going forward.

Larry Maslowski: You're asking for the economic, non-economic, punitive damage amounts.

Rep. Zaiser: And all the cases that had gone over the non-economic cap and what happened in the judgment. Could that be included.

Larry Maslowski: I would say no, because that's court information. The people that are reporting it to us, are the insurance companies.

Chairman DeKrey: Thank you. We will close the hearing.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1390

House Judiciary Committee

☐ Check here for Conference Committee

Hearing Date: 2/16/09

Recorder Job Number: 9532

Committee Clerk Signature

Minutes:

Chairman DeKrey: We will take more information on HB 1390 and act on the bill.

Rep. Koppelman: I move a Do Not Pass.

Rep. Boehning: Second.

Rep. Griffin: I have an amendment that I would like to offer.

Rep. Koppelman: I just feel that in listening to the testimony and visiting with several people after our hearing, I guess my thinking is that the cap has really served us well in North Dakota. As I look at other states, in the printout we received, showing where we are as a state. I was surprised that we're not in the law echelon as some testimony led us to believe, and that there are a lot of very populous states that have lower caps than ours. I think we all certainly are concerned about those cases where people feel they are being wronged, but it keeps coming back to the issue that for damages that are proven and can be demonstrated, there is no cap. It's just these non-economic damages that we're dealing with that are capped. So I really think that keeping the cap in place would serve us best. When we pass legislation, I think we have to look at, whether this is for one person or for the good of the whole state. You shouldn't pass legislation just for one person.

Rep. Delmore: If I had received some documentation from ND that told me what the situation was, and I was informed, maybe I could agree with you Rep. Koppelman but I don't have a lot of ND data. It was asked for and we hadn't received anything yet. We don't have runaway juries in ND.

Rep. Zaiser: I have some information here that I recently obtained that shows Minnesota, where they have no caps, the insurance is no higher, and in fact it's lower, than in ND. I'm not advocating no caps; but I am advocating a higher cap than we now have, because the last time we changed the cap was in 1980...

Rep. Klemin: 1995.

Rep. Zaiser: Well, there's been a lot of inflation since then. We heard from cases that in my opinion, should have been higher. I am opposed to this motion. I would urge that this committee get more information. People haven't abused this.

Chairman DeKrey: Mr. Levi has information that the committee asked him for. He will go through his information.

Rep. Koppelman: Should I withdraw my motion.

Chairman DeKrey: It is up to you two.

Rep. Delmore: This is an important bill for discussion.

Rep. Koppelman: We are discussing it now, so I don't think we are losing that; but I don't intend to limit anyone's opportunity for debate or to offer other suggestions; so I withdraw my Do Not Pass.

Rep. Boehning: I withdraw my second.

Chairman DeKrey: We do not have a motion on the floor. The Chair recognizes Mr. Levi.

Bruce Levi, Executive Director, ND Medical Association: (supplemental testimony and attachments). I believe some additional documentation came from the Insurance Department

as well. I talked with Larry Maslowski and he was going to get the information together. This is the chart I referred to in my testimony previously. This describes in numbered chronological the claims that were settled. We don't know precisely what the cases were because they are just referred to as settlements. The chart will give you a flavor for the kinds of cases since 1984 that have come through the process. From our perspective, you can see the three cases for 2008 and then 2007 under the closed case category. On the second page of my prepared testimony, I took a calculator over the weekend and just tried to break them out by year and have for each year the total number of settlements, total dollar amounts of those settlements and added them up and divided that total amount by the number of cases, to come up with an average settlement number. We don't have information breaking down the economic and non-economic, punitive damages in ND jury awards. I don't think there are any other sources identified than what we have here. I also had some information that I shared with the congressional delegation regarding the early 2000's nationally, particularly in medical liability reform, as well as what is happening across the country. I have from the National Practitioner Databank, claims filed for ND and in the realm about caps in 1995, that looks at 1991-2001 of data that looks very similar to the insurance data in terms of the numbers claimed and the average payment. At the bottom of the third page of my prepared remarks shows the ND premiums that I got from one company, Midwest Medical Insurance Company showing the premium changes in Internal and General Surgery and Ob/Gyn from 1983 to 2008. I don't have the specifics for those groups but you can see the changes for the decade of the 80's before the cap was put in place, as well as the amounts since that time. The range of change was dramatic and you can see that rate of change throughout the information there and going over to page 4. I did provide information in 2003 when it was issued at the federal level, there were reports that came out with US Dept. of Health & Human Services that talked about the

premiums rates in ND among other states. The numbers that they used in those to track the numbers that we have as well. I think the premium dollars they sent us are accurate.

Chairman DeKrey: Three or four pages in where you talk about Rep. Pomeroy who supported the bill with $250,000 on non-economic damages, where did that bill end up.

Bruce Levi: At the federal level, liability reform on the House passed several times, it never passed the Senate.

Rep. Wolf: In your testimony you talked about this cap having an impact on the amount of liability fees. I'm looking at MN, ND and SD and ND and SD both have a high $500,000 cap on non-economic damages and look at MN without caps. And it is significantly less in premiums on a no cap state than the states with caps. What does that mean.

Bruce Levi: I think the explanation there, particularly in the context of a single liability carrier, is that they work regionally. MMIC is a physician-run organization run by the MN Medical Association that formed MMIC back in the '80s when we were going through a tough time to find insurance carriers. I assume that because they were a regionally based insurance company, and worked on a regional basis, that the stability that was achieved in the region, it seems to have created that result. I don't know the answer to that question.

Rep. Delmore: Thanks for going to this work but I'm not sure that we are getting the full picture here, with no records being kept that break down each settlement into the categories.

Chairman DeKrey: Thank you.

Mark Harmon, ND Insurance Department: (attachment from Larry Maslowski). Explained the attachments.

Rep. Delmore: Can you talk about the number of claims and if they were with and without payment.

Mark Harmon: Are you asking what type of claim that was.

Rep. Delmore: For 2007 there are no claims payment on 28 cases. What specifically are these numbers for, is it for the whole year.

Mark Harmon: Yes, 28 is the total dollars paid.

Rep. Kretschmar: When you say settlement amount, it's information you received from the insurance companies.

Mark Harmon: Yes.

Rep. Kretschmar: That's the amount the insurance company gave out to satisfy those claims.

Mark Harmon: Yes.

Rep. Kretschmar: But it doesn't sound like that was all of the money.

Mark Harmon: Right, that was what the insurance company reported. I don't see any claims where a physician self-insured on here.

Rep. Kretschmar: That's not required under our law, is it.

Mark Harmon: It is, all medical agencies have to report as well.

Rep. Boehning: I move a Do Not Pass.

Rep. Koppelman: Second.

Chairman DeKrey: Roll call vote.

Rep. Koppelman: I don't mean to step on anyone's toes. If this motion fails, we can certainly look at the amendment and pass it if we want. After hearing the testimony, and looking at the numbers, it appears that ND is right up near the top in terms of the cap set at $500,000 for non-economic damages. The larger states in the nation don't even have that high of a cap in most cases. The states around us don't even come close. I was led to believe that ND was on the low end of the cap, but we are actually on the high end.

Rep. Zaiser: I would like to hand out information from the Trial Lawyers Association.

Rep. Delmore: We wanted to offer a compromise with the amendment to raise the limit a little. As far as California and its low cap, ND has very little in common with CA. I think we only heard from one very moving person who was from here. There are some people who have been entitled to non-economic damages and with the cap, you know you are never going to come to that number even if it is deserved. I was hoping that there could be talking points for the citizens of ND when dealing with non-economic damages. We've done this with a lot of other issues. I was hoping that we could make that offer today and people give it an up or down.

Rep. Klemin: Are there other states that have a $1 million dollar cap.

Rep. Koppelman: I believe there are 9 or 10 states that have no cap. As far as the states, in the other 40 that have caps, I think there are 1 or 2 that are in that range, but we are pretty close to the top of the heap of capped states in terms of the amount we capped them at.

Rep. Klemin: Where did that come from.

Rep. Koppelman: This was MCSL which was passed out during the original hearing.

Rep. Delmore: Would you like someone to not even get the medical.

Rep. Koppelman: I wouldn't favor a cap on economic damages at all, because I think if you are entitled to something, and you can demonstrate it, then that's what the courts are for. I think the problem with the runaway litigation and malpractice issues in the country, have stemmed from these kinds of issues like non-economic damages. The other thing that I've been told, that got my attention, is that in the state that had really dealt with and struggled with it, if you look at Mississippi on this chart, they now have the same cap that we do. Their malpractice insurance is still through the roof; it's come down and getting better and been court reform, and the legislature and governor have worked very hard on it and it 's going in the right direction in terms of fairness. There are areas in the Mississippi delta where they have

physicians that were drive out because of the high malpractice premiums. Now there's no medical care. I look at that, and ask if that is what we want. It only takes a case or two like this to really get the bandwagon going in the wrong direction, that's why we need the cap to remain in place.

Rep. Klemin: I just wanted to comment, I looked up the CPI adjustment to see what it would be on $500,000 in 1995. In 2008, that's $696,932.00. So it's about a 40% increase, say $700,000 to round it off. One million dollars would be 100% increase. So if you wanted to stay even with inflation you would be looking at $700,000.

Rep. Zaiser: My concern is that there isn't a record of claims not being reported at all, there are efforts made to cover up.

Rep. Dahl: I'm going to vote against this bill because from the testimony we heard, the judgments when folks are going to trial aren't even approaching the half million dollars. I think that the cap that we have in place right now is working and there hasn't been any demonstration that there needs to be an upward adjustment because we're not even hitting against it yet. I thought that there was one gal that come in and made a very good point, that a cap right now pushes parties to a settlement. To raise that cap, that same incentive might not be there.

Rep. Griffin: Looking at what these other states do, is not really an argument, it's more of an observation. That's not saying that if we move it up that's going to create some sort of problem. We got a lot of testimony and asked them to show us the numbers of what's happening with m medical malpractice in ND. Insurance rates are after we put the caps in place. We've already tested it, we never did have those numbers. While we do have unlimited economic damages there are instances where with a handicapped spouse that wasn't working, doesn't earn a check, they could be paralyzed and they can be looking at recovery and they

are looking at 2/3 or 60% at most of $500,000. I think you could have a situation where people are unfairly treated. The last thing I would mention is if we did move this cap to $1 million dollars, how much affect would it have. Currently, we have the $500,000 as Rep. Dahl pointed out, juries aren't awarding it either. So if we exposed an insurance company or offered another $500,000 in payout, when we're not even giving that anyway and in the rare case that it's necessary, I can't imagine we would go that high.

Rep. Zaiser: I'm sure you heard the same that I did, that we're not bumping against those caps. I also understand that it's almost impossible to bump up against those caps when you get in negotiation. The highest we could possibly start is that number. Who is going to give you that number when you enter settlement. That's the highest it could go. I think that's more of a reason why we haven't bumped up against it and think we need to go higher.

Rep. Klemin: To me if you change the cap to $1 million dollars, it would have an effect, and that effect would be that a lot more cases would go to trial.

Rep. Delmore: We didn't have a chance to look at those figures, we didn't have a chance to talk about them. As you looked at these settlements it might have made a difference.

Rep. Koppelman: I think if we're going to start entertaining amendments, one that I thought of that I didn't bring was if the objective here is to really get more money for victims. We heard testimony that in some cases, at certain levels, attorneys' contingency percentages are cut, at 25%, that would be, if we kept our cap at the same place at $500,000, and capped attorney contingency fees at 25%, that theoretically would get more money to a victim. That would be another approach. I think what we have is working.

Chairman DeKrey: The clerk will call the roll on a DNP motion on HB 1390.

7 YES 6 NO 0 ABSENT DO NOT PASS CARRIER: Rep. Koppelman

Motion carried.

Rep. Griffin: I move the amendment 90254.0201, title .0300.

Chairman DeKrey: Only the minority can vote on the amendment for the Minority Report. We will take a roll call vote for the Minority Report.

5 YES 1 NO AMENDMENT MOTION CARRIED CARRIER: Rep. Griffin

MINORITY REPORT WILL BE DEBATED ON THE 6TH ORDER

Chairman DeKrey: IF THE AMENDMENT IS APPROVED, WE WOULD HAVE TO BRING THE BILL BACK TO COMMITTEE; BUT IF THE MINORITY REPORT FAILS ON THE FLOOR IT GOES BACK TO THE WAY IT CAME OUT OF COMMITTEE WHICH IS A DO NOT PASS.

Date: 2/16/09
Roll Call Vote #: 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1390

HOUSE JUDICIARY COMMITTEE

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☐ DP ☑ DNP ☐ DP AS AMEND ☐ DNP AS AMEND

Motion Made By Rep. Boehning Seconded By Rep. Koppelman

Representatives	Yes	No	Representatives	Yes	No
Ch. DeKrey	✓		Rep. Delmore		✓
Rep. Klemin	✓		Rep. Griffin		✓
Rep. Boehning	✓		Rep. Vig		✓
Rep. Dahl	✓		Rep. Wolf		✓
Rep. Hatlestad	✓		Rep. Zaiser		✓
Rep. Kingsbury	✓				
Rep. Koppelman	✓				
Rep. Kretschmar		✓			

Total (Yes) 7 No 6

Absent —

Floor Carrier: Rep. Koppelman

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

REPORT OF STANDING COMMITTEE (MAJORITY)

HB 1390: Judiciary (Rep. D. DeKrey, Chairman) A **MAJORITY** of your committee (Reps. Boehning, Dahl, DeKrey, Hatlestad, Kingsbury, Klemin, Koppelman) recommends **DO NOT PASS.**

Prepared by the Legislative Council staff for
Representative Griffin - Minority Report
February 11, 2009

VR
2/16/09

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1390

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to amend and reenact section 32-42-02 of the North Dakota Century Code, relating to noneconomic damages in health care malpractice actions.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 32-42-02 of the North Dakota Century Code is amended and reenacted as follows:

32-42-02. Noneconomic damages limited - Reduction of award. With respect to a health care malpractice action or claim, the total amount of compensation that may be awarded to a claimant or members of the claimant's family for noneconomic damage resulting from an injury alleged under the action or claim may not exceed ~~five hundred thousand~~ one million dollars, regardless of the number of health care providers and other defendants against whom the action or claim is brought or the number of actions or claims brought with respect to the injury. With respect to actions heard by a jury, the jury may not be informed of the limitation contained in this section. If necessary, the court shall reduce the damages awarded by a jury to comply with the limitation in this section."

Renumber accordingly

Date: 2/16/09
Roll Call Vote #: 2

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1390

HOUSE JUDICIARY COMMITTEE

☐ Check here for Conference Committee

Legislative Council Amendment Number Amendment - Minority Report

Action Taken ☐ DP ☐ DNP ☐ DP AS AMEND ☐ DNP AS AMEND

Motion Made By _____ Seconded By _____

Representatives	Yes	No	Representatives	Yes	No
Ch. DeKrey			Rep. Delmore	✓	
Rep. Klemin			Rep. Griffin	✓	
Rep. Boehning			Rep. Vig	✓	
Rep. Dahl			Rep. Wolf	✓	
Rep. Hatlestad			Rep. Zaiser	✓	
Rep. Kingsbury					
Rep. Koppelman					
Rep. Kretschmar		✓			

Total (Yes) 5 No 1

Absent _____

Floor Carrier: Rep. Griffin

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

REPORT OF STANDING COMMITTEE (MINORITY)

HB 1390: Judiciary (Rep. D. DeKrey, Chairman) A **MINORITY** of your committee (Reps. Delmore, Griffin, Kretschmar, Vig, Wolf, Zaiser) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS.**

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to amend and reenact section 32-42-02 of the North Dakota Century Code, relating to noneconomic damages in health care malpractice actions.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 32-42-02 of the North Dakota Century Code is amended and reenacted as follows:

32-42-02. Noneconomic damages limited - Reduction of award. With respect to a health care malpractice action or claim, the total amount of compensation that may be awarded to a claimant or members of the claimant's family for noneconomic damage resulting from an injury alleged under the action or claim may not exceed ~~five hundred thousand~~ one million dollars, regardless of the number of health care providers and other defendants against whom the action or claim is brought or the number of actions or claims brought with respect to the injury. With respect to actions heard by a jury, the jury may not be informed of the limitation contained in this section. If necessary, the court shall reduce the damages awarded by a jury to comply with the limitation in this section."

Renumber accordingly

The reports of the majority and the minority were placed on the Seventh order of business on the calendar for the succeeding legislative day.

2009 TESTIMONY

HB 1390

Rep. Belter

HB 1390

HB 1390 removes the five hundred thousand dollar cap on noneconomic damages in health care malpractice actions. Noneconomic damages are defined on page 2 lines 6 thru 11. This cap was put into place in by the 1995 legislative assemble. I voted for this cap because at the time we were concerned about heath care costs and we all thought this was a way we could reduce health care cost. You may wonder why is a conservative Republican joining with trial lawyer in repeal of this cap. I support the repeal because I am the victim of medical practice, and my personal experience has made me realize what a great injustice we have inflicted on the injured, and unwarranted protection to the defendant.

I ask you as a committee to consider yourselves as members of a jury, where only certain evidence is permissible. What I mean by this statement we all have our own impression of frivolous lawsuits.

Examples GM. Some multimillion dollar class action suit: The person who removes the shield off the lawn mower and then puts there foot in it and gets a big settlement.

What we are dealing with here is damage done to an individual by a health care provider resulting in damages to an individual because of action that does not meet the standards of medical care.

Medical malpractice is entirely differ from the respect of the plaintiff often not knowing whether there was medical malpractice or if a procedure just didn't turn out like planned.

I was fortunate to have had contact with a surgeon from a world renowned hospital, and a retired dean of school of general surgery at a large university that I learn that what happened to me was grounds for medical malpractice.

My case resulted in an out of court settlement. My experience as a victim quickly brought to my attention how our actions in1995 forgot about the victim, instead we created protection for the defendant.

I want to impress upon the members of this committee until it happens to you, a family member or a friend, it is only understandable that you, like me, do not know the inequity the caps has created for the victim.

It is not easy to prove medical malpractice. Insurance companies do not settle cases by paying out a small sum to a plaintiff in order to minimize legal fees.

No you need a very good case with substantial evidence. One before an attorney will even consider your case, and two you are going to have to have expert testimony from qualified medical experts before you ever have a chance of winning a case. You will find that it is not easy to get medical professional to testify against their medical colleagues.

When the victim files action and the defendant offers a settlement you than know you have a case, what than needs to be determined is whether you can settle out of court or whether you will have to go to court.

At this point you than realize how the cap leaves the defendant in the driver seat because they are now in a situation where they are protected by the $500,000 cap and so once they get to a certain level they don't have to negotiate because e they know they can always go to court and possible win or if they lose the jury my award less than the $500,000 cap.

Keep in mind that the victim's attorney's fees are one third to forty percent of the settlement. Future more if the plaintiff has additional medical expenses due to the medical injury you may have to pay some of those medical costs out of your settlement. That's another issue that I'm not going to address today. I was 60 years old when I became a victim so I have probably only have 15 to 30 years to live with the quality of life issues I face and secondly my circumstances could have been worse.

But I think of those who are much younger and could have much more serious injuries than I have. These are the victims who are really prejudiced by the $500,000 cap that I and my fellow legislators enacted in 1995.

In closing we need to undo the injustice to victims that we imposed. If you remember one thing from my testimony it would be.

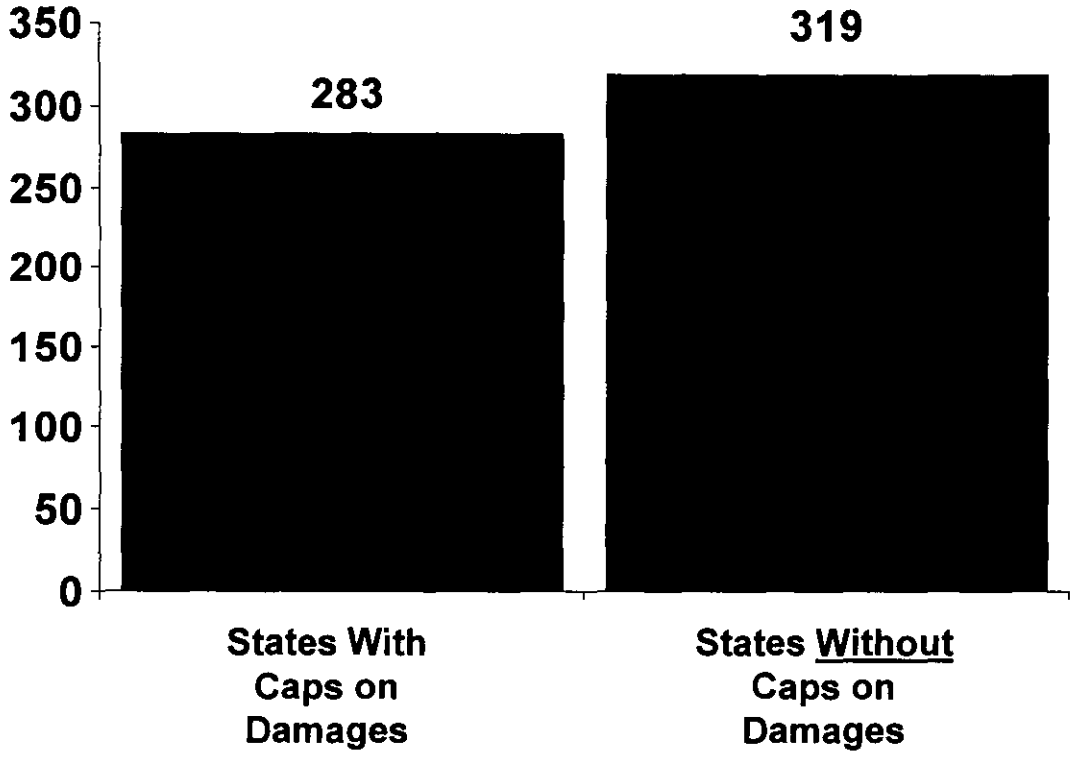
Until it happens to you, a love one or a friend, it's just hard to realize the injustice to the victim. I ask you to remove the $500,000 cap

Roger Bekta

Belter

Are Doctors Really Closing Their Doors?

Number of Physicians
Per 100,000 Population: 2007

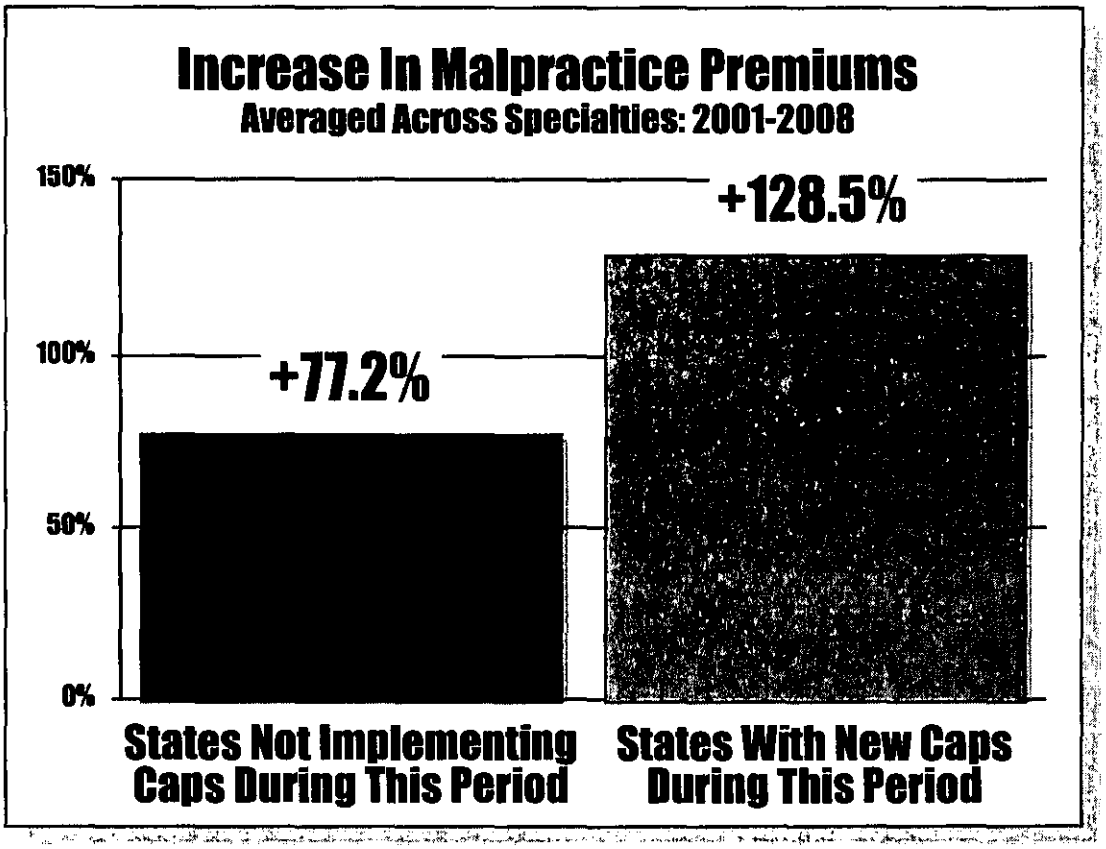


In 2007, there were 13% more physicians per 100,000 population in states without caps than there were in states with caps.

A state is classified as having a cap when the state has enacted either a general non-economic damage cap that affects medical malpractice cases or a medical malpractice specific cap on non-economic and/or compensatory damages. Caps that affect one area of medical malpractice (e.g. just wrongful death cases) or punitive damage caps are not counted since these represent a small number of cases. Physician numbers from "Physician Characteristics and Distribution 2009, American Medical Association.

Medical Malpractice

How Has The Medmal Crisis Affected Premiums?



During The Period Of The Medical Malpractice Crisis, States Implementing New Malpractice Caps Experienced Much Higher Increases In Premiums Than Those States Not Doing So.

Derived from data provided by Medical Liability Monitor (Oct 2001 & Oct 2008) A state's average premium is calculated as the unweighted mean value of premiums for all companies for which data is provided across all regions. A state is classified as having a cap when the state has enacted either a general non-economic damage cap that affects medical malpractice cases or a medical malpractice specific cap on non-economic and/or compensatory damages. Caps that affect one area of medical malpractice (e.g. just wrongful death cases) or punitive damage caps are not counted since these represent a small number of cases. Premiums represent the average of internal medicine, general surgery and OB/Gyn rates.

WEST'S NORTH DAKOTA CENTURY CODE ANNOTATED
TITLE 32. JUDICIAL REMEDIES
CHAPTER 32-42. ALTERNATIVE DISPUTE RESOLUTION

§ 32-42-02. Noneconomic damages limited--Reduction of award

With respect to a health care malpractice action or claim, the total amount of compensation that may be awarded to a claimant or members of the claimant's family for noneconomic damage resulting from an injury alleged under the action or claim may not exceed five hundred thousand dollars, regardless of the number of health care providers and other defendants against whom the action or claim is brought or the number of actions or claims brought with respect to the injury. With respect to actions heard by a jury, the jury may not be informed of the limitation contained in this section. If necessary, the court shall reduce the damages awarded by a jury to comply with the limitation in this section.

Current through the 2008 general election

END OF DOCUMENT

Testimony in Support of House Bill No. 1390

Respectfully Submitted by:

Rodney Pagel
Pagel Weikum, PLLP
1715 Burnt Boat Drive
Madison Suite
Bismarck, ND 58503
701-250-1369

Mr. Chairman and members of the Committee:

I appreciate your taking the time consider House Bill No. 1390.

I. ND currently has a cap of $500,000.00 on any non-economic damages award.

II. This cap was touted as being necessary because of:

A. Frivolous lawsuits

1. Reality is that damage caps have no impact on frivolous lawsuits because by definition the damage caps only impact the very serious, legitimate case, and
2. There has never been a showing of frivolous lawsuit problem in ND.

B. Need to retain physicians in ND.

1. Studies performed have established that caps do nothing to retain physicians, and
2. The absence of caps is not driving physicians away. There simply is no physician shortage / damage caps correlation.

C. Physicians are having hard time finding and paying for insurance due to large verdicts.

1. Insurance rates have increased due to insurance company investments, not due to too many lawsuits or too many verdicts in excess $500,000.00

2. Placing caps on damages awards has no correlation to reasonable insurance rates.

III. The current cap on medical malpractice damages awards serves no real purpose other than to:

A. Limit the ability of the severely injured and most deserving from getting appropriate and adequate compensation for their devastating injuries.

B. Ensuring that the most negligent members of the medical community will not be held accountable for the injuries they cause.

IV. Problem with placing caps on damages awards

A. No other negligence-based action has caps. No other professional malpractice area has caps.

B. It holds the medical community in a position of non-accountability not given to the rest of society.

C. We place an arbitrary limit on the value of life, on the degree of pain or suffering.

D. It damages the credibility of the system and the ability to hold citizens accountable for their actions.

E. It puts medical malpractice cases into a box that does not fit every scenario.

Thank you again for your time.

If you have any questions, please feel free to contact me.

Page 1

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CJ&D

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MYTHBUSTER!

"CAPS" DO NOT CAUSE INSURANCE RATES TO DROP

In recent years, during the medical malpractice insurance "crisis" for doctors, great pressure was brought to bear on state legislatures to restrict the rights of injured patients to be compensated for their injuries. As during past insurance "crises,"[i] the insurance industry told lawmakers that enacting "tort reform," particularly caps on compensation for patients was the only way to reduce skyrocketing insurance rates - even though other statements by industry insiders repeatedly contradict this.[ii]

Today, medical malpractice rates have stabilized and availability has improved around the country.[iii] The flattening of rates had nothing to do with tort law restrictions enacted in particular states, but rather to modulations in the insurance cycle everywhere. Whether a state has enacted strong insurance regulatory laws has also helped.[iv] The following are a few examples:

- **Illinois**. In October 2006, Illinois Division of Insurance announced that an Illinois malpractice insurer, Berkshire Hathaway's MedPro, would be expanding its coverage and cutting premiums for doctors by more than 30 percent. According to state officials and the company itself, this was made possible because of new *insurance* reforms enacted by Illinois lawmakers in 2005, and expressly *not* the cap on compensation for patients that was enacted at the same time.[v] The law requires malpractice insurers to disclose data on how to set their rates. This, according to Michael McRaith, director of the state's Division of Insurance, allows MedPro to "set rates that are more competitive than they could have set before."

- **Connecticut:** "Rate increases are even slowing or stopping in some states that have not limited awards for pain and suffering, including Connecticut, where premium increases in the past have soared as much as 90 percent in a single year."[vi] Connecticut has no cap on damages.

- **Maryland.** "[T]he state's largest malpractice insurer said it does not need a rate increase for next year, leading some to question whether the much-debated malpractice crisis ever existed."[vii] In 2006, Maryland's largest malpractice insurer, Med Mutual, announced plans to cut their malpractice rates by 8 percent in 2007.[viii] Maryland has had a cap on damages since 1986. Sixteen years later, during the most recent insurance crisis, the state still experienced premiums that "rose by more than 70 percent in the last two years."[ix]

- **Pennsylvania.** In Pennsylvania in recent years, rates across the med mal marketplace "have found a new plateau," according to an associate counsel and director of patient safety and risk management at the University of Pittsburgh Medical Center, Richard P. Kidwell.[x] Pennsylvania has no cap.

- **Massachusetts.** In early 2005, "[T]he state's largest malpractice insurer said it will not raise doctors' premiums..."[xi] Massachusetts has had a cap, but with significant exceptions, since 1986.

- **Washington.** In 2005, the state's largest med mal insurer Physicians Insurance, which is owned by doctors, requested a 7.7 percent reduction in medical malpractice rates, with the company reporting record-breaking net income.[xii] Washington does not have a cap on damages.

THE CALIFORNIA EXPERIENCE

- Thirteen years after the state's severe $250,000 cap on damages was enacted (MICRA, passed in 1975), "doctors' premiums had increased by 450 percent and reached an all-time high in California." But in 1988 California voters passed a stringent insurance regulatory law, Proposition 103, which "reduced California doctors' premiums by 20 per within three years," and stabilized rates.[xiii]
- In the thirteen years after MICRA, but before the insurance reforms of Prop. 103, California medical malpractice premiums rose faster than the national average. In the twelve years after Prop. 103 (1988-2000), malpractice premiums dropped 8 percent in California, while nationally they were up 25 percent.[xiv] Moreover, the law has led to public hearings on recent rate requests by medical malpractice insurers in California, which resulted in rate hikes being lowered three times.[xv]

The "liability insurance crisis" of the mid-1980s was ultimately found to be caused not by legal system excesses but by the economic cycle of the insurance industry.[xvi] Just as the liability insurance crisis was found to be driven by this cycle and not a tort law cost explosion as many insurance companies and others had claimed, the "tort reform" remedy pushed by these advocates failed. It has failed again.

Only effective insurance reforms will stop these cyclical insurance crises.

NOTES

[i] Volcanic eruptions in insurance premiums for doctors have occurred three times in the last 30 years – in the mid 1970s, again in the mid-1980s, and between 2001 and 2005 (the "hard" insurance market.) *See, e.g.*, "Malpractice - Doctors in Revolt," *Newsweek*, June 9, 1975; "Malpractice: MD's Revolt," *Newsweek*, June 9, 1975; "Some of the Losers who 'Won,'" *Newsweek*, June 9, 1975; George J. Church, "Sorry, Your Policy Is Canceled," *Time Magazine,* March 24, 1986; "Let the Free Market End Malpractice Warfare," *Business Week*, Aug. 3, 1987. The cause is always the same: a severe drop in investment income for insurers compounded by underpricing in prior years (the "soft" insurance market). Because insurers make most of their money from investment income, insurance is a cyclical business. Americans for Insurance Reform [AIR], "Insurance Industry Admits: Insurance Business Practices and Investment Cycle to Blame for Insurance Liability 'Crisis,'" http://centerjd.org/air/pr/Investments.pdf. But each time the "hard" market takes hold, insurers have tried to blame lawyers and the legal system for the problems caused by this cyclical underwriting. Compounding the impact of the most recent cycle was some insurers' misleading business and accounting practices. As the *Wall Street Journal* found in a front page investigative story on June 24, 2002: "[A] price war that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims.... A decade of short-sighted price slashing led to industry losses of nearly $3 billion last year." Christopher Oster & Rachel Zimmerman, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal*, June 24, 2002.

[ii] Americans for Insurance Reform, "Insurance Industry Admits: Tort Reform Will Not Lower Insurance Rates," http://centerjd.org/air/pr/Quotes.pdf; Americans for Insurance Reform, *"ATRA Admits Tort Reform Won't Lower Rates,"* http://www.insurance-reform.org/AIRATRARelease.pdf; CJ&D, *"Center for Justice & Democracy Response to AIA Attack on Premium Deceit: The Failure of Tort Reform to Cut Insurance Prices,"* http://centerjd.org/press/release/020319.response.pdf.

[iii] Americans for Insurance Reform, "Commercial Insurance Rates Continue to Fall While Insurer Profits Continue to Skyrocket to Record Levels," (October 25, 2006) http://www.insurance-reform.org/AIRSoftMarketProfits.pdf

[iv] Credible studies reject the notion that enactment of caps on damages will lower insurance rates. A study by law professors at the University of Texas, Columbia University and the University of Illinois based on closed claim data compiled by the Texas Department of Insurance since 1988 concluded that "the rapid changes in insurance premiums that sparked the crisis appear to reflect insurance market dynamics, largely disconnected from claim outcomes." Black, Silver, Hyman, and Sage, "Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002," *Journal of Empirical Legal Studies* (2005). That study further concluded that, after controlling for the quantity of health care delivered, the frequency of large paid claims declined, the number of small paid claims declined sharply, and payout per claim on large claims remained constant over a 15-year period. Similarly, an econometric analysis of the malpractice market by two Dartmouth economists found that "past and present malpractice payments do not seem to be the driving force behind increases in premiums," and that premium growth may be affected by many factors beyond increases in claims payments, such as industry competition and the insurance underwriting cycle. Katherine Baicker and Amitabh Chandra, National Bureau of Economic Research, "The Effect of Malpractice Liability on the Delivery of Health Care," at 14 and 20 (Aug. 2004). *See also,* Amitabh Chandra, Shantanu Nundy, Seth A. Seabury, "The Growth of Physician Medical Malpractice Payments: Evidence from the National Practitioner Data Bank," *Health Affairs*, May 31, 2005. The study analyzed National Practitioner Data Bank data on payments, as well as data on premiums, physicians, and treatments. Weiss Ratings, an independent insurance-rating agency, found that between 1991 and 2002, states with caps on noneconomic damage awards saw median doctors' malpractice insurance premiums rise 48 percent – *a greater increase than in states without caps.* In states without caps, median premiums increased only 36 percent. Moreover, according to Weiss, "median 2002 premiums were about the same" whether or not a state capped damage awards. Weiss Ratings, "Medical Malpractice Caps Fail to Prevent Premium Increases," http://weissratings.com/News/Ins_General/20030602pc.htm; http://www.weissratings.com/malpractice.asp A study released by the congressional General Accounting Office in 2003, "Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates," found absolutely no support for capping damages as a solution to bring down insurance rates for doctors. Americans for Insurance Reform, "New GAO Study Finds No Support For Caps on Damages; Findings On 'Losses' Challenged by Consumer Groups," http://centerjd.org/air/pr/AIRGAO.pdf See also, Americans for Insurance Reform, "Measured Costs," July 2005, http://www.insurance-reform.org/measured_costs.pdf; Americans for Insurance Reform" Stable Losses, Unstable Rates," October 2004, http://www.insurance-reform.org/StableLosses04.pdf; See, also, Jay Angoff, "Falling Claims and Rising Premiums in the Medical Malpractice Insurance Industry," July 2005, http://www.centerjd.org/ANGOFFReport.pdf.

[v] See, Adam Jadhav, "Minor insurer is cutting malpractice rates for doctors," *St. Louis Post-Dispatch*, October 13, 2006; 10/13/2006; http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=1&RecNum=5414 http://www.dailysouthtown.com/business/blesch/100695.1BIZ3-18.article

[vi] Diane Levick, "Malpractice Premiums Begin to Level Off," *Hartford Courant,* September 18, 2005

[vii] M. William Salganik, "Doctor insurer says malpractice rate increase not needed this year," Baltimore Sun, August 20, 2005..

[viii] M. William Salganik, "Physicians' insurer to lower premiums," *Baltimore Sun*, Dec. 15, 2006.

[ix] James Dao, "A Push in States to Curb Malpractice Costs," *New York Times*, Jan. 14, 2005.

[x] KIertesz, Louise, "Medical malpractice rates stable, but still at 'very high levels'," *Business Insurance,* October 30, 2006.

[xi] Liz Kowalczyk, "Malpractice insurer says it won't raise rates," *Boston Globe*, April 5, 2005.

[xii] Rebecca Cook, "How Sick is Malpractice Mess?" *Associated Press*, Jan. 17, 2005.

[xiii] Foundation for Taxpayer and Consumer Rights, "How Insurance Reform Lowered Doctors' Medical Malpractice Rates in California and How Malpractice Caps Failed" (March 7, 2003), http://www.consumerwatchdog.org/healthcare/rp/rp003103.pdf.

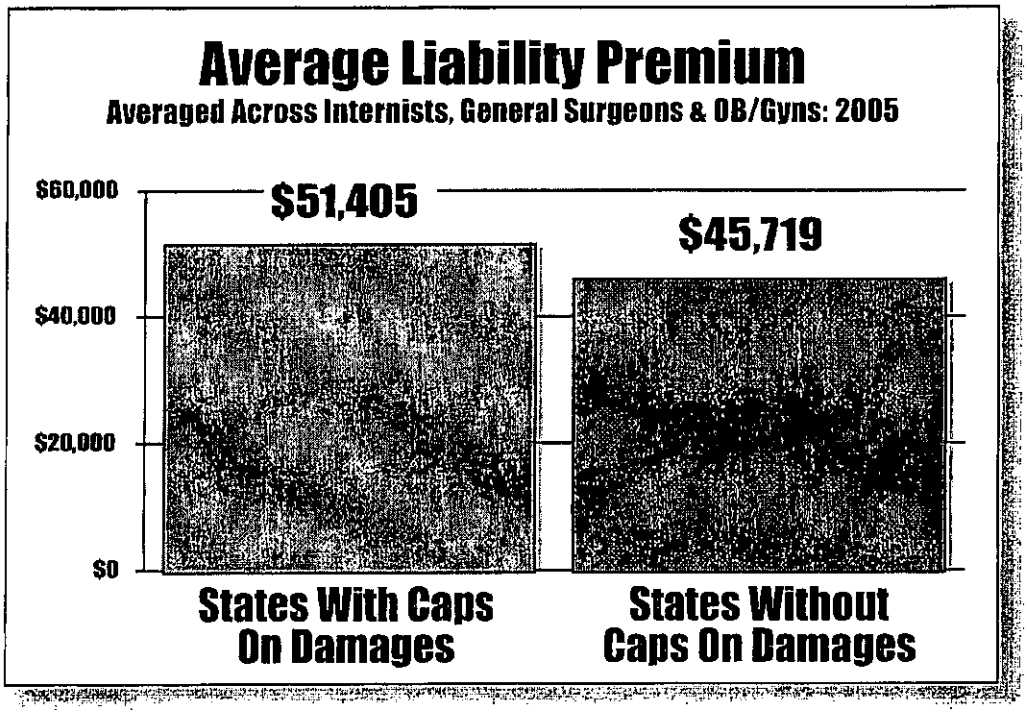
[xiv] Foundation for Taxpayer and Consumer Rights, "Insurance Regulation, Not Malpractice Caps, Stabilize Doctors' Premiums," http://www.ftcr.org/healthcare/fs/fs003013.php3.

[xv] Foundation for Taxpayer and Consumer Rights, "California Group Successfully Challenges 29.2% Rate Hike Proposed by California's Ninth Largest Medical Malpractice Insurer; Proposition 103 Invoked to Slash Medical Protective Company's Requested Increase by 60%," Sep 16, 2004, http://consumerwatchdog.org/insurance/pr/pr004625.php3.

[xvi] The Ad Hoc Insurance Committee of the National Association of Attorneys General concluded after studying the "crisis" in 1986: "The facts do not bear out the allegations of an "explosion" in litigation or in claim size, nor do they bear out the allegations of a financial disaster suffered by property/casualty insurers today. They finally do not support any correlation between the current crisis in availability and affordability of insurance and such a litigation 'explosion.' Instead, the available data indicate that the causes of, and therefore solutions to, the current crisis lie with the insurance industry itself." Francis X. Bellotti, Attorney General of Massachusetts, et al., "Analysis of the Causes of the Current Crisis of Unavailability and Unaffordability of Liability Insurance" (Boston, Mass.: Ad Hoc Insurance Committee of the National Association of Attorneys General, May, 1986). State commissions in New Mexico, Michigan and Pennsylvania reached similar conclusions. See, e.g., New Mexico State Legislature, "Report of the Interim Legislative Workmen's Compensation Comm. on Liability Insurance and Tort Reform," November 12, 1986; Michigan House of Representatives, "Study of the Profitability of Commercial Liability Insurance", November 10, 1986; Insurance Comm. Pennsylvania House of Representatives, "Liability Insurance Crisis in Pennsylvania," September 29, 1986. Even the insurance industry admitted this internally. In 1986, Maurice R. Greenberg, then President and Chief Executive Officer of American International Group, Inc., one of the country's leading property/casualty companies, told an insurance audience in Boston that the industry's problems were due to price cuts taken "to the point of absurdity" in the early 1980s. Had it not been for these cuts, Greenberg said, there would not be 'all this hullabaloo' about the tort system." Greewald, "Insurers Must Share Blame: AIG Head," *Business Insurance,* March 31 1986, p. 3.

Medical Malpractice Insurance

Do Caps Reduce Malpractice Premiums?

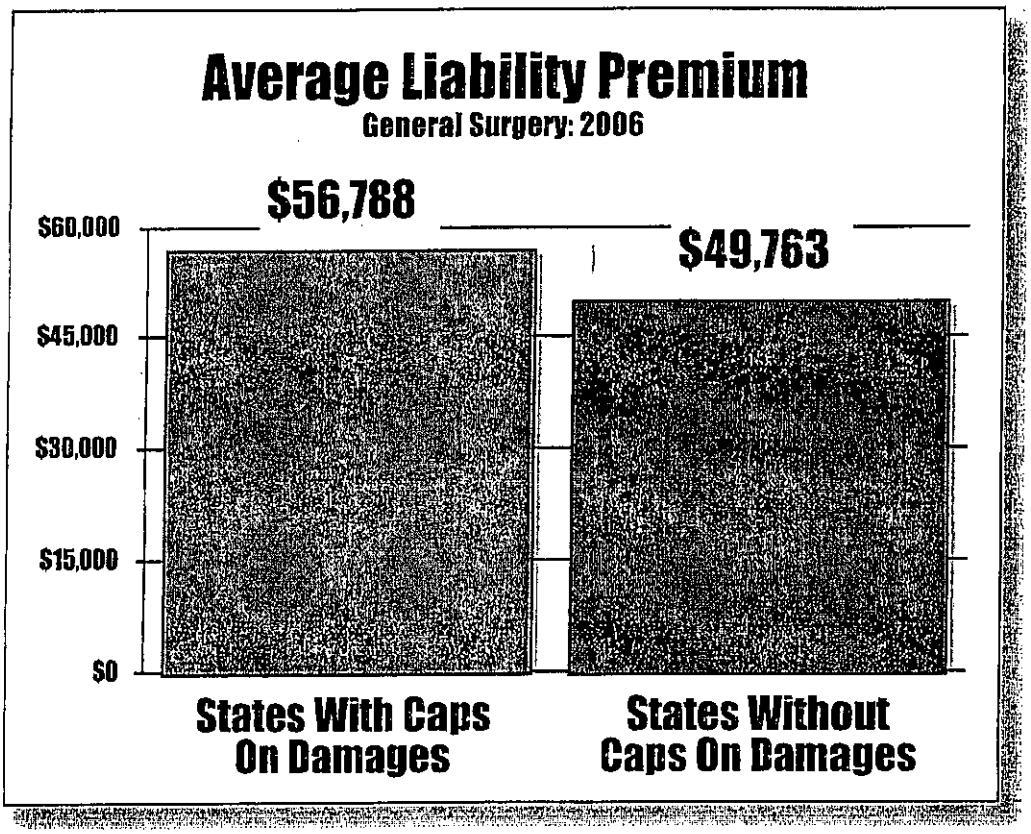


- **Caps Were Designed To Lower Medical Malpractice Insurance Premiums**
- **Premiums In States With Caps Are 12.4% Higher Than In States Without Caps**
- **Caps On Malpractice Damages Do Not Reduce Medical Malpractice Insurance Premiums**

Derived from data provided by Medical Liability Monitor (Oct 2005) A state's average premium is calculated as the unweighted mean value of premiums for all companies for which data is provided across all regions. A state is classified as having a cap when the state has enacted either a general non-economic damage cap that affects medical malpractice cases or a medical malpractice specific cap on non-economic and/or compensatory damages. Caps that affect one area of medical malpractice (e.g. just wrongful death cases) or punitive damage caps are not counted since these represent a small number of cases. GA, IL, SC & WI switched categories in 2005. Calculating based on 2004 categories results in cap states at $50,130 and non-cap states at $47,727.

Medical Malpractice Insurance

Do Caps Reduce Malpractice Premiums?

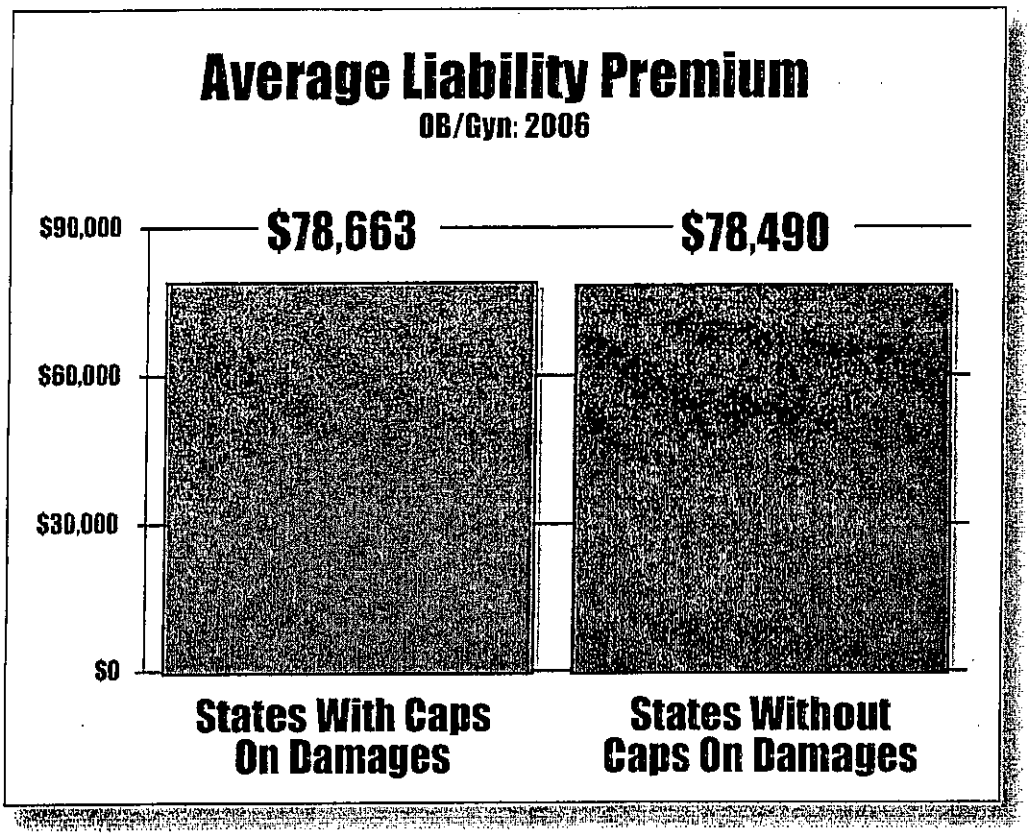


General Surgery Premiums In States With Caps Are 14.1% Higher Than In States Without Caps.

Derived from data provided by Medical Liability Monitor (Oct 2006) A state's average premium is calculated as the unweighted mean value of premiums for all companies for which data is provided across all regions. A state is classified as having a cap when the state has enacted either a general non-economic damage cap that affects medical malpractice cases or a medical malpractice specific cap on non-economic and/or compensatory damages. Caps that affect one area of medical malpractice (e.g. just wrongful death cases) or punitive damage caps are not counted since these represent a small number of cases.

Medical Malpractice Insurance

Do Caps Reduce Malpractice Premiums?

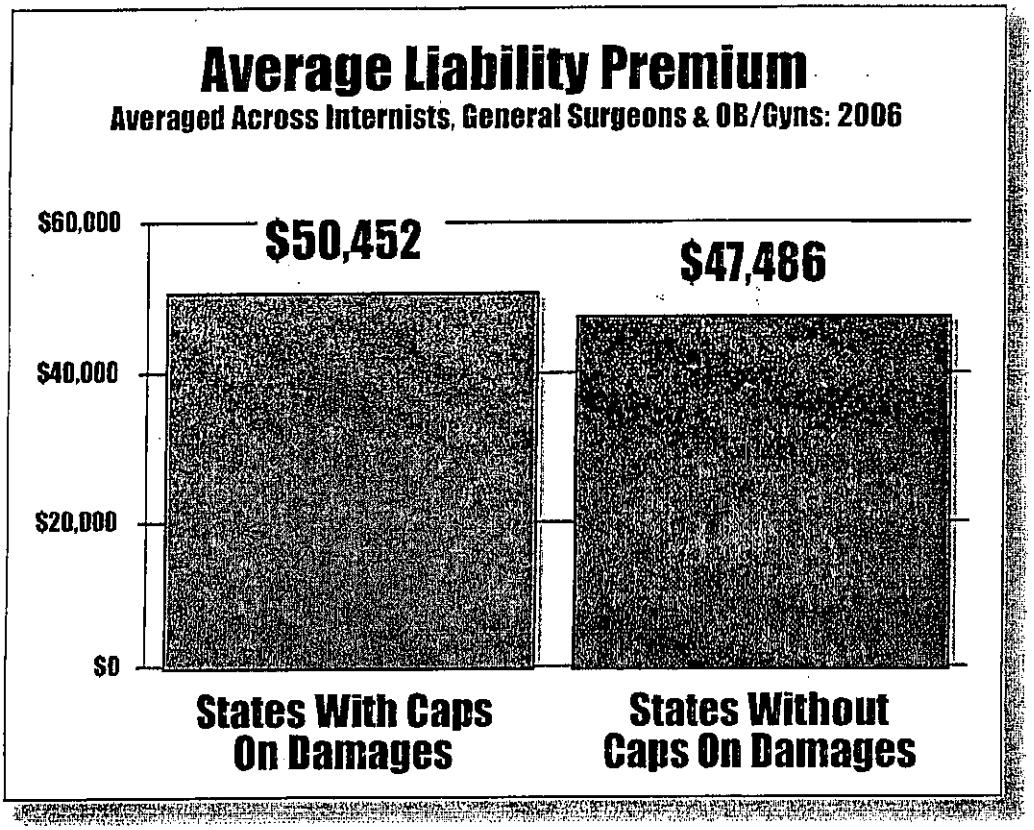


Malpractice Premiums For Doctors Of Obstetrics and Gynecology Are Slightly Lower In States Without Caps On Noneconomic Damages.

Derived from data provided by Medical Liability Monitor (Oct 2006) A state's average premium is calculated as the unweighted mean value of premiums for all companies for which data is provided across all regions. A state is classified as having a cap when the state has enacted either a general non-economic damage cap that affects medical malpractice cases or a medical malpractice specific cap on non-economic and/or compensatory damages. Caps that affect one area of medical malpractice (e.g. just wrongful death cases) or punitive damage caps are not counted since these represent a small number of cases.

Medical Malpractice Insurance

Do Caps Reduce Malpractice Premiums?



Malpractice Premiums Averaged Across Specialities In States With Caps Are 6.3% Higher Than In States Without Caps.

Derived from data provided by Medical Liability Monitor (Oct 2006) A state's average premium is calculated as the unweighted mean value of premiums for all companies for which data is provided across all regions. A state is classified as having a cap when the state has enacted either a general non-economic damage cap that affects medical malpractice cases or a medical malpractice specific cap on non-economic and/or compensatory damages. Caps that affect one area of medical malpractice (e.g. just wrongful death cases) or punitive damage caps are not counted since these represent a small number of cases.

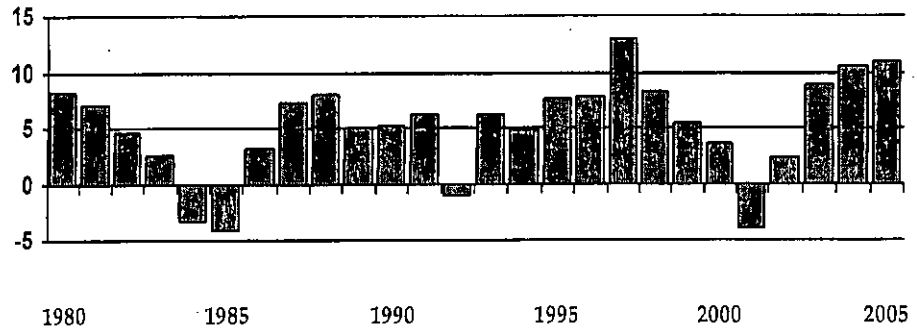
Medical Malpractice and the Insurance Cycle

If premiums are going down in states with AND without tort reform, then clearly the underlying cycle is the prime mover of rates and not any kind of changes in laws.

What is the insurance cycle?
Insurance is a cyclical business. "Boom and bust" cycles are driven largely by underlying market conditions, insurer practices and the overall investment climate. During "soft" markets, when insurers enjoy a positive investment climate, coverage is readily available and many insurers compete on price to increase their market share. During "hard" markets, the investment climate is less forgiving of premium price cuts, insurers become less willing to underwrite risks, and prices rise.

Insurance Industry Operating Income

as a % of Premiums



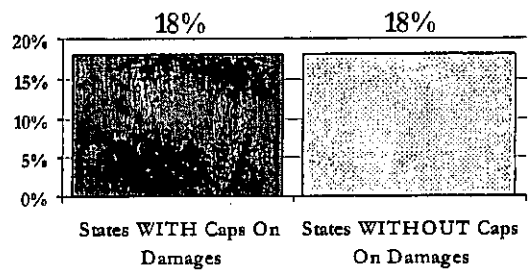
Source: AM Best Aggregates & Averages, 2006

What causes the insurance cycle?
There are two explanations for the recent trends in premiums. The first claims that limiting the rights of injured patients is the only way to stop skyrocketing premiums. If this were true we would expect to find very large differences in premium increases between states that implemented tort reform and those that did not. The second explanation says that premiums will rise and fall with underlying market conditions and are relatively unaffected by "tort reform." If this were true we would find little difference in the rate of premium increases in states with and without tort reform.

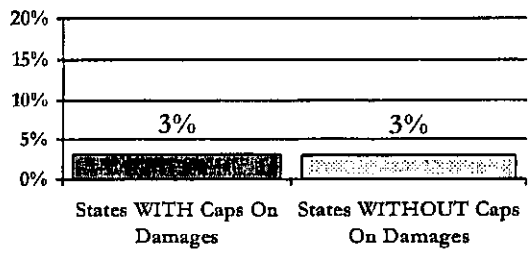
So which is it?
In 2003 both cap and noncap states saw premiums increase about 18%.

Three years later premiums in states with and without caps rose at about 3%.

Premium Increases 2003



Premium Increases 2006



Source: Medical Liability Monitor[1]

The data clearly show that premiums rise and fall regardless of the kinds of laws states have implemented. **If premiums are going down in states with AND without tort reform, then clearly the underlying cycle is the prime mover of rates and not any kind of changes in laws.** In fact, states with the largest premiums decreases have been states without caps and states with the largest premium increases have been states with caps.

Meanwhile, the insurance industry enjoyed record profits, despite Hurricane Katrina.
The U.S. property/casualty industry's underwriting profit for the first half of 2006 was $15.1 billion - 31.8% higher than the first six months of 2005 which were already record-breaking. (BestWeek, October 6, 2006.) The property-casualty insurance industry's after-tax net income for 2005 was the highest ever, a record-breaking $44.8 billion! (Los Angeles Times, April 5, 2006.)

And when push comes to shove insurance industry executives will never promise tort reform will reduce premiums.
"We have not promised price reductions with tort reform."
~Dennis Kelly, American Insurance Association spokesman, Chicago Tribune, January 3, 2005.

"There is no question that it is very rare that frivolous suits are brought against doctors. They are too expensive to bring."
~Victor Schwartz, General Counsel of the American Tort Reform Association, Los Angeles Times, October 22, 2004.

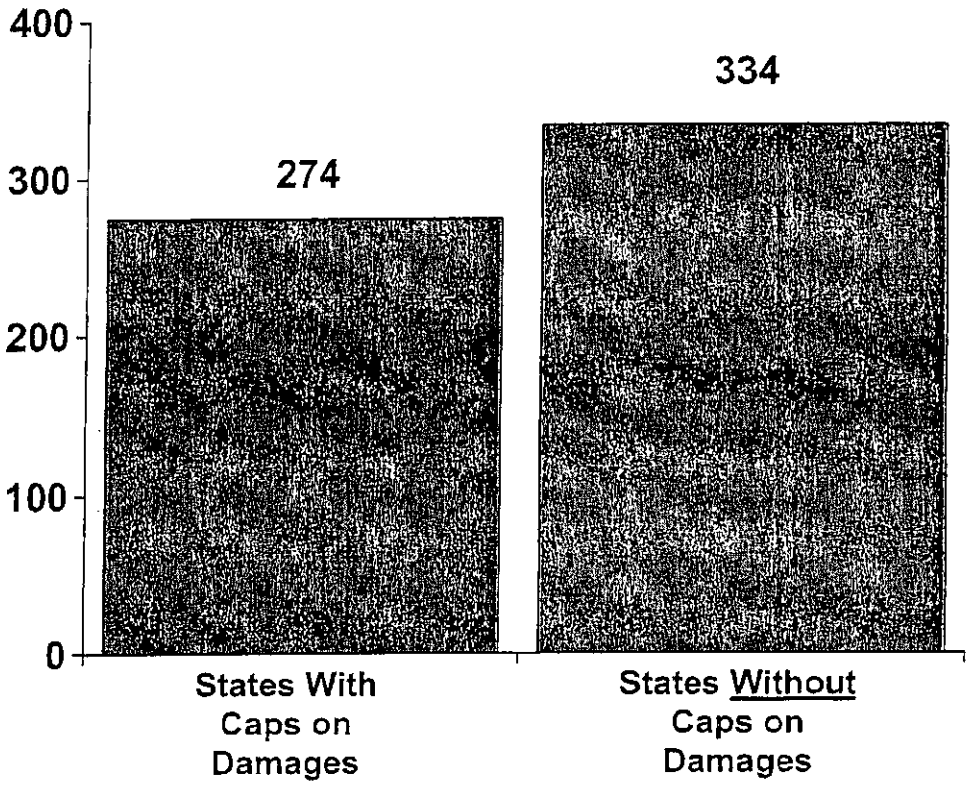
"To be sure, rising medical costs have played a role in premium increases. But premium growth has outstripped that of claims expenses. And many health plans have posted solid profits and continue to pay CEO salaries and bonuses exceeding $1 million."
~ AMedNews Editorial, Oct. 14, 2002

[1] Derived from data provided by Medical Liability Monitor (Oct 2006) A state's average premium increase is calculated as the unweighted mean value of premiums for all companies for which data is provided across all regions. A state is classified as having a cap when the state has enacted either a general non-economic damage cap that affects medical malpractice cases or a medical malpractice specific cap on non-economic and/or compensatory damages. Caps that affect one area of medical malpractice (e.g. just wrongful death cases) or punitive damage caps are not counted since these represent a small number of cases.

Are Doctors Really Closing Their Doors?

Number of Physicians

Per 100,000 Population: 2005



In 2005, there were 22% more physicians per 100,000 population in states without caps than there were in states with caps.

A state is classified as having a cap when the state has enacted either a general non-economic damage cap that affects medical malpractice cases or a medical malpractice specific cap on non-economic and/or compensatory damages. Caps that affect one area of medical malpractice (e.g. just wrongful death cases) or punitive damage caps are not counted since these represent a small number of cases.

HOUSE BILL 1390

Judiciary Committee

Testimony by Mathew C. Schwarz

February 11, 2009

Good morning Chairman DeKrey and members of the Judiciary Committee.

My name is Matt Schwarz. I am here to speak in support of House Bill 1390 to remove the cap on non-economic damages in healthcare malpractice actions.

Our daughter, Stephanie, age 29, died while under the care of a hospitalist whom we had never met until her death.

My wife Marcia and our daughter Jessica live in District 47, Bismarck. They both have Myotonic Muscular Dystrophy. Jessica is on life support and Marcia's health has also deteriorated where she has serious physical limitations and uses a wheelchair. Stephanie also had MD. However she was the healthiest of all, was our helper, and most important of all, was mentor and best friend to her sister, Jessica, who also has mental retardation. Stephanie died unexpectedly on Valentines Day, 2004, three hours after we (Marcia, Jessica, and I) left her hospital room to have a Valentines dinner.

Upon Stephanie's admission we had given clear instructions that we refused to have treatment by a hospitalist and that if we couldn't have our family physician treat Stephanie, then they should tell us and we would go

elsewhere. We were under the impression that our primary doctor was the treating physician until, to our surprise, we found out differently. Subsequently, in trial testimony, it was discovered the hospital had a program that puts the authority to treat by a hospitalist, regardless of our clear instructions. A trial by jury found the medical facility (hospitalist) at fault in the care provided to Stephanie.

Our family did not file a lawsuit just because of the money. But we understand that the penalty of doing something wrong is most often the only motivation for a company or corporation to change their ways. What we really wanted was the medical provider to acknowledge what they did wrong and to fix the system! Unfortunately that did not happen and business continues with the potential the same thing could happen to another patient.

Our legal team informed us of the limited amount of money that may potentially be recovered due to the cap put on noneconomic damages by the ND Century Code. Our medical experts believed there were multiple contributions that led to the result of our daughter's death, but because of the cost involved in litigation and limited recovery we had to prioritize our efforts. Unfortunately, the defendants' did not have such constraints and were willing to spend whatever necessary to counter every detail of the case. To further add insult, economic damages to someone like our daughter is very difficult to prove because of her disabilities. It made me pause as I get older. The power to persuade a medical provider because of the penalty of a large medical claim becomes less as we all get older due to the lower economic value for the balance of our lives. Watch out the next time you go to the hospital. Your loss may not be that big of an economic deal!

From what I'm able to discern from all the data available, the insurance industry has created a myth about the crisis involving malpractice cases. I am attaching copies of several documents that support this claim. Several myths vs. reality sited are as follows:

MYTH: The courts are "clogged" with "frivolous" medical malpractice lawsuits.

FACT: Medical malpractice litigation in this country is far from frivolous. In a major study released in 1999, the National Academy of Sciences Institute of Medicine found up to 98,000 people are killed each year by medical errors in hospitals. Our attorneys told me in Burleigh County there hasn't been a successful medical malpractice verdict in 52 years.

FACT: Numerous hospital and medical procedures have been made safer as a result of lawsuits.

FACT: Punitive damages are awarded only for the most egregious wrongdoing; "capping" damages hurts exclusively the most seriously injured patients.

MYTH: Medical malpractice lawsuits drive up health care costs and insurance premiums.

FACT: Medical malpractice costs make up only a tiny fraction of total health care costs.

FACT: Far more costly than malpractice lawsuits are the costs of medical errors.

I'd like to provide you information from the book entitled *Wall of Silence* by Rosemary Gibson & Janardan Prasad Singh. The book is well praised by notable people (read names from page 1 of handout). Inside the front flap the following questions are posed:

1. Why is there no national reporting of medical mistakes?
2. Why are hospitals spending hundreds of millions of dollars on aesthetic repairs while nurses flee hospitals in droves?
3. Why must patients and their families plead with hospitals to acknowledge harm done?
4. How can we prevent millions more from falling victim to medical mistakes in the next ten years?

Pages 52-54 of the book talk about the firestorm over Firestone "that erupted over reports that approximately 200 people had died in accidents resulting from faulty Firestone tires. When the tires were linked to deaths and injuries, the news sent shock waves across the nation."

So, "where's the firestorm over medical mistakes?" "Eight months earlier, in December 1999, the IOM (Institute of Medicine) report was released with estimates of the number of preventable deaths from medical mistakes....there was no comparable outcry about almost 100,000 deaths a year from medical mistakes. No one commented that it had been nearly a

decade – and nearly a million deaths—since publication of the original study in the *New England Journal of Medicne* that had first identified the toll associated with medical mistakes.

"Meanwhile, defenders of the status quo say that medical mistakes are inevitable because providing medical care today is complex. While it is true that humans will always make mistakes, this fact of life doesn't let the health care system off the hook. In fact, one health system CEO says he becomes "livid" when he hears a hospital has a goal of reducing medical mistakes by 10 percent...Who would be satisfied if an airline had a goal of reducing the number of fatalities in air crashes by ten percent? It would be unacceptable."

According to the National Practitioner Data Bank of the Department of Health and Human Services (The data bank allows hospitals and medical boards to see the records of individual doctors but, thanks to the pressure from the American Medical Association, Congress forbids it to release information to doctors or the public,) from 1990 to 2002, just 5 percent of doctors were involved in 54 percent of the payouts.

It's time to let the free market operate like every other business. Lawsuits cause self correction. It's time the special interest groups stop upsetting the balance against patients who are injured or have died due to medical malpractice!

Our family asks you to support SB 2323 in memory of our daughter, Stephanie.

"*Wall of Silence* does something no one else has done—tell the real stories of medical errors."

—Gail Warden, CEO, Henry Ford Health System
Former Chairman, American Hospital Association

"In a clear and eloquent voice, *Wall of Silence* reinforces an issue that the health care system has not wanted to address."

—James A. Block, M.D., Former CEO,
Johns Hopkins Health System

"*Wall of Silence* does a really terrific job of putting a face on the statistics regarding medical error. . . . [D]emonstrates many of the different ways this serious problem is manifest throughout the health care system." *—Bill Novelli, CEO, AARP*

"This very readable and comprehensive book puts medical errors in a compelling human context. The lay reader will better understand the complex underlying issues that affect mistakes being made, but also will better understand the human toll."

—William C. Richardson, President and CEO,
W.K. Kellogg Foundation, Chair, Institute of Medicine
Committee on Quality of Health Care in America

"*Wall of Silence* should be required reading for every American who uses, or is a potential user of, the health care system. . . . [W]ithout placing unfair blame on dedicated health providers, the authors alert us to this major and complex problem. Most important, it empowers each of us to guard against being a victim by being an educated consumer. . . . Wall of Silence will serve as a wake-up call for each of us."

—Rheba de Tornyay, R.N., Ed.D., Dean Emeritus,
University of Washington School of Nursing

". . . a repository of information and a set of clear opportunities for safety that the public can use."

—Geraldine Bednash, R.N., Ph.D., F.A.A.N., Executive Director,
American Association of Colleges of Nursing

"This is a book that should interest all Americans, as we are all affected by the health care system. With an array of examples that are revealing and sometimes shocking, the authors clearly illustrate many of the systemic problems that need addressing and offer some pragmatic steps that the public and health care professionals can take to enhance the reliability of care.

—The Honorable Matthew F. McHugh,
Former New York State Congressman

"A compelling story of what the public needs to be concerned about."

—William Roper, M.D., M.P.H., Dean, School of Public Health,
University of North Carolina at Chapel Hill,
Former Director, Centers for Disease Control
Former Administrator, Health Care Financing Administration
Former White House health care advisor

What is the total cost of medical mistakes, added up for all the people affected? While the human toll of medical mistakes is incalculable, the financial toll of preventable injuries resulting from medical mistakes is estimated by the IOM to cost $17 to $29 billion a year.

Paul O'Neill, former Secretary of the Treasury under President George W. Bush, put the cost of medical mistakes and poor-quality medical care in perspective. As the managing trustee of the Medicare trust fund while Treasury Secretary, O'Neill said that Medicare could save taxpayers' money by reducing medical mistakes and improving the overall quality of care. "If we could capture the potential that exists to do it right the first time, we'd probably reduce health and medical care costs 30 to 50 percent." Experts may differ on how accurate that estimate is, but the fact is that poor-quality health care costs a lot of money—and we're all paying for it.

The Firestorm Over Firestone

On August 9, 2000, the Bridgestone/Firestone Company announced that it was recalling 6.5 million tires, an event that was followed in May 2001 by an additional recall of 13 million tires by Ford Motor Company. These unprecedented corporate actions resulted from the firestorm that erupted over reports that approximately 200 people had died in accidents resulting from faulty Firestone tires. When the tires were linked to deaths and injuries, the news sent shock waves across the nation. Pictures of crashes caused by defective tires appeared on the nightly television news.

Almost immediately, Congress sprung into action. Corporate executives from Ford Motor Company and Bridgestone/Firestone appeared before Congress to be held publicly accountable, and members of Congress had harsh words for company executives for not acting quickly enough. The hearings started off with a news clip from a television station that put a human face on the deaths associated with the tires. Senator Richard Shelby, Chairman of the Senate Transportation Subcommittee of the Senate Appropriations Committee, said, "I would like to know how it could take us ten years, dozens of lives, numerous lawsuits, substantial consumer complaints . . . before any action was taken to initiate an investigation into the safety of a product being used by millions of American families. Simply put, the American people deserve better." Officials of the National Highway Traffic Safety Administration were chided, too, by members of Congress for being asleep at the wheel. Two years earlier NHTSA had been told about the tread separation of the tires and the resulting roadway fatalities.

To quell fears among a worried public, Ford executives said that they planned to contact every owner of a Ford Explorer to show concern and make amends. Both companies had a vested interest in making things right because if they didn't, American consumers would exercise their right to take their business elsewhere. People would stop buying Ford Explorers and Bridgestone/Firestone tires. Millions, if not billions, of dollars were at stake, and the two companies took action to quell the public relations nightmare and, most importantly, prevent another needless death.

WHERE'S THE FIRESTORM OVER MEDICAL MISTAKES?

So what does the Bridgestone/Firestone debacle have to do with medical mistakes? Eight months earlier, in December 1999, the IOM report was released with estimates of the number of preventable deaths from medical mistakes. While widely covered in the media, there was no comparable outcry about the almost 100,000 deaths a year from medical mistakes. No one commented that it had been nearly a decade—and nearly a million deaths—since publication of the original study in the *New England Journal of Medicine* that had first identified the toll associated with medical mistakes. Congressional hearings were held but no health care executives were called on the carpet. No harsh words were exchanged, no one was scolded for inaction.

Why was the response by Congress to medical errors so muted and polite, compared with its response to the defective Bridgestone/Firestone tires? One reason might be that no federal agency tracks deaths and injuries from medical mistakes, as NHTSA tracks deaths and injuries from defective tires, or as the Occupational Safety and Health Administration monitors workplace accidents. Or it might be that deaths from defective tires are visible and can be shown on television news, while deaths from medical mistakes are not so obvious. In many cases, family members may not even know their loved one died from a medical mistake.

American society pays a great deal of deference to doctors, so much so that it may be politically incorrect to hold their actions up to public scrutiny. Their services may be needed someday, and no one wants to antagonize those who might be there to help when needed. In other instances, we may not really want to know what goes on because the reality could be too frightening.

Meanwhile, defenders of the status quo say that medical mistakes are inevitable because providing medical care today is complex. While it is true that humans will always make mistakes, this fact of life doesn't let the health care system off the hook. In fact, one health system CEO says he becomes "livid" when he hears that a hospital has a goal of reducing medical mistakes by 10 percent. He says, "Who would be satisfied if an airline had a goal of reducing the number of fatalities in air crashes by ten percent? It would be unacceptable."

Another reason for a light touch from Congress might be that no one is held accountable for mistakes in the health care system. There are few negative consequences to health care organizations that tolerate care that is not safe enough. This occurs even though the federal government pays—with taxpayer money—the bulk of the cost of medical mistakes through the Medicare program, since older Americans are more likely to experience medical mistakes. As a group, older Americans use the health care system more than others and are therefore more exposed to the possibility of error.

Members of Congress make decisions on how to allocate vast sums of our money for health care. They might use a light touch either because they don't know what to do, have a self-interest in maintaining the status quo, or don't have the political courage or muscle to face the special interests that benefit from the status quo. Yet medical mistakes don't discriminate; they affect Democrats, Republicans, and Independents alike.

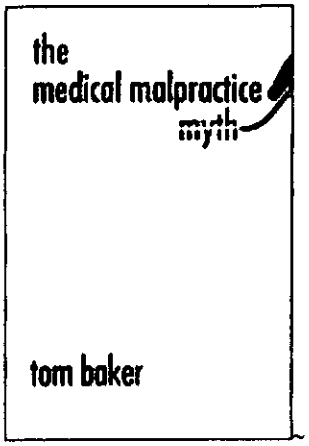
Whatever the reason for the absence of a firestorm over medical errors—and the truth probably lies in all of these reasons—in the end, most of us Americans will be in a hospital someday as a patient, or require medical care that goes beyond "take two aspirin and call me in the morning." This is reason enough to do everything to make medical mistakes as rare as possible.

Among the people whose stories you have read here, there is little optimism that medical mistakes will be corrected anytime soon. Patients don't boycott hospitals or doctors, in an obvious fashion—at least not yet. But some people who have had a bad experience in health care quietly vow to stay away from doctors and hospitals as much as they can. One woman in her forties who, with her husband, has had a series of bad but not life-threatening experiences put it bluntly: "I won't go back." This is the only way they know to fight back—and protect themselves.

Hitting Rock Bottom over Mounting Numbers

Medical errors are like the stock market: sometimes things have to get really bad and hit rock bottom before they turn around and go up again. Have we hit rock bottom with medical mistakes? Probably not, and here's why.

Some hospitals with conscientious and capable leadership have made changes for the better. Dana-Farber Cancer Institute in Boston hit rock bottom in November 1994 when a patient named Betsy Lehman was given an overdose of chemotherapy that killed her. Bad publicity put the tragedy in the spotlight and the hospital



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An excerpt from

The Medical Malpractice Myth

Tom Baker

Medical malpractice premiums are skyrocketing. “Closed” signs are sprouting on health clinic doors. Doctors are leaving the field of medicine, and those who remain are practicing in fear and silence. Pregnant women cannot find obstetricians. Billions of dollars are wasted on defensive medicine. And angry doctors are marching on state capitols across the country.

All this is because medical malpractice litigation is exploding. Egged on by greedy lawyers, plaintiffs sue at the drop of a hat. Juries award eye-popping sums to undeserving claimants, leaving doctors, hospitals, and their insurance companies no choice but to pay huge ransoms for release from the clutches of the so-called “civil justice” system. Medical malpractice litigation is a sick joke, a roulette game rigged so that plaintiffs and their lawyers’ numbers come up all too often, and doctors and the honest people who pay in the end always lose.

This is the medical malpractice myth.

Built on a foundation of urban legend mixed with the occasional true story, supported by selective references to academic studies, and repeated so often that even the mythmakers forget the exaggeration, half truth, and outright misinformation employed in the service of their greater good, the medical malpractice myth has filled doctors, patients, legislators, and voters with the kind of fear that short circuits critical thinking.

This fear has inspired legislative action on a nationwide scale three times in my lifetime. The first time was back in the mid-1970s. I remember sitting at the dinner table listening to my father report what he’d heard at his medical society meeting: “Medical malpractice insurance premiums are going through the roof. Frivolous litigation and runaway juries will drive doctors out of the profession.” The answer, the medical societies and their insurance companies said, was medical malpractice tort reform—to make it harder for misguided patients and their lawyers to sue.

What the medical societies did not tell my father, or almost anyone else, was that their own research showed that the real problem was too much medical malpractice, not too much litigation. In the mid-1970s the California Hospital and Medical Associations sponsored a study on medical malpractice that they expected would support their tort reform efforts. But, to their surprise and dismay, the study showed that medical malpractice injured tens of thousands of people every year—more than

automobile and workplace accidents. The study also showed that, despite the rhetoric, most of the victims did not sue. But almost nobody heard about the study because the associations decided that these facts conflicted with their tort reform message.

Two years after they achieved their goal of enacting restrictive medical malpractice tort reform in California, the associations printed the results of the study, but only as an association report. All that was published for outside consumption was a technical summary, which did not feature the dramatic findings. The report was not widely distributed, and it was written in exceptionally dry and technical language.

The next time I heard about frivolous litigation and runaway juries driving doctors out of practice was while I was in law school in the mid-1980s. Medical malpractice premiums were back through the roof. And, once again, the answer from the medical societies and their insurance companies was tort reform: raise the bar on getting into the courthouse and, in many states, limit what juries could do once victims got inside.

That time, more people were skeptical about the claims of the medical societies. But this was the 1980s, and organized medicine still knew best. Nobody had pulled together enough facts about medical malpractice litigation. And hardly anyone knew about, or could have easily understood, that buried California report. The result was a virtual avalanche of restrictive tort reform legislation proposed—and often enacted—in legislatures across the county.

The third time began in 2002 and continues today. This time around we have a lot more information. But you would not know it from the tort reform remedies that the medical societies, the hospitals, and their insurance companies are pushing.

What do we know?

First, we know from the California study, as confirmed by more recent, better publicized studies, that the real problem is too much medical malpractice, not too much litigation. Most people do not sue, which means that victims—not doctors, hospitals, or liability insurance companies—bear the lion's share of the costs of medical malpractice.

Second, because of those same studies, we know that the real costs of medical malpractice have little to do with litigation. The real costs of medical malpractice are the lost lives, extra medical expenses, time out of work, and pain and suffering of tens of thousands of people every year, the vast majority of whom do not sue. There is lots of talk about the heavy burden that "defensive medicine" imposes on health costs, but the research shows this is not true.

Third, we know that medical malpractice insurance premiums are cyclical, and that it is not frivolous litigation or runaway juries that drive that cycle. The sharp spikes in malpractice premiums in the 1970s, the 1980s, and the early 2000s are the result of financial trends and competitive behavior in the insurance industry, not sudden changes in the litigation environment.

Fourth, we know that "undeserving" people sometimes bring medical malpractice claims because they do not know that the claims lack merit and because they cannot find out what happened to them (or their loved ones) without making a claim. Most undeserving claims disappear before trial; most trials end in a verdict for the doctor; doctors almost never pay claims out of their own pockets; and hospitals and insurance companies refuse to pay claims unless there is good evidence of malpractice. If a hospital or insurance company does settle a questionable claim to avoid a huge risk, there is a very large discount. This means that big payments to undeserving claimants are the very rare exception, not the rule.

Finally, we know that there is one sure thing—and only one thing—that the proposed remedies can be counted on to do. They can be counted on to distract attention long enough for the inevitable turn in the insurance cycle to take the edge off the doctors' pain. That way, people can keep ignoring the real, public health problem. Injured patients and their lawyers are the messengers here, not the cause of the medical malpractice problem.

Jesica and Jeanella

No one who follows the medical news is likely to forget Jesica Santillan, who died after a receiving a heart and lung transplant at Duke University Hospital in February 2003. Brought to the United States from a poor Mexican town in search of better medical care, she inspired her new North Carolina community to raise money for a heart and lung transplant, and she inspired people to care about the problem of the medically uninsured.

When she received the transplant, it turned out to be the wrong blood type—a basic, easily avoidable, and tragic mistake. Her body began rejecting the new organs even before the transplant surgery was over. Her supporters launched a national public relations effort to find a second, compatible, set of heart and lungs, while accusing Duke of trying to stifle their efforts to avoid publicizing the mistake. She died shortly after receiving a second transplant, less than two weeks after the first, while the whole world watched.

At the same time, doctors, hospitals, medical liability insurance companies, and their trade and professional organizations were mounting a fierce campaign for tort reform all over the United

States. Beginning in about June 2002 and reaching a peak in early 2003, the medical malpractice crisis dominated the medical news. This, too, contributed to the attention on Jesica: a public and almost impossible to understand mistake at a leading medical center, at a time when doctors claimed that frivolous medical malpractice lawsuits and outrageous jury verdicts were the problem.

Fewer people know that Jesica Santillan was actually the second girl in seven months to die after receiving a transplant with the wrong blood type at a prominent medical center. Jeanella Aranda was the first. She received a transplant of part of her father's liver at Children's Medical Center in Dallas in July 2002, allegedly after a surgical mistake in an earlier operation had destroyed her own liver.

Due to a "laboratory mix-up," according to the *New York Times*, doctors thought that her father's blood type was a good match, when it was actually her mother's who matched. "The blood type mismatch was not detected until Aug. 5, 19 days after the surgery, when Mrs. Aranda, who was aware that her husband had type A blood, noticed that Jeanella's transfusions were Type O, and asked whether the transplant had been a mismatch." Jeanella died on August 6, 2002.

Shortly after Jesica died in February 2003, the *Los Angeles Times* linked her story to Jeanella's while criticizing medical liability reform proposals in Congress. "Communication errors of the sort that doomed Jesica and Jeanella are all too common in medicine," the *Times* reported. The *Times* quoted Carolyn M. Clancy, director of the federal Agency for Healthcare Research and Quality, who said, "There's more double-checking and systematic avoidance of mistakes at Starbucks than at most health-care institutions." And the *Times* cited a survey published in the *New England Journal of Medicine*, reporting, "Only 30% of patients harmed by a medical error were told of the problem by the professional responsible for the mistake."

Jesica's and Jeanella's stories became even more tightly linked to the medical malpractice debate when the families of both girls brought medical malpractice claims. As far as I have been able to tell, no one called those claims frivolous. Quite the reverse. Duke Hospital publicly apologized to Jesica's family, offered to fund a new program in her name, and announced that it had changed its organ transplant procedures. Children's Medical Center appointed a new medical chief for its organ transplant program and announced that it had adopted new policies and procedures "designed to improve every link of the quality control chain." Both cases settled.

Throughout the medical malpractice crisis, leading newspapers carried accounts of other obvious medical mistakes. Like the *L.A.*

Times piece on Jesica and Jeanella, the accounts often linked the particular mistakes to the larger story about the extent of medical malpractice in U.S. health care. The report by the Institute of Medicine of the National Academy of Science, *To Err Is Human,* was a common source. That report summarized research showing that nearly 100,000 people die in the United States each year from medical mistakes—more than die from automobile and workplace accidents combined.

Because of that research and reporting, public opinion is coming around to the view that, distressingly, Jesica's and Jeanella's problems are not unique; our health care system has a serious medical-injury problem. But at the same time, public opinion remains firmly anchored to the view that we have an explosion of what President George W. Bush calls "junk lawsuits" and that medical malpractice lawsuits contribute significantly to the high cost of health care in the United States.

Stories like Jesica's and Jeanella's helped shift public opinion about medical malpractice only because they were linked to research and reporting that reframed medical malpractice as a public health problem. But their stories did not shift public opinion about medical malpractice lawsuits, because they were not linked to research and reporting that reframed malpractice lawsuits as a public good.

Like any durable and effective myth, the medical malpractice myth can accommodate almost any number of real-life examples that conflict with the myth—by classifying those examples as exceptions. Nobody but a researcher has the time or inclination to go out and take a systematic look at medical malpractice lawsuits in order to evaluate what is the rule and what is the exception. Everyone else has to take individual examples as they come.

As a result, lawsuits like Jesica's and Jeanella's do not pose a serious challenge to the myth. No one says that all the lawsuits are frivolous. But everyone "knows" that most of them are. Even a regular drumbeat of contrary examples does not call the myth into question, because the myth provides the context in which we understand the examples, not the reverse. It is time to change that context.

The Power of the Tort Litigation Myth

The medical malpractice myth is part of a larger story about the litigation explosion, the litigiousness of Americans, and the debilitating effect that lawsuits have on the U.S. economy. I have often encountered this larger story in my work directing the Insurance Law Center at the University of Connecticut School of Law in Hartford, Connecticut. We try very hard to get university and insurance industry people to talk to each other. People in

universities call on me to find out what is happening in the insurance industry, and people in the insurance industry call on me to find out about the university research.

One good example came in the summer of 2003 when I was invited to speak to a meeting of insurance company CEOs in London. My assignment was to provide an overview of the academic research on how the U.S. tort system really works and, in particular, to report on the substantial research debunking many of the claims about the litigation explosion.

My host invited me to come to the whole meeting, even though my session was near the end. I had never met a CEO from any significant company, let alone an insurance company. For me, the chance to spend two days with dozens of insurance company CEOs was quite an opportunity.

I used the time to meet and talk with quite a few of the CEOs, to see what they were like and also to get a sense of what they were expecting to hear from me. They were smart, hard-working people. They were at least as well read and informed about current events as most of my university colleagues, and on the whole they were more informed about what was happening in countries other than their own.

I was surprised and a bit concerned, however, to find that almost everyone assumed I was there to provide them with the latest research on the extent of the litigation explosion and the particular ways in which the U.S. tort system was out of control. At first I worried that they thought I had been paid to tell them whatever they wanted to hear. (I had not been paid and, even if I had, I would not have done that.) So I checked with my host to make sure he knew what they were in for. He did. In fact, he was rather looking forward to the fireworks.

My concerns addressed, I put on my participant observation research hat and resolved to find out why the CEOs expected that from me. What I learned was that they assumed I was there to talk about the out-of-control tort system not because they thought I was paid to tell them what they wanted to hear, but rather because they believed, intensely, that chaos was the real situation.

That was interesting. I had always harbored a suspicion that insurance industry leaders promoted the tort litigation myth despite what they really knew to the contrary. Maybe some do, but not these people.

The CEOs were well informed about political and economic matters generally. They were especially well informed about things that affect their business. And the U.S. liability situation affects their business. So, as far as they were concerned, if they

thought that there was a tort litigation explosion in the United States and if they thought that the U.S. tort system was out of control, then that was how it was.

Whatever else anyone might think, their support for tort reform was not a cynical effort to make money at the public's expense. While the CEOs did in fact think that tort reform was in their industry's interest, the emotion that fired them up came from belief—a belief that is *not* rooted entirely in self-interest. The debate over the other major issue for which they brought outside experts to their meeting (new international accounting standards) was pale by comparison. Yet, in financial terms that other issue would have a much bigger immediate impact on their business than liability reform, especially for the life insurance CEOs, who are not even in the liability insurance business. The CEOs tried to get fired up about it, but they could not. Accounting rules simply do not plug into beliefs about right and wrong in remotely the same way as tort liability.

They were concerned about the litigation explosion, not just because it affected their business, but also because of the impact they expected it to have on the larger economy and society. They were concerned about the United States, where they saw the explosion originating, and Europe, where they saw signs that it was spreading. They were looking forward to hearing from me so they could better understand and treat this American disease.

In this regard at least, I am sure that I disappointed my audience. As I reported to them, except for auto accidents and the occasional "mass tort" situation like asbestos, Agent Orange, or breast implants, Americans actually do not bring tort claims all that often, especially compared to the number of accidents and injuries there are. We now have two decades of solid research documenting this fact. What is more, the rate of auto lawsuits—the most frequent kind of tort lawsuit—is going down. And, despite the media focus on mass torts, products liability, and medical malpractice, those kinds of cases are far less important in dollar terms than either auto accidents or workers' compensation.

In 2003 U.S. businesses paid $27 billion for auto liability insurance premiums, $57 billion for workers' compensation insurance premiums, and less than $5 billion for products liability insurance premiums. Doctors, hospitals, and other health professionals paid only about $11 billion in medical malpractice insurance premiums. This means that the real insurance money and the real claiming action for U.S. business does not lie in high-profile areas like products liability and medical malpractice. The real action lies in routine, below-the-radar areas like workers' compensation and automobile lawsuits. U.S. businesses paid less than half as much for products liability and medical malpractice insurance, combined, as they paid for auto insurance,

alone, and only a quarter of what they paid for workers' compensation insurance.

Products liability and medical malpractice insurance look even less significant compared to what ordinary Americans paid for personal auto liability and no-fault auto insurance: $115.5 billion in 2003. That is more than U.S. business paid for auto, workers' compensation, products liability, and medical malpractice insurance combined. Adding all the premiums of all the different kinds of liability insurance together results in a big number—about $215 billion in 2003—but that number is hardly exploding, and the medical malpractice insurance share—$11 billion—looks pretty small by comparison. It looks even smaller next to the $1.5 trillion plus (that is more than 1,500 billion dollars) we spent on health care that year. Something that amounts to less than 1 percent of health-care costs simply cannot have the impact on health care that the medical malpractice myth would have us believe.

Even on a per doctor basis, that medical malpractice insurance number is not as high as many people think. There were nearly 900,000 doctors in the United States in 2003. That means that medical malpractice insurance premiums were about $12,000 per doctor, and of course hospitals, dentists, and other health-care professionals buy malpractice insurance, too. So the average premium doctors paid was less. Some kinds of doctors have to pay much more. Obstetricians are the best-known example. But there is a simple insurance reform that will solve that problem, as I will explain in chapter 8.

Where Americans do excel in litigation is in the area of business lawsuits. If you read the business section of the newspaper, you know that B2B—business-to-business—sales are hot. So is B2B litigation. Some of the business executives who complain about the litigation explosion must be thinking about their own behavior. In one indication, the proportion of lawyers who bring personal-injury lawsuits has remained steady since 1975, while the share of lawyers involved in business litigation has more than tripled.

I enjoyed the London presentation, and, as predicted, we had some vigorous debate. Did I persuade the CEOs that the tort litigation explosion is a myth? They did not get to be CEOs by lacking confidence, so they were not shy about telling me what they thought. Some argued with me then. Some continue to argue with me. But we are still talking. And their people are reading the research.

I also told them, and I continue to repeat every chance I get, that they should be careful what they wish for. What other industry asks the government to reduce the demand for its product? Tame the tort system, and hospitals and other big businesses will

decide that they do not need liability insurance. Take away the risk of a really big lawsuit, and a line of credit is nearly as good as an insurance policy, and, with a line of credit, you pay only for the credit you use. Once businesses can predict their liability losses with enough certainty, a monthly savings plan is even better, and it costs even less.

Who knows how long it will take me to convince them, if I ever will. But I have already noticed a change in the rhetoric, from complaints about the *number* of lawsuits to complaints about the *size* of the lawsuits. Complaints about the size of lawsuits represent a real improvement, because at least they have some basis in reality. Medical malpractice claims *are* getting bigger. So are auto claims and workers' compensation claims. Of course, the fact that claims are getting bigger does not mean that the tort system is out of control. Tort claims are getting larger mostly because health care costs more than ever before.

Putting the Medical Malpractice Myth in a Political Context

My interest in the medical malpractice myth grows out of a variety of experiences that have nothing to do with politics. My father and father-in-law are both doctors. I regularly teach tort law, the branch of law that includes medical malpractice law. My field research on personal-injury litigation introduced me to many lawyers on both sides of medical malpractice lawsuits. And my role as the director of an insurance education and research program virtually guaranteed that I would want to understand the medical malpractice insurance crisis that broke out in 2002.

Despite the fact that my interest in medical malpractice is not political, there is no avoiding the fact that medical liability reform has become a very partisan issue. With some exceptions, Republican legislators favor cutting back on tort liability and Democratic legislators do not. And over the course of the last thirty years, tort reform has become one of the top political objectives of groups like the Chamber of Commerce, the American Manufacturers Association and other traditionally business-oriented trade associations. These groups support medical liability reform as part of their effort to limit tort law more broadly.

The effort currently underway in Washington to include pharmaceutical companies and medical device manufacturers under the umbrella of national medical liability reform shows how medical malpractice reform can pave the way for broader efforts to limit liability. Pharmaceutical companies and medical device manufacturers are not the target of medical malpractice lawsuits. Instead they face the same kinds of product liability claims as any other manufacturer. But their products are used in the medical field, and therefore the medical liability reform tent

may be big enough to hold them, too—or so their Washington, D.C., lobbyists contend. From there, it is a small step to limit liability in other areas, so that all defendants receive equal treatment.

Doctors have conflicting interests in the larger political struggle over access to the courts. On the one hand, efforts to limit medical liability serve their long-term interest in self-regulation and professional autonomy. As researchers from Harvard Medical School have explained, "Physicians and their societies are actively resisting the legitimacy of the law as a means of controlling and regulating the practice of medicine. . . . The profession's organizations have invested extensive financial, cultural and political resources to resist what both rank-and-file practitioners and the professional collective regard as infringements on medical work."

On the other hand, doctors are consumers and, increasingly, employees and independent contractors who work for large organizations. In these roles they have a strong interest in maintaining access to courts.

These conflicting interests are playing out right now in my state of Connecticut. On the one hand, our state medical society has been lobbying the Connecticut legislature, hard, in favor of medical liability reform. On the other hand, the society has filed lawsuits against several big health insurance companies that doctors believe are not playing fair. After the medical society achieved a favorable result in one of the lawsuits, I spoke to their executive director, suggesting that there might be some irony in their using the courts to advance doctors' interests—while at the same time trying to limit what patients could do in court.

He explained that there is no conflict in the two positions: the medical society's lawsuits involve different issues and different fields of law than medical malpractice. I had to agree that he was correct in technical, legal terms. But to my mind, the society is walking a tightrope. The skilled artisans and craftsmen who formed the American Federation of Labor used to think that they had more in common with businessmen than with the industrial trade unions. They changed their view in the early part of the twentieth century, when the expansion in the scope of manufacturing and construction restricted their independence and control over the workplace. Will doctors follow a similar path in the twenty-first century, when large health plans place greater pressure on health-care providers to control costs and take a more businesslike approach to health care?

Part of the art of politics is keeping supporters focused on the things they agree upon so they don't break up the coalition by fighting about other things. Tort reform is one issue on which doctors, health insurers, and most businesses clearly agree. The

medical malpractice myth helps to maintain that alliance, by keeping rank-and-file doctors and the medical societies completely committed to tort reform and grateful to the (mostly Republican) politicians who deliver it.

President Bush's January 2005 speech on medical liability reform in Collinsville, Illinois, shows just how strongly his administration is promoting the medical malpractice myth. As with any major political address by a politician from either party, the visual images, alone, tell a significant story. The White House video of the speech opens with a wide-angle shot of the president walking toward a podium stationed in front of a bleacher full of cheering doctors in white coats, beneath a large banner on which the words "Affordable Healthcare" are framed between two large images of the caduceus—the twined snake and wing symbol of the American medical profession. When the camera pulls in tight for the speech, we see a striking image: President Bush, the presidential seal on the podium below, and doctors in white coats all around.

In advance of the Collinsville address, the White House had announced that the president would be discussing medical liability reform. By linking "affordable health care" with medical liability reform and surrounding the president with cheering doctors, the image conveyed a clear message. Medical malpractice lawsuits are a big reason health care is so expensive. The president supports doctors' efforts to eliminate that cost. And doctors support the president.

The speech itself delivered the same message. "I'm here to talk about how we need to fix a broken medical liability system," the president announced to a roar of applause. He mentioned by name the Illinois Republican politicians attending the speech, explained how they are supporting the cause, and offered special thanks to the Republican legislator who was "leading the medical liability reform effort" in the Illinois state legislature. After running through the top agenda items for his administration and a few other health-care reform ideas designed to control health-care costs, he arrived at his main topic:

> What's happening all across this country is that lawyers are filing baseless suits against hospitals and doctors. That's just a plain fact. And they're doing it for a simple reason. They know the medical liability system is tilted in their favor. Jury awards in medical liability cases have skyrocketed in recent years. That means every claim filed by a personal-injury lawyer brings the chance of a huge payoff or a profitable settlement out of court. That's what that means. Doctors and hospitals realize this. They know it's expensive to fight a lawsuit, even if it doesn't have any merit. And because the system is so

> unpredictable, there is a constant risk of being hit by a massive jury award. So doctors end up paying tens of thousands, or even hundreds of thousands of dollars to settle claims out of court, even when they know they have done nothing wrong.

From there, the speech proceeded point by point through the medical malpractice myth: the frivolous lawsuits, the courts' bias against doctors, the skyrocketing jury awards, the huge settlements in cases in which doctors did nothing wrong, the direct link between lawsuits and insurance premiums, the doctors leaving the practice of medicine, the patients who cannot find doctors, and the huge waste of money on defensive medicine. "This liability system of ours is," the president said, "what I'm telling you, is out of control." It was an effective, succinct, and powerful statement of the medical malpractice myth.

It would take a book—this book I hope—to set the record straight after a speech like that.

Tom Baker
The Medical Malpractice Myth
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MYTHBUSTER!

HOW THE INSURANCE INDUSTRY CREATES "CRISES" AND LEADS THE CHARGE FOR "TORT REFORM"

From 1985 through the late 1980s, manufacturers, municipalities, doctors, nurse-midwives, day-care centers, non-profit groups and many other commercial customers of liability insurance, found themselves in the midst of a "crisis." Insurance rates were skyrocketing, up 300 percent or more for some. Many could not find coverage at any price.

Insurance companies said that their costs were being driven up by a so-called "explosion" in litigation, claiming "frivolous lawsuits" and "out of control" juries were suddenly forcing insurers to make insurance unaffordable and sometimes unavailable. They told state legislatures around the country that the only way to ease this crisis was to limit "tort" or liability laws, to make it more difficult for sick and injured consumers to sue and be compensated by wrongdoers in court (also known as "tort reform").

In 1986 alone - the year of the American Tort Reform Association's founding -- 41 states passed legislation to limit the liability of wrongdoers, restrict the amount of monetary damages injured consumers could receive in court, or make it more difficult for the injured to obtain attorneys to represent them against insurance companies. In a few states, legislatures enacted across-the-board tort law limits, overturning years of common law that for generations had afforded harmed citizens the right to challenge corporate wrongdoing in court.

For the most part, these new "tort limits" have remained on the books. Moreover, in every year since, states have enacted additional "tort reforms," based on the same rationale first advanced in the mid-1980s -- that restricting victims' rights will lead to more affordable liability insurance rates.

But what ultimately proved to be the true cause of the "liability insurance crisis" of the mid-1980s was not the legal system at all. Study after study that examined the property/casualty insurance industry found that the "insurance crisis" was actually a self-inflicted phenomenon caused by the mismanaged underwriting practices of the industry itself.

The insurance industry's profits and underwriting practices are cyclical, often characterized by sharp ups and downs. In fact, these underwriting practices and the insurance cycle caused a similar, less severe "insurance crisis" in the mid-1970s. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premiums dollars to invest for maximum return. Insurers lower prices and insure very poor risks just to get the premium dollars. In the mid-1980s, the cycle's effects were exacerbated by a particularly exaggerated underwriting response to the high interest rates of the early 1980s, characterized by such risky underwriting as insuring the MGM Grand Hotel months after it burned down in a fire.[1]

By 1985 when interest rates had dropped and investment income had decreased accordingly, the industry responded by sharply increasing premiums and reducing availability of coverage, creating a "liability insurance crisis."

As *Business Week* magazine explained a January, 1987 editorial:

> Even while the industry was blaming its troubles on the tort system, many experts pointed out that its problems were largely self-made. In previous years the industry had slashed prices competitively to the point that it incurred enormous losses. That, rather than excessive jury awards, explained most of the industry's financial difficulties.[2]

The Ad Hoc Insurance Committee of the National Association of Attorneys General concluded after studying the "crisis" in

1986:

> The facts do not bear out the allegations of an "explosion" in litigation or in claim size, nor do they bear out the allegations of a financial disaster suffered by property/casualty insurers today. They finally do not support any correlation between the current crisis in availability and affordability of insurance and such a litigation "explosion." Instead, the available data indicate that the causes of, and therefore solutions to, the current crisis lie with the insurance industry itself.[3]

State commissions in New Mexico, Michigan and Pennsylvania reached similar conclusions.[4] Even the insurance industry admitted this internally. In 1986, Maurice R. Greenberg, President and Chief Executive Officer of American International Group, Inc., one of the country's leading property/casualty companies, told an insurance audience in Boston that the industry's problems were due to price cuts taken "to the point of absurdity" in the early 1980s. Had it not been for these cuts, Greenberg said, there would not be 'all this hullabaloo' about the tort system."[5]

But to the public and to lawmakers, insurers told a different story. In fact, coming out of their bottom year of 1984, insurance companies began a "massive effort to market the idea that there is something wrong with the civil justice system."[6] The goal, in the words of one of the industry's leading spokespersons, GEICO's chairman John J. Byrne, was "to withdraw [from the market] and let the pressure for reform build in the courts and in the state legislatures."[7] Evidence gathered by over a dozen state attorneys general for an antitrust class action filed in 1988, and settled in 1995, found that a number of insurance companies actually conspired to create this insurance crisis by restricting coverage to commercial customers and raising prices, creating an atmosphere intended to coax states into enacting "tort reform."[8]

To support this effort, the Insurance Information Institute purchased $6.5 million worth of print and television ads in 1986, designed to reach 90 percent of all U.S. adults, in order "to change the widely held perception that there is an 'insurance crisis' to a perception of a 'lawsuit crisis.'"[9] The ads targeted groups that were having difficulty obtaining affordable insurance. Headlines read: The Lawsuit Crisis is Bad for Babies, The Lawsuit Crisis is Penalizing School Sports and Even Clergy Can't Escape the Lawsuit Crisis, and they appeared in *Readers' Digest, Time* and *Newsweek*, as well as in Sunday magazine supplements.[10] In 1986, after Congressman John J. LaFalce (D-N.Y.) asked the Insurance Information Institute to submit information to Congress to back up the "clergy" ads, he stated:

> The information they gave us would lead us to conclude that there are only about a dozen of these religious malpractice cases pending throughout the country, and that the only one that has gone to trial was dismissed in favor of the defendant. In other words, ... at the time these ads were run, the insurance industry had not yet paid out one cent pursuant to any court judgment in any of these cases. Yet, they form an integral part of its national advertising campaign.[11]

Insurance companies and other insurance trade associations complemented the Insurance Information Institute campaign with their own ads. For example

- Johnson & Higgins ran several ads in 1985 and 1986. One that appeared in the Wall Street Journal on November 19, 1985, stated, "the mounting wave of losses, which last year cost insurers more than $116 for every $100 of premium taken in, has forced insurers to act defensively. Most have stopped offering pollution insurance entirely and have cut back on other vital liability coverages ... Nothing has done more to create this ominous situation than the field day plaintiffs are having in court."[12]

- Aetna ran a series of ads in 1987. One contained a pull-quote that read, "Somehow we've managed to create a [civil justice] system that makes good people behave badly." The ad blamed the civil justice system for the fact that "insurers, whose reasons for being in business is to pool risks so that they are affordable, start looking for reasons not to take risks."[13]

- A full-page ad in the September 11, 1987, Sacramento Bee, placed by the Association of California Insurance Companies, "invited the California Trial Lawyers Association to help put the brakes on insurance costs by supporting a cut in contingency fees and limiting non-economic damages from auto accidents."

State legislatures, regulators, and voters in ballot initiative states, were all told by business and insurance lobbyists (and their PR firms) that the way to bring down insurance rates was to make it more difficult for injured consumers to sue in court. For example,

- At a 1986 meeting of National Association of Insurance Commissioners, Iowa's commissioner, William D. Hager, remarked, "The insurance industry has argued for some time that insurance rates and availability are predicated upon the high costs associated with the expanding tort system. It should clearly follow, therefore, that insurance rates will decrease and the availability improve with the advent of legislative reforms of the tort system."[14]

- Iowa's Attorney General Tom Miller asserted in 1986, "reforms are needed to reduce tort liability in the state and consequently cut spiraling insurance rates."[15]

- A spokesman for the Texas Medical Association promised in 1986, "If significant tort reform is passed next year, there will be an immediate stabilization of premiums."[16]

- In its March, 1987 newsletter, the Association for California Tort Reform, announced, "[D]oes significant reform mean lower insurance premiums? Yes!"

- Ralph Gaines, Jr., a spokesman for the Alabama Civil Justice Reform Committee, said in 1987, "rigorous and meaningful tort reform will go a long way to reduce rates in insurance premiums."[17]

- In New York in 1986, just months after state lawmakers responded once to the "insurance crisis" by enacting major "tort reforms," Minority Leader Clarence D. Rappleyea (R-Norwich) called for even more changes -- complete elimination of joint and several liability and a $250,000 cap on "non-economic damages -- saying these measures were still needed "to ease the liability insurance crisis."[18]

- To garner support for Florida's Amendment 10, the unsuccessful 1988 ballot initiative that would have capped noneconomic damages at $100,000, the Florida Medical Association argued that "the cap was a necessary tradeoff to stop spiraling insurance rates."[19]

- Doctors in Montana and their insurers believed in 1988, "if tort reform is enacted to make the system more predictable, insurance rates will stabilize or drop."[20]

- In a November 7, 1988, editorial entitled "Prepare for the backlash," the National Underwriter, an insurance trade publication, bluntly conceded, "Let's face it. The only reason tort reform was granted in many states is because people accepted our argument that it was needed to control soaring insurance rates."

However, notwithstanding this well-orchestrated public relations and lobbying campaign, there was a "virtual absence of empirical evidence that tort reform [would] indeed lower liability insurance rates or expand the insurance's availability," as one business trade publication put it."[21] What's more, when they were pushed hard by legislators to provide guarantees that rates would drop, they could not. And their subsequent rate filings with insurance departments confirmed this. For example,

- In 1986, lobbyist Peter G. Strauss of the Alliance of American Insurers, testified that "liability insurance rates would go down" if the New Jersey legislature enacted a cap on damages, repealed the collateral source rule and eliminated joint and several liability. However, "he said he could not say how much rates would drop." And, under questioning from New Jersey Senate President John F. Russo (D-Ocean County), "he said that he knew of no state where rates had declined as a result of such 'caps' or other revisions in the civil justice system."[22]

- In 1986, Washington State enacted what was considered at the time "one of the most comprehensive [tort] reform bills yet." Before it passed, Ted E. Linham, president of the Washington State Physicians Insurance Association, "testified in the state legislature that the new law would reduce premiums charged by the association, which is a mutual company, by 25% to 30% within 18 months after the legislation takes effect Aug. 1." However, after the law passed, the company asked for a rate hike, and state regulators began "looking for an explanation of why the insurer wants a premium hike after the industry was successful in getting tort reform."[23]

- Following enactment of extensive "tort reforms" in Florida in 1986, Aetna and St. Paul Marine Insurance Company filed rate documents notifying Florida's insurance commissioner that even these extensive tort changes would not reduce rates. Filings made in 1986 by 104 insurers licensed in Florida showed that out of 277 filings, 175, or 63 percent showed no savings from "tort reform" while none showed savings of more than 10 percent.[24]

- In 1986, Connecticut enacted major "tort reforms" to "bring insurance premiums down by setting ceilings and other

> restrictions on liability." But by 1987, one state lawmaker was noting, "the insurance industry now says those measures will have no effect on insurance rates. We have been disappointed by the response of the insurance industry. The reforms we passed should have led to rate reductions because we made it more difficult to recover, or set limits on recovery. But this hasn't happened."[25]

Eventually, a few years after the mid-1980s insurance crisis, the insurance cycle flattened out, rates stabilized and availability improved everywhere. This had nothing to do with tort law restrictions enacted in particular states, but rather to modulations in the insurance cycle everywhere. In 1991, for example, Washington's insurance commissioner Dick Marquardt concluded in a report that it was "impossible to attribute stable insurance rates to tort-law changes or the damages cap," since rates also improved in states that did not pass tort reform.[26] The reason, of course, is that "tort reform" is based on an untrue premise: that the legal system, rather than the underwriting practices of the insurance industry, is responsible for gyrations in the cost and availability of insurance.

Despite this evidence, states have continued to enact sometimes drastic limitations on the rights of severely injured people, in the hopes that insurance rates still might drop. For example, Illinois passed such severe restrictions in 1995 (although the law was largely declared unconstitutional in 1997)[27] in part, "to protect the availability of affordable liability insurance.[28] As recently as the spring of 1999, Florida passed an extensive "tort reform" package including caps on punitive damages, severe limits on joint and several liability and a statute of repose in products liability cases. Florida's business lobbyists frequently cited the insurance argument before the bill finally passed.[29]

Premium Deceit: The Failure of "Tort Reform" to Cut Insurance Prices, is the first comprehensive empirical study of "tort reform's" impact on insurance costs and rates since 1985, shows that legislative attempts to reduce insurance rates by taking away the rights of the most seriously injured in our society, has been and continues to be a failed public policy.

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1. One actuary at this time was quoted as saying "we don't need premiums anymore," relying instead on tax credits coupled with high interest rates.
2. "What Insurance Crisis?," *Business Week*, January 12, 1987, p. 154.
3. Francis X. Bellotti, Attorney General of Massachusetts, et al., *Analysis of the Causes of the Current Crisis of Unavailability and Unaffordability of Liability Insurance* (Boston, Mass.: Ad Hoc Insurance Committee of the National Association of Attorneys General, May, 1986).
4. See, e.g., New Mexico State Legislature, *Report of the Interim Legislative Workmen's Compensation Comm. on Liability Insurance and Tort Reform*, November 12, 1986; Michigan House of Representatives, *Study of the Profitability of Commercial Liability Insurance*, November 10, 1986; Insurance Comm. Pennsylvania House of Representatives, *Liability Insurance Crisis in Pennsylvania,* September 29, 1986.
5. Greewald, "Insurers Must Share Blame: AIG Head," *Business Insurance*, March 31 1986, p. 3.
6. *National Underwriter*, December 21, 1984, p. 2.
7. *Journal of Commerce*, June 18, 1985, p. 10A.
8. *In re Insurance Antitrust Litigation*, MDL No. 767, No. C 88 1688 [CAL], N.D. Calif.); "Final Approval Given To Insurance Antitrust Settlement," *Mealey's Litigation Reports*, April 18, 1995.
9. Herbert, "$6.5 Million In Ads Targets Lawsuit Crisis," *Journal of Commerce*, March 19, 1986, p. 1.
10. *Ibid.*
11. The Liability Insurance Crisis, Hearings before the Subcomm. on Economic Stabilization of the Comm. on Banking, Finance and Urban Affairs, House of Representatives, 99th Cong., 2d. Sess., Part 1, July 23, 1986, p. 2.
12. Stephen Daniels, "The Question of Jury Competence and the Politics of Civil Justice Reform: Symbols, Rhetoric, and Agenda-Building," 52 Law & Contemp. Prob. 261 (1989).
13. *Ibid.*
14. Kenneth Reich, "Insurers told rate cuts must precede more legal reform" *Los Angeles Times*, December 14, 1986.
15. Scott Sonner, "Miller calls for liability reform", *UPI*, February 21, 1986.
16. *UPI*, October 24, 1986.
17. Dana Beyerle, "Civil liability law reform urged," *UPI*, April 7, 1987. "Tort Reform, Banks on NY Insurance Agenda", *Journal of Commerce*, January 22, 1987.
18. "Tort Reform, Banks on NY Insurance Agenda", *Journal of Commerce*, January 22, 1987.
19. Stephen Koff, "Voters deal hard blow to limits on liability," *St. Petersburg Times*, November 9, 1988.

20. Mike Dinnison, "In rural areas, doctors are delivering sad message to mothers-to-be," *Los Angeles Times*, May 1, 1988.
21. Editorial, *Crain's Chicago Business*, June 9, 1986.
22. Carolyn Acker, "Russo: Pending legislation won't ease insurance rates," *Philadelphia Inquirer*, September 5, 1986; Vincent R. Zarate, "$500,000 liability lid proposed by Russo," *Star-Ledger*, Sept. 5, 1986.
23. "State hires outside firm to look at liability rate request," *UPI*, December 4, 1986. See also, "Tort reform legislation: Did state get 'suckered,'" *The Seattle Times*, July 1, 1986, p. 1.
24. "'Tort Reform' a Fraud, Insurers Admit," and "Tort Reform Will Not Reduce Insurance Rates, Say 100+ Florida Insurers," National Insurance Consumer Organization (1986).
25. "Insurers Warn," *UPI*, March 9, 1987.
26. "Health care Reform - Bush's insurance cap plan a proven failure", *The Seattle Times*, May 16, 1991.
27. *Best v. Taylor Machine Works*, 689 N.E. 2d 1057 (1997)
28. Among the legislature's "findings" in the Illinois 1995 Tort Reform Act were: "drastic restrictions in coverage accompanied by vastly increased premiums have become permanent realities for many products and services ... [It] is the purpose of this Act to modify and improve the civil justice system in order to ... [p]rotect the availability of affordable liability insurance."
29. Jon Shebel of Associated Industries said severe restrictions on attorneys' fees would "lower liability insurance rates." William March, "Tort Reform Weighs In Race For District 58," *The Tampa Tribune*, September 19, 1997. Lee Hinkle, a lobbyist for the Florida Chamber of Commerce, said that with tort reform, "families would see ... savings in the form of ... smaller insurance premiums." Gordon Russell, "Business Sees A Victory After Tort Reform Law Changes Pass," *Sarasota Herald-Tribune*, May 1, 1998

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MYTHBUSTER!

MEDICAL MALPRACTICE: MYTH VS. REALITY

MYTH: The courts are "clogged" with "frivolous" medical malpractice lawsuits.

FACT: Medical malpractice litigation in this country is far from frivolous. In a major study released in 1999, the National Academy of Sciences Institute of Medicine found that up to 98,000 people are killed each year by medical errors in hospitals -- far more than die from car accidents, breast cancer or AIDS. Kohn, Corrigan, Donaldson, Eds., To *Err is Human; Building a Safer Health System,* Institute of Medicine, National Academy Press: Washington, DC, 1999 (These figures vastly underestimate the magnitude of the problem since hospital patients represent only a small percentage of the total population at risk). Yet eight times as many patients are injured by medical malpractice as ever file a claim; 16 times as many suffer injuries as receive any compensation. Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York,* 1990.

FACT: Numerous hospital and medical procedures have been made safer as a result of lawsuits. These include: anesthesia procedures, catheter placements, drug prescriptions, hospital staffing levels, infection control, nursing home care and trauma care.

MYTH: Jurors - who are trusted to make life and death decisions every day - are so arbitrary in medical malpractice cases that their power and authority must be taken away by cash-greased politicians.

FACT: Despite the hype, juries are extremely conservative while insurance companies are making huge profits. The average claims payout by medical malpractice insurance companies is about $30,000 per year and has been virtually unchanged for the last decade, according to a 2001 study by the Consumer Federation of America of actual claims paid. In fact, total insurance payouts to all claimants have hovered between $2.5 billion and $4 billion per year. Memo from to Interested Persons with attached spreadsheet prepared by J. Robert Hunter, Director of Insurance, Consumer Federation of America, November 14, 2001. By comparison, Americans spend twice that much – about $8 billion -- on dog food each year. As a result, medical malpractice insurance companies are raking it in, with profits 65 percent higher than the rest of the property/casualty insurance industry over the last decade. "'Malpractice Suits Not Driving Medical Costs Up,' Says Group," *Times Picayune*, May 5, 1999.

FACT: In most cases, juries award nothing at all to medical malpractice patients. Injured victims win before juries in only 23 percent of cases. In 1992, the rate of medical malpractice plaintiff victories in front of juries was 7.5 percent higher at 30.5 percent. *Examining the Work of State Courts, 2001; A National Perspective from the Court Statistics Project* (2001), p. 94; "Tort Trials and Verdicts in Large Counties, 1996," U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, NCJ-179769 (August 2000), p. 9.

FACT: Punitive damages are awarded only for the most egregious wrongdoing; "capping" damages hurts exclusively the most seriously injured patients. According to the Bureau of Justice Statistics, only 1.1 percent of medical malpractice plaintiffs who prevailed at

trial were awarded punitive damages in 1996. Of these, 1.2 percent of plaintiff winners were awarded punitive damages by juries. No plaintiffs were awarded punitive damages by judges in 1996. "Tort Trials and Verdicts in Large Counties, 1996," U.S. Department of Justice, Bureau of Justice Statistics, NCJ 179769 (August 2000), p. 7.

FACT: "A doctor-led research group examined 8231 closed malpractice cases in New Jersey and found that the verdicts rendered by juries in the few cases that went to trial correlated with the judgment of the insurers' reviewing physicians." Marc Galanter, "Real World Torts: An Antidote to Anecdote," 55 *Md L.Rev.* 1093, 1111 (1996), citing Mark I. Taragin et al., "The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims," 117 *Annals Internal Med.* 780, 782, 780 (1992).

FACT: In Maryland, which also has a law that caps damages, a jury rendered a $5.4 million verdict in a case in which a young man lost a leg due to malpractice at Maryland hospital. When one juror, who spoke to the *New York Times*, learned during an interview that a judge had reduced the award to $515,000, he said, "'It's like a slap in the face. We get your opinion and then we just go decide it our way.'" William Glaberson, "Juries, Their Powers Under Siege, Find Their Role Is Being Eroded," *New York Times,* March 2, 2001.

MYTH: Medical malpractice lawsuits drive up health care costs and insurance premiums.

FACT: Medical malpractice costs make up only a tiny fraction of total health care costs. According to a study by the Consumer Federation of America, medical malpractice costs, as a percentage of health care costs, are at an all time low, 0.55 percent. Report author J. Robert Hunter, former Texas Insurance Commissioner and Federal Insurance Administrator, said, "Medical malpractice insurance is amazing value, considering that it covers all medical injuries for about one-half of one percent of health system costs!" Memo from to Interested Persons with attached spreadsheet prepared by J. Robert Hunter, Director of Insurance, Consumer Federation of America, November 14, 2001.

FACT: Far more costly than malpractice lawsuits are the costs of medical errors. Total national costs (lost income, lost household production, disability and health care costs) of negligence in hospitals are already estimated to be between $17 billion and $29 billion each year, of which health care costs represent over one-half. Moreover, these figures vastly underestimate the magnitude of the problem since hospital patients represent only a small percentage of the total population at risk, and direct hospital costs are only a fraction of the total costs. Kohn, Corrigan, Donaldson, Eds., *To Err is Human; Building a Safer Health System,* Institute of Medicine, National Academy Press: Washington, DC, 1999.

FACT: Limiting a patient's right to sue will do nothing to control insurance rates. A 1999 Center for Justice & Democracy study, *Premium Deceit; The Failure of "Tort Reform" to Cut Insurance Prices*, co-written by J. Robert Hunter, was the first-ever exhaustive look at the impact of tort restrictions on state-by-state insurance costs over the last 14 years. According to Hunter, "Despite years of claims by insurance companies that rates would go down following enactment of tort reform, we found that tort law limits enacted since the mid-1980s have not lowered insurance rates in the ensuing years. States with little or no tort law restrictions have experienced approximately the same changes in insurance rates as those states that have enacted severe restrictions on victims' rights." Following the release of Premium Deceit, spokespeople for the American Tort Reform Association (ATRA) agreed. Both ATRA's president and general counsel said in published statements that lawmakers who enact restrictions on consumers' legal rights should not expect insurance rates to drop.

And in a startling March 13, 2002 admission, the American Insurance Association (AIA), a major industry trade group, said lawmakers who enact "tort reform" should not expect insurance rates to drop. Specifically, an AIA press release, evidently issued to critique *Premium Deceit*, led with an astounding face-saving pronouncement: "[T]he insurance industry never promised that tort reform would achieve specific premium savings." If legislators really want to control insurance costs, they would be best served by taking a closer look at the insurance industry's waste, inefficiency and mismanagement.

MYTH: Medical malpractice lawsuits are causing doctors to move to states where they are less

likely to be sued.

FACT: There is no correlation between where physicians decide to practice and state liability laws. In West Virginia, the state medical association has said that "meritless" malpractice claims are driving up insurance rates and causing a mass exodus of doctors from the state. However, *Charleston Gazette* reporters Lawrence Messina and Martha Leonard uncovered data proving just the opposite. In a landmark series, "The Price of Practice," Messina and Leonard found that the number of doctors in West Virginia has increased yearly, with the state seeing a 14.3 percent increase in its number of doctors between 1990 and 2000. This increase is at a rate about 20 times greater than the population. Martha Leonard, "State has seen sharp increase in number of doctors," *Sunday Gazette Mail,* February 25, 2001.

Similar findings have recently been made of Pennsylvania doctors. According to a recent census conducted by the Pennsylvania CAT fund, the state agency that provided backup malpractice coverage for doctors and hospitals, the number of Pennsylvania doctors increased by 13.5 percent between 1990 and 2000, a period the population grew just 3.4 percent. Then-head of the CAT fund, John H. Reed, reported not only that there was no evidence of "any major departure of physicians from the state" but also that Pennsylvania had "more doctors [in 2001] than we did five years ago or ten years ago." Ann Wlazelek, "Doctors' ad campaign baseless; They're not fleeing Pa., but malpractice straits create 'hostile' climate," *Morning Call,* March 24, 2002; Josh Goldstein, "Recent census of doctors shows no flight from Pa," *Philadelphia Inquirer*, October 2, 2001. Moreover, *Morning Call* reporter Ann Wlazelek found that in the year 2000 "Pennsylvania ranked ninth-highest nationally for physician concentration, a top-10 position it has held since 1992. There were 318 doctors for every 100,000 residents in 2000, according to the American Medical Association." Ann Wlazelek, "Doctors' ad campaign baseless; They're not fleeing Pa., but malpractice straits create 'hostile' climate," *Morning Call*, March 24, 2002.

In New York, where OB/GYN's say they are threatening to leave the states, the New York Public Interest Research Group (NYPIRG) released figures showing that New York State is third in the nation in its number of obstetricians and gynecologists per capita, well ahead of California (ranked 27th). When compared to the region, only Connecticut (ranked 2nd) is ahead of New York State in the number of ob gyns per capita. Moreover, the number of physicians practicing in New York State has skyrocketed and is increasing at a rate faster than the national average. The number of physicians in New York State has risen dramatically over the past twenty years. New York had 280 doctors per 100,000 people in 1980; it had 414 physicians per 100,000 population in 1998. The nation's ratio of physicians per capita rose by 43.6% compared with the 47.9% increase in New York during that same period. New York State is now ranked second to Massachusetts in the number of doctors per capita.

Other analyses have come to similar conclusions. One recent study found that, "despite anecdotal reports that favorable state tort environments with strict...tort and insurance reforms attract and retain physicians, no evidence suggests that states with strong...reforms have done so." Eleanor D. Kinney, "Malpractice Reform in the 1990s: Past Disappointment, Future Success?" 20 *J. Health Pol. Pol'y & L.* 99, 120 (1995), cited in Marc Galanter, "Real World Torts," 55 *Md. L. Rev.* 1093, 1152 (1996). A 1995 study of the impact of Indiana's medical malpractice "tort reforms," which were enacted with the promise that the number of physicians would increase, found that "data indicate that Indiana's population continues to have considerably lower per capita access to physicians than the national average." Eleanor D. Kinney and William P. Gronfein, "Indiana's Malpractice System: No-Fault by Accident," 54 *Law & Contemp. Probs.* 169, 188 (1991), cited in Marc Galanter, "Real World Torts," 55 *Md. L. Rev.* 1093, 1152-1153 (1996).

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Testimony of John Risch
Before the House Judiciary Committee
In Support of HB 1390
February 11, 2009

Mr. Chairman and members of the committee, my name is John Risch. I am the elected North Dakota legislative director of the United Transportation Union. The UTU is the largest rail labor union in North America. Our membership includes conductors, engineers, switchmen, trainmen, and yardmasters.

I am here today in support of HB 1390 because North Dakota's legal system should provide for equality of justice under law, that is, we should all be held responsible for our actions. No one should receive special protection from the harm they do to others.

That's really what this bill is all about--removing an unjust special legal protection for medical providers.

Lawyers, farmers, railroad workers and others have no special legal protection for any harm we may do to others. Virtually every North Dakotan is held accountable for their actions except medical providers.

Why should a doctor or medical facility have their liability for damages capped when any other citizen who cripples someone must pay the full damages assessed by a jury? There is no reliable data to suggest that capping noneconomic damages reduces costs for anyone except the person or facility found responsible for causing the damages.

One of my former members (he died recently) was paralyzed by a very aggressive and unnecessary surgical procedure performed by a North Dakota doctor. The procedure the doctor attempted to perform was an 11-level fusion to "relieve" back pain.

Malpractice was established through the testimony and affidavits of the former chief of the orthopedic department at the University of Minnesota and a highly respected spinal surgeon. The surgery paralyzed my member from the waist down and he never took another step. He suffered both emotionally and physically for the rest of his life. He lost any semblance of enjoyment in life and required assisted

living arrangements. He could not go to the bathroom alone, get out of bed without assistance and suffered numerous indignities for the rest of his life. This man's non-economic loss was capped at $500,000.

He died recently after becoming sick with pneumonia and being unable to shake it due to his immobility. He was basically suffocating and died of heart failure after a number of years of suffering.

His out of court settlement is confidential and perhaps the $500,000 cap was adequate. But it begs the question, "Why should medical providers be singled out for special protection under law?" The answer is they shouldn't, a jury should decide these cases like they do any other case.

Many states have no caps on noneconomic damages and some that have caps, have had their state supreme courts rule them unconstitutional.

North Dakota juries are not known for runaway verdicts. And there is no justification for providing this "Special Treatment Under Law" for medical providers.

I commend Representative Belter for bringing this issue before the committee, and I respectfully request that the committee recommend a Do Pass on HB 1390.

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

STATE MEDICAL MALPRACTICE TORT LAWS

States	Statutes of Limitation	Limits on Damage Awards	Pre-trial Screening and Arbitration	Joint and Several Liability	Expert Witnesses	Attorney Fees	Patient Compensation or Stabilization Fund
Alabama	**§6.5.482.** 2 years from date of injury or 6 months from discovery. No suit may be brought 4 years after date of injury. Minors under 4 by age 8 if statute would have otherwise expired by that time.	None. Limits declared unconstitutional by State Supreme Court.	**§6.5.485.** Voluntary arbitration, agreed to in writing.	No separation of joint and several liability.	**§6.5.548.** Expert witness must be licensed in same specialty as defendant and must have practiced within previous year.	No limitations.	None provided.
Alaska	**§09.10.070.** 2 years from discovery of injury.	**§09.17.010.** Noneconomic damages limited to $400,000 or plaintiff's life expectancy calculation. Severe injury, $1 million or life expectancy calculation. **§9.17.020.** Punitive damages limited to $500,000 or 3 times compensatory damages.	**§09.55.535.** Voluntary arbitration, cannot be a prerequisite to receiving care or treatment. **§09.55.536.** Expert advisory panel used after lawsuit is filed. Must issue report within 30 days of selection on the facts of the case. Report is admissible evidence in trial.	**§09.17.080.** Defendants are proportionally liable for damages awarded according to percentage of fault.	**§09.20.185.** Expert witness must be trained and licensed in defendant's discipline and certified by a board recognized by state.	No limitations.	None provided.
Arizona	**§12-542.** 2 years after cause of action, and not afterward for personal injury and wrongful death.	None. Limits constitutionally prohibited.	**§12-583.** Good cause hearing determines if a basis exists to go to trial.	**§12-2506.** Defendants are proportionally liable for damages awarded according to percentage of fault, unless defendant acted in concert with another person.	No provisions.	**§12-568.** Not limited, but court reviews reasonableness of fees upon request of either party.	None provided.

States	Statutes of Limitation	Limits on Damage Awards	Pre-trial Screening and Arbitration	Joint and Several Liability	Expert Witnesses	Attorney Fees	Patient Compensation or Stabilization Fund
Arkansas	**§16-114-203.** 2 years from date of injury. Foreign objects: 1 year from discovery. Minors: before age 9, until age 11.	**§16-55-205 – 209.** Punitive damages limited to $250,000 per plaintiff or 3 times amount of economic damages. Not to exceed $1 million. Limits adjusted for inflation at 3-year intervals beginning in 2006. Contingent on proof of recklessness or intentional malice.	**§16-108-102.** Voluntary arbitration and dispute resolution. **§16-7-101.** Permits courts to set mediation and/or arbitration to encourage their use to promote settlement of cases.	**§16-55-201.** Defendants are proportionally liable for damages awarded according to percentage of fault.	**§16-114-206.** Expert witness must be medical care provider of same type of specialty as defendant.	No limitations.	None provided.
California	**Civil Procedure §340.5.** 3 years after injury or 1 year after discovery, whichever is first. No more than 3 years after injury unless caused by fraud, concealment, or foreign object. Minor under age 6: 3 years or before age 8, whichever is longer. **Civil Procedure §364.** Physician must have 90 days notice of action to commence.	**Civil Code §3333.2.** $250,000 limit for noneconomic damages.	**Civil Procedure §1295.** Voluntary arbitration contract. Entering contract removes option for trial and is binding.	**Civil Code §1431.2.** Defendants are proportionally liable for noneconomic damages according to percentage of fault, but jointly and severally liable for economic damages.	**Business and Professions §2220.08.** Expert witnesses to have pertinent education and training to evaluate specifics to claim and case.	**Business and Professions §6146.** Sliding scale, not to exceed 40% of first $50,000, 33 1/3% of next $50,000, 25% of next $500,000, and 15% of damages exceeding $600,000.	None provided.
Colorado	**§13-80-102.5.** 2 years from date of injury, no more than 3 years from act. Foreign objects: 2 years from discovery. Minors under age 6: before age 8.	**§13-64-302.** $1 million total limit on all damages; $300,000 noneconomic limitation.	**§13-22-311.** Court may refer case to mediation. **§13-22-201 – 223.** Voluntary arbitration.	**§13-21-111(5).** Defendants are proportionally liable for damages awarded according to percentage of fault, unless act proved deliberate.	**§13-64-401.** Expert witness must be licensed physician and substantially familiar with standard of care on date of injury.	No limitations.	**§10-4-901 – 913.** Stabilization Reserve Fund fully outlined and enacted; **however, provisions never funded and implemented.**
Connecticut	**§52-584.** 2 years from date of injury, but no later than 3 years of the act or omission.	None.	**§38a-32 and 33.** Medical Screening Panel selected when all parties agree. Proceedings confidential.	**§52-572h.** Defendants are proportionally liable according to percentage of fault for damages awarded.	**§52-184c.** Expert witness must be similar health care provider or have sufficient training and experience in related field of medicine.	**§52-251c.** Sliding scale, not to exceed 1/3 of first $300,000; 25% of next $300,000; 20% of next $300,000; 15% of next $300,000; and 10% of damages exceeding $1.2 million.	None provided.

States	Statutes of Limitation	Limits on Damage Awards	Pre-trial Screening and Arbitration	Joint and Several Liability	Expert Witnesses	Attorney Fees	Patient Compensation or Stabilization Fund
Delaware	**§18.6856.** 2 years from injury; 3 years from discovery if latent injury. Minor: age 6 or same as adult.	**§18.6855.** Punitive damages may be awarded only on finding of malicious intent to injure or willful or wanton misconduct. No mandated limit.	**§18.6803-6812.** Medical negligence review panel part of court review; panel's findings admissible as evidence at trial.	No separation of joint and several liability.	**§18.6853-6854.** Expert witness required to establish deviation from applicable standard of care unless panel found negligence to have caused injury; expert's knowledge of similar field to testify.	**§18.6865.** Sliding scale, not to exceed 35% of first $100,000; 25% of next $100,000; and 10% of all damages exceeding $200,000.	**§18.6833.** Stabilization Reserve Fund created.
Florida	**§95.11.** 2 years from injury or discovery, no more than 4 years from injury. Minors: age 8. If fraud, concealment of injury or intentional misrepresentation prevented discovery within 4-year period, 2 year limit from discovery, not to exceed 7 years after the act.	**§766.118.** Noneconomic damages limited to $500,000 per claimant. Death or permanent vegetative state, noneconomic damages not to exceed $1 million. **§768.73.** Punitive damages limited to the greater of 3 times amount of economic damages or $500,000. If deliberate intent to harm, no limit on punitive damages.	**§766.106.** Pre-suit investigation and informal discovery conducted by defendant's insurer prior to submission to courts. **§766.107.** Court may require submission of claim to arbitration, non-binding, limits on what is admissible at trial **§766.108.** Mandatory mediation and mandatory settlement conference held prior to trial if no binding arbitration agreed to.	**§768.81.** Defendants are proportionally liable according to percentage of fault for damages awarded, monetary limits in liability according to percentage as level of fault increases.	**§766.102.** Expert testimony by licensed physician in same practice or practicing for 5 years before claim filed.	**Florida Ballot, 2004 Election. Constitutional amendment adopted, effective immediately.** Limits attorney fees in malpractice lawsuits to 30% of first $250,000; 10% of any award over $250,000.	**§766.102.** Patient's Compensation Fund and Birth Related Neurological Compensation Fund fully outlined and enacted; **however, provisions never implemented.**
Georgia	**§9.3.71-73.** 2 years from injury or death; in no event longer than 5 years from act or death. Foreign object: 1 year from discovery. Minors: 2 years from age 5 if action arose before 5th birthday.	**§51.12.5.1.** $250,000 limit on punitive damages, unless demonstrated intent to harm.	**§9.9.61-63.** Voluntary arbitration subject to court review; binding if prior agreement to make it so.	**§51.12.33.** Defendants are proportionally liable according to percentage of fault for damages awarded.	**§9.11.9.1.** Complaint must contain affidavit of expert stating that facts justify a claim of negligence.	No limitations.	**§33.20.13 (c).** Health care corporation regulations require insurers to establish and maintain reserve funds for unpaid claims and other known liabilities.
Hawaii	**§657.7.3.** 2 years from discovery, not to exceed 6 years from act. Minors: age 10 or within 6 years, whichever is longer. **§671.18.** Arbitration tolls statute until 60 days after panel's decision is delivered.	**§663.8.5, 8.7.** $375,000 limit for pain and suffering damages.	**§601.20.** Mandatory nonbonding arbitration for all cases involving $150,000 or less. **§671.11-20.** (1976) mandatory submission to medical claim conciliation panel; results not admissible at trial.	**§663.10.9.** When negligence is less than 25%, noneconomic damages awarded in proportion according to degree of fault.	No provisions.	**§607.15.5.** Attorney fees must be approved by court.	None provided.

States	Statutes of Limitation	Limits on Damage Awards	Pre-trial Screening and Arbitration	Joint and Several Liability	Expert Witnesses	Attorney Fees	Patient Compensation or Stabilization Fund
Idaho	**§5.219.** 2 years from injury. Foreign object: 1 year from reasonable discovery or 2 years from injury, whichever is later.	**§6.1603-4.** $250,000 limit on noneconomic damages, adjusted annually according to the state's adjustment of the average annual wage. Punitive damages limited to $250,000 or amount 3 times of compensatory damages.	**§6.1001-1011.** Mandatory submission of claim to hearing panel; results non-binding and not admissible at trial.	**§6.803.** Defendants are proportionally liable according to percentage of fault for damages awarded, except in cases of intentional act.	**§6.1013.** Expert witness must have professional expertise, practical knowledge of community standards.	No limitations.	None provided.
Illinois	**§735 5/13-212.** 2 years from discovery but not more than 4 years from act. Minors: 8 years after act but not after age 22. **§740 180/2.** Wrongful death: 2 years if limitation on personal injury still valid at time of death.	**§735 5/2-1115.** Punitive damages not recoverable in medical malpractice cases. All other limits held unconstitutional.	**§735 5/2-1001A.** Arbitration may be court ordered for cases totaling less than $50,000.	**§735 5/2-1117.** No separation of joint and several liability.	**§735 5/8-2501.** Expert witness licensed and certified in same medical specialties as defendant, for at least 10 years preceding devoted 75% of time to practice, teaching or research relating to treatment at issue.	**§735 5/2-1114.** Sliding scale, not to exceed 1/3 of first $150,000; 25% of next $850,000; 20% of damages over $1 million.	None provided.
Indiana	**§34-18-7-1.** 2 years from act, omission, or neglect. Minors: under age 6 until age 8.	**§34-18-4-3.** $1,250,000 total limit. Liability limited to $250,000 per health care provider. Any award beyond limits covered by Patient Compensation Fund.	**§34-18-10.** Optional Medical Review Panel at request of either party; 2 panelists must be of same specialty as defendant. Panel findings are admissible at trial.	No separation of joint and several liability.	**§34-18-10-22.** Medical Review Panel findings and testimony qualify as expert testimony.	**§34-18-18-1.** Plaintiff's attorney fees may not exceed 15% of any award made from Patient Compensation Fund.	**§34-18-6.** Patient Compensation Fund pays awards over $250,000 up to $1,250,000.
Iowa	**§614.1.** 2 years from reasonable discovery but not more than 6 years from injury unless foreign object. Minors under age 8: until age 10 or same as adults, whichever is later. Mentally ill: extends to 1 year from removal of disability.	None.	**§679A.1.** Written arbitration agreement not mandatory, but binding once entered into.	**§668.4.** Defendants are proportionally liable according to percentage of fault. Several liability not granted for economic damages when defendant is found more than 50% at fault.	**§147.139.** Qualifications of expert must relate directly to medical problem or type of treatment at issue.	**§147.138.** Court to review plaintiff attorney fees in any personal injury or wrongful death action against specified health care providers or hospitals.	None provided.

States	Statutes of Limitation	Limits on Damage Awards	Pre-trial Screening and Arbitration	Joint and Several Liability	Expert Witnesses	Attorney Fees	Patient Compensation or Stabilization Fund
Kansas	**§60.513.** 2 years from act or reasonable discovery, but can be up to 10 years after reasonable discovery.	**§60.19a02.** $250,000 limit on noneconomic damages recoverable by each party from all defendants. **§60.3702.** Punitive damages limited to lesser of defendant's highest gross income for prior 5 years or $5 million. If profitability of misconduct exceeds limit, court may award 1.5 times profit instead, Judge determines punitive damage.	**§65.4901, §60.3502.** Voluntary submission to medical screening panel upon request of party; panelists must include medical professional of same specialty as defendant.	No separation of joint and several liability.	**§60.3412.** 50% of the expert's professional time over preceding 2 years must have been devoted to clinical practice.	**§7.121b.** Attorney fees must be approved by court.	**§40.3403.** Health Care Stabilization Fund pays claims over $200,000, maximum payout of $300,000 per year on claim. Mandatory participation by medical professionals.
Kentucky	**§413.140.** 1 year from act or reasonable discovery, but not more than 5 years after act.	None.	**§417.050.** Written arbitration agreements voluntary, once entered are considered enforceable and irrevocable. **§454.011.** Courts encouraged to make referrals to mediation prior to trials.	**§411.182.** When court apportions percentage of fault, defendant is only liable for comparable share of damages.	No provisions.	No limitations.	None provided.
Louisiana	**RS §9.5628.** 1 year from act or date of discovery, but no later than 3 years from date of injury. **CC §2315.2.** Wrongful death: 1 year from death.	**RS §40:1299.42.** $500,000 limit for total recovery. Health care provider liability limited to $100,000. Any award in excess of all liable providers paid from Patient's Compensation Fund.	**RS §9.4231.** Voluntary arbitration, considered binding and enforceable once entered.	**CC §2324.** Defendants are liable only for percentage of fault unless conspiracy to commit intentional or willful act.	**RS §9.2794.** Expert witness must be licensed physician trained in specialty at question, practicing when claim arose, possess knowledge of accepted standards of care and treatment.	No limitations.	**RS §40:1299.44.** Patient Compensation Fund pays claims over $100,000 up to $500,000. Physicians levied surcharge directly into fund for purpose of paying malpractice claims.
Maine	**§24.2902.** 3 years from cause of action. Minors: 6 years after accrual or within 3 years of minority, whichever is first. Foreign objects: accrue from reasonable discovery.	**§18A.2.804.** Damage limits granted only in wrongful death cases. Noneconomic damages limited to $400,000, punitive damages limited to $75,000.	**§24.2851-59.** Mandatory pre-litigation screening and mediation panel, findings confidential except under certain provisions.	No separation of joint and several liability.	No provisions.	**§24.2961.** Sliding scale, not to exceed 1/3 of first $100,000; 25% of next $100,000; and 20% of damages exceeding $200,000.	Stabilization Reserve Fund repealed in 1995. Was part of Title 24, Chapter 20, Insurance Underwriting.

States	Statutes of Limitation	Limits on Damage Awards	Pre-trial Screening and Arbitration	Joint and Several Liability	Expert Witnesses	Attorney Fees	Patient Compensation or Stabilization Fund
Maryland	**§5-109.** 5 years from act or 3 years from discovery.	**§3-2A-09(A).** Noneconomic damages limited to $650,000 from 2005 to 2008, thereafter increasing by $15,000 per year beginning on January 1 of the applicable year.	**§3-2A-06-C.** Mandatory ADR or mediation within 30 days of filing defendant's answer or defendant's certificate of qualified expert, whichever is later. No mandatory mediation if court finds it unproductive and if all parties file agreement not to participate.	No separation of joint and several liability.	**§3-2A-02.** Expert witness must have clinical experience, provided consultation relating to clinical practice, or taught in defendant's specialty or a related field within 5 years of act or omission. Can't spend more than 20% of time testifying in personal injury cases.	No limitations.	**§6-101 - 104, 6-301.** People's Insurance Counsel reviews rate increases of 10% or more. Premium tax of 2% assessed on HMOs and MCOs and used to offset malpractice premium rates. (Other providers already pay this, HMOs and MCOs are now no longer exempt.)
Massachusetts	**§260.4.** 3 years from injury and no more than 7 years, unless foreign object discovered. **§231.60D.** Minors: before age 6 until age 9, no longer than 7 years from injury.	**§231.60H.** $500,000 limit for noneconomic damages, some exceptions released from limitations.	**§231.60B.** Mandatory submission of claims to medical malpractice court tribunal, decision admissible at trial.	No separation of joint and several liability.	No provisions.	**§231.601.** Sliding scale, not to exceed 40% of first $150,000; 33.33% of next $150,000; 30% of next $200,000 and 25% of award over $500,000.	None provided.
Michigan	**§600.5805.** 2 years from injury. **§600.5838a.** 6 months from reasonable discovery. No more than 6 years from injury. **§600.5851.** Minors under age 8: 6 years or age 10, whichever is later. Reproductive injuries until age 13.	**§600.1483.** $280,000 limit on noneconomic damages; $500,000 limit on noneconomic damages applies to certain other circumstance. Limit adjusted annually by state treasurer according to consumer price index.	**§600.4903 - 4919.** Mandatory review by mediation panel, findings not admissible at trial. **§600.2912g**. Voluntary arbitration binding if total damages claimed less than $75,000.	**§600.2925a.** Defendants are proportionally liable according to percentage of fault for damages awarded, except when uncollectible shares are reallocated among solvent defendants.	**§600.2169.** Expert must be licensed and board certified health professional in practice of similar specialty, in active practice or education during year preceding action.	**Court Rules 8.121(b).** Maximum contingency fee for personal injury action is third of amount recovered.	None provided.
Minnesota	**§541.076.** 4 years from injury or termination of treatment. **§541.15.** Disability extends limitation to 7 years.	**§549.20.** No limitation for punitive damages but are only allowed if defendant proven to have deliberate disregard to safety. Award subject to judicial review.	**§484.76** Alternative dispute resolution program. **§145.682.** Plaintiff must consult with expert prior to trial to determine validity of claims asserted.	**§604.02.** Defendants are proportionally liable according to percentage of fault for damages awarded, except when defendant is assessed greater than 50% of fault, or proven to have intentional malice.	**§145.682.** Claimant must file affidavit stating that expert has been consulted.	No limitations.	None provided.

States	Statutes of Limitation	Limits on Damage Awards	Pre-trial Screening and Arbitration	Joint and Several Liability	Expert Witnesses	Attorney Fees	Patient Compensation or Stabilization Fund
Mississippi	**§15.1.36.** 2 years from act or reasonable discovery, no more than 7 years.	**§11.1.60.** $500,000 limit on noneconomic damages. **§11.1.65.** Punitive damages only awarded if willful malice or gross negligence proved. Court determines if award granted and amount. Damages limited based on defendant's net worth.	**§11.15.1.** Voluntary arbitration must be agreed to in writing. **§11.1.58.** Malpractice complaint filed must be accompanied by certificate stating that plaintiff's attorney consulted with at least 1 medical expert qualified to render testimony on standard of care.	**§85.5.7.** Defendants are proportionally liable according to percentage of fault for damages awarded, except when defendant is proven to have intentional malice.	**§11.1.61.** Expert witness must be licensed physician.	No limitations.	None provided.
Missouri	**§516.105.** 2 years from act. Foreign object: 2 years from discovery. Minor under 8: until age 20, or 10 years from 20th birthday. In no event longer than 10 years from injury.	**§538.210.** Limit on noneconomic damages adjusted annually for inflation; set at $565,000 in 2004.	No provisions.	**§538.230.** Defendants are proportionally liable according to percentage of fault for damages awarded.	**§538.225.** Affidavit of expert consultation must be filed within 90 days of beginning action.	No limitations.	Tort Victim's Compensation Fund does ***not*** apply in actions of improper health care.
Montana	**§27.2.205.** 3 years from injury or discovery, no more than 5 years from act. Minors under age 4: age 11 or death, whichever occurs first.	**§25.9.411.** $250,000 limit on noneconomic damages. **§27-1-221.** Liability for punitive damages determined by court, defendant must have been proven guilty of deliberate malice.	**§27.6.101-704.** All malpractice claims submitted to Medical Legal Panel for review unless voluntary arbitration agreed to. Findings not admissible into court evidence.	**§27.1.703.** Defendants are proportionally liable according to percentage of fault for damages awarded, except when defendant is assessed greater than 50% of fault.	No provisions.	No limitations.	None provided.
Nebraska	**§25.222.** 2 years from act or 1 year from reasonable discovery.	**§44.2825.** Total damages limited to $1,750,000. Health care provider liability limited to $500,000. Any excess of total liability of all health care providers paid from Excess Liability Fund.	**§44.2840.** Mandatory review of malpractice claims by medical review panel.	**§25-21,185.10.** Defendants are proportionally liable according to percentage of fault for noneconomic damages awarded, and jointly liable for economic damages.	No provisions.	**§44.976.** No limitations, but court can review for reasonableness.	**§44.2829-2831.** Excess Liability Fund established, participation required and surcharge assessed to physicians. Pays claims over $500,000 per defendant up to $1,750,000.

States	Statutes of Limitation	Limits on Damage Awards	Pre-trial Screening and Arbitration	Joint and Several Liability	Expert Witnesses	Attorney Fees	Patient Compensation or Stabilization Fund
Nevada	**Nevada Ballot, 2004 Election. Question 3, Passed.** Amends NRS Ch. 41A.097. 4 years from injury or 2 years from reasonable discovery if injury or wrongful death prior to Oct. 1, 2002. If after Oct. 1, 2002, 3 years from injury or 1 year from discovery.	**Nevada Ballot, 2004 Election. Question 3, Passed.** Amends NRS Ch. 41A. $350,000 limit on noneconomic damages, no exceptions. **§42.005.** $300,000 or 3 times compensatory damages limit on punitive damages, only awarded by court for fraud, oppression, or malice.	**§41A.081.** All parties, insurers and attorneys required to participate in settlement conference before district judge other than trial judge.	**Nevada Ballot, 2004 Election. Question 3, Passed.** Amends NRS Ch. 41A. Defendants proportionally liable according to percentage of fault for economic and noneconomic damages awarded.	**§41A.071.** Affidavit must be filed by medical expert practicing in area similar to defendant, failure to submit results in dismissal.	**Nevada Ballot, 2004 Election. Question 3, Passed.** Amends NRS Ch. 7. Creates sliding scale for attorney fees, not to exceed 40% of first $50,000; 33 1/3% of next $50,000; 25% of next $500,000; 15% of any amount over $600,000.	**§686B.180.** State insurance commissioner may create insurance coverage through regulation if access to essential insurance in voluntary market is limited.
New Hampshire	**§507-C:4.** 2 years from injury or 2 years from discovery. Minors under age 8: until age 10.	None. Limits declared unconstitutional by State Supreme Court.	**519-A:1, 2.** Claimant may informally and voluntarily submit to hearing panel prior to beginning litigation. Panel to have layman, doctor selected by court, judicial representation.	**507:7-d.** Defendants are proportionally liable according to percentage of fault for damages awarded.	**§507-C:3.** Expert witness must be competent and duly qualified to render or supervise equivalent care to defendant's specialty.	**§507-C:8.** Sliding scale, not to exceed 50% of first $1000; 40% of next $2000; 1/3 of next $97,000; 20% of excess of $100,000. When settled out of court, fee limited to 25% of up to $50,000.	None provided.
New Jersey	**§2A:14-2.** 2 years from accrual of claim or discovery. Minor from birth: until age 13.	**§2A:15-5.14.** $350,000 limit on punitive damages, or 5 times compensatory damages, whichever is greater.	**§2A:23A-20.** Mandatory arbitration of medical claims under $20,000; voluntary if over $20,000. **§2A:53A-39.** Presiding judge may refer malpractice action to complementary dispute resolution mechanism within 30 days after trial discovery end date.	**§2A:15-5.2.** Defendants only responsible for share of fault if less than 60% . Defendants found more than 60% at fault subject to modified rule.	**§2A:53A-41.** Expert witness must be licensed and practicing physician in same specialty as defendant, authorized to administer treatment in question.	**Court Rules §1:2107.** Sliding scale, not to exceed 1/3 of first $500,000; 30% of next $500,000; 25% of third $500,000; and 20% of fourth $500,000. 25% limit for minor or incompetent plaintiff.	None provided.
New Mexico	**§41.5.13.** 3 years from injury.	**§41.5.6-7.** $600,000 total limit on all damages. Health care providers not liable for any amount over $200,000; any judgment in excess paid from Patient's Compensation Fund.	**§41.5.14-20.** Mandatory submission of malpractice claims to hearing panel; panel report not admissible as court evidence.	**§41.3A.1.** Defendants are proportionally liable according to percentage of fault for damages awarded, except when defendant is proven to have intentional malice.	No provisions.	No limitations.	**§41.5.25-29.** Patient's Compensation Fund only expended for purposes of and to extent provided in Medical Malpractice Act. Superintendent has authority to use fund money to purchase insurance for fund and its obligations.

States	Statutes of Limitation	Limits on Damage Awards	Pre-trial Screening and Arbitration	Joint and Several Liability	Expert Witnesses	Attorney Fees	Patient Compensation or Stabilization Fund
New York	**§214.A.** 2 1/2 years from injury, 1 year from discovery. **§208.** Minors: statute tolled until disability ceases, not to exceed 10 years.	None.	**§3045.** When liability is conceded, either party may call for arbitration of damages amounts.	**§16-1601.** Defendants are proportionally liable according to percentage of fault for noneconomic damages awarded, unless found more than 50% at fault. Defendants can be held jointly liable for economic damages.	**§3012.** Certificate of consultation of expert submitted within 90 days of filing complaint.	**Jud. §474-A.** Sliding scale, not to exceed 30% of first $250,000; 25% of second $250,000; 20% of next $500,000; 15% of next $250,000; 10% over $1.25 million.	None provided.
North Carolina	**§1-15.17.** 3 years from act or 1 year from reasonable discovery, not more than 4 years after injury. Foreign object: 1 year from discovery but not more than 10 years. Minors: until age 19.	**§1D-25.** $250,000 limit on punitive damages, or 3 times economic damages, whichever is greater.	**§7A-38.1.** Mandatory pre-trial, mediated settlement conference for all civil actions filed in Superior Court.	**§1B-7.** No separation of joint and several liability.	**§90-21.12.** Expert witness must testify as to the standard of care used in community. Must be licensed physician.	No limitations.	None provided.
North Dakota	**§28.01.18.** 2 years from act or reasonable discovery but not more than 6 years after act unless concealed by fraud. **§28.01.25.** Minors: 12 years	**§32.42.02.** $500,000 limit on noneconomic damages. **§32.03.2.08.** Economic damage awards in excess of $250,000 subject to court review.	**§32.42.03.** Attorneys must disclose alternative dispute resolutions; good faith effort to resolve dispute required.	**§32.03.2.02.** Defendants are proportionally liable according to percentage of fault for damages awarded, except when defendant is proven to have intentional malice.	No provisions.	No limitations.	**§26.1.14.01-09.** Reserve fund enacted but not implemented unless majority of doctors in state have difficulty securing malpractice insurance.
Ohio	**§2305.11-13.** 1 year from act, no more than 4 years for discovery. Foreign object: 1 year from discovery. Minors: 4 years from act.	**§2323.43.** No limits on economic damages. $250,000 limit on noneconomic damages or amount equal to three times plaintiff's economic loss, determined by court. Maximum noneconomic damages $350,000 per plaintiff or $500,000 per occurrence.	**§2711.01.** Voluntary arbitration, decision is not admissible as court evidence.	**§2307.22.** Defendants are proportionally liable according to percentage of fault for damages awarded, unless found more than 50% at fault.	**§2743.43.** Expert testimony limited to licensed physician or surgeon who devotes 3/4 time to active clinical practice or teaching.	No limitations.	None provided.

States	Statutes of Limitation	Limits on Damage Awards	Pre-trial Screening and Arbitration	Joint and Several Liability	Expert Witnesses	Attorney Fees	Patient Compensation or Stabilization Fund
Oklahoma	**§76-18.** 2 years from reasonable discovery. **§12-96.** Minors under 12: 7 years. Minors over 12: 1 year after attaining majority but in no event less than 2 years from injury.	**§63-1-1708.1F.** $300,000 limit on noneconomic damages in all malpractice cases; limit also specific to obstetric and emergency room care. No limits for negligence or wrongful death. **§23-9.1.** Punitive damages awarded based on condition of misconduct.	**§63-1-1708.1E.** Affidavit to be submitted by plaintiff stating consultation with qualified expert; includes written opinion from expert that act or omission constituted professional negligence and claim is meritorious.	**§23-15.** Defendants are proportionally liable according to percentage of fault for damages awarded, unless found more than 50% at fault or guilty of willful misconduct or reckless disregard.	**§63-1-1708.1I.** Expert witness must be licensed to practice medicine or have other substantial training and experience in area of health care relevant to claim; actively practicing or retired from services relevant to claim.	**§5-7.** Fee may not exceed 50% of net judgment.	**§76-22.** State Insurance Fund authorized to offer malpractice insurance and/or reinsurance based on claims and loss ratio. State Board for Property and Casualty Rates must approve prior to release, based on finding that available reserves are sufficient.
Oregon	**§12.110.** 2 years from injury or reasonable discovery, not more than 5 years from act.	None. 2004 ballot measure to institute noneconomic damage limits rejected by voters. **§31.740.** Punitive damages not awarded if physician is found acting in scope of duties without malice.	**§31.250.** All parties and attorneys to participate in some form of dispute resolution within 270 days of action filed unless case is settled or parties voluntarily waive in writing.	**§31.610.** Defendants are proportionally liable according to percentage of fault for damages awarded.	No provisions.	**§31.735.** No more than 20% of punitive damages to attorney, no limitation of percentage of economic damages.	**§752.035.** Professional Liability Fund established to pay sums as provided that members are legally obligated to as result of malpractice. Maintained by Director of Department of Consumer and Business Services.
Pennsylvania	**§42.5524.** 2 years from injury or discovery. **§42.5533.** Minor: 2 years after age of majority.	None. Constitutionally prohibited. **§40.1301.812-A.** Punitive damages granted only if defendant found guilty of willful misconduct or reckless disregard.	**§40.1301.825-A.** Mandatory conciliation hearing, which may be a settlement conference or mediation as the parties prefer.	**§42.71.7102.** Defendants are proportionally liable according to percentage of fault for damages awarded, unless found more than 60% at fault or guilty of intentional misconduct.	**§40.1301.821-A.** Attorney's signature on a complaint certifies that attorney has consulted an expert who will attest to position.	No limitations.	**§971.165.** Medical Professional Liability Catastrophe Loss Fund to provide up to $700,000 per occurrence. Participating physicians pay annual surcharge.
Rhode Island	**§9.1.14.1.** 3 years from injury, death or reasonable discovery. **§10.7.2.** Minors and incompetents: 3 years from removal of disability.	None. **§9.19.34.1.** Collateral source rule requiring jury to reduce award for damages by sum equal to difference between total benefits received and total amount paid to secure benefits by plaintiff.	**§10.3.1.** Arbitration Act requires request for arbitration be in writing. Voluntary.	No separation of joint and several liability.	**§9.19.41.** Expert witness qualifications are training/education levels. **§9.19.30.** Statements in published material, as found by court to relevant and that author is recognized as expert, are admissible as evidence.	No limitations.	None provided.

States	Statutes of Limitation	Limits on Damage Awards	Pre-trial Screening and Arbitration	Joint and Several Liability	Expert Witnesses	Attorney Fees	Patient Compensation or Stabilization Fund
South Carolina	**§15-3-545.** 3 years from act or omission, or 3 years from discovery. not to exceed 6 years. Foreign object: 2 years from discovery. Minors: tolled for up to 7 years while a minor.	None.	No provisions.	**§15-38-10.** No separation of joint and several liability.	No provisions.	No limitations.	**§38-79-420.** Patients' Compensation Fund to pay portion of malpractice claim, settlement or judgment over $200,000 for each incident or over $600,000 in aggregate for one year.
South Dakota	**§15-2-14.1.** 2 years from act or omission.	**§21-3-11.** $500,000 limit on noneconomic damages. No limit on special damages.	**§21-25-B.1.** Voluntary arbitration.	**§15-8-15.1.** Defendants are proportionally liable according to percentage of fault for damages awarded; defendants found less than 50% liable not jointly liable for more than twice percentage of fault allocated.	No provisions.	No limitations.	None provided.
Tennessee	**§29.26.116.** 1 year from injury or discovery, no more than 3 years from act unless foreign object.	None.	**§29.5.101.** Voluntary arbitration.	Joint and several liability provisions in statute, but overridden by State Supreme Court.	**§29.26.115.** Expert witness must be licensed in state or contiguous state and practice in corresponding specialty for one year preceding date of injury.	**§29.26.120.** Fees limited to 1/3 of award to plaintiff.	None provided.
Texas	**§74.151.** 2 years from occurrence, no more than 10 years. Minors under 12: until age 14.	**§74.301.** $250,000 limit per claimant for noneconomic damages. $500,000 limit per claimant for noneconomic damages in judgments against health care institutions.	**§74.351.** Expert reports to be submitted to defendant and defendant's attorney within 120 days of filing claim. **§74.451.** Voluntary arbitration.	**§33.013.** Defendants are proportionally liable according to percentage of fault for damages awarded, unless found more than 50% at fault.	**§74.401.** Expert witness must be licensed physician practicing medicine and/or with knowledge of accepted standards of practice.	No limitations.	None provided.
Utah	**§78.14.4.** 2 years from discovery but not more than 4 years from act; foreign object or fraud: 1 year from discovery, applies to all persons regardless of minority or disability	**§78.14.7.1.** $400,000 limit on noneconomic damages for actions arising after July 1, 2002. Adjusted annually by Administrative Office of Courts.	**§78.14.12.** Voluntary pre-litigation panel may be requested. **§78.14.16.** Upon written agreement by all parties, proceedings may be considered a binding arbitration hearing.	**§78.27.40.** Defendants are proportionally liable according to percentage of fault for damages awarded.	No provisions.	**§78.14.7.5.** Contingency fee not to exceed 1/3 of award.	None provided.

States	Statutes of Limitation	Limits on Damage Awards	Pre-trial Screening and Arbitration	Joint and Several Liability	Expert Witnesses	Attorney Fees	Patient Compensation or Stabilization Fund
Vermont	**§12.521.** 3 years from incident or 2 years from discovery, whichever is later. No later than 7 years. Fraud: no statute of limitations. Foreign object: 2 years from discovery.	None.	**§12.7002.** Voluntary arbitration, panel consists of judicial referee selected by court administrator, layman and member of same profession as defendant.	No separation of joint and several liability.	No provisions.	No limitations.	None provided.
Virginia	**§8.01-243.** 2 years from occurrence, no more than 10 years unless under disability. Foreign object: 1 year from discovery.	**§8.01-581.15.** $1.5 million limit on recovery damages. Increased by $50,000 each year from 2001 to 2006. Increased by $75,000 each year in 2007 and 2008.	**§8.01-581.2 - 8.** Review by pre-trial panel by request of either party. Findings admissible in court but not considered conclusive. **§8.01-581.12.** Voluntary arbitration, decision binding.	No separation of joint and several liability.	**§8.01-581.20.** Expert witness must be licensed and have active clinical practice in defendant's field or related specialty.	No limitations.	**§38.2-5000-5020.** Birth-Related Neurological Injury Compensation Fund to provide compensation for infant sustaining brain damage during birth delivery. Physicians pay annual assessment to fund.
Washington	**§4.16.350.** 3 years from injury or 1 year from discovery, whichever is later. No more than 8 years after act.	**§4.56.250.** No specific limits on damage awards. Judgment for noneconomic damages cannot exceed formulation of average annual wage and life expectancy of injured.	**§7.70.100.** Mandatory pre-trial mediation. Panel members shall have expertise related specialty or action in question, and be a member of state bar association for minimum of 5 years or is a retired judge.	**§4.22.070.** Defendants are proportionally liable according to percentage of fault for damages awarded, unless found to be deliberately acting in concert with others.	No provisions.	**§7.70.070.** Court to determine reasonableness of each party's attorney fees.	None provided.
West Virginia	**§55.7B.4.** 2 years from injury or reasonable discovery, no longer than 10 years after injury. Minors under 10: 2 years from injury or age 12, whichever is longer.	**§55.7B.8.** $250,000 limit for noneconomic damages. $500,000 limit for compensatory damages, limit goes up beginning in 2004 according to inflation index. Physicians must carry at least $1 million malpractice insurance to qualify for limits.	**§55.7B.6.** Plaintiff must file notice with certificate of merit stating expert's familiarity with standards, qualifications, opinion of breach of standard of care. Certificates must be filed at least 30 days before filing action, and one certificate for each defendant named.	**§55.7B.9.** Defendants are proportionally liable according to percentage of fault for damages awarded.	**§55.7B.7.** Expert witness must be currently trained and licensed to practice in same or similar specialty as defendant, must devote at least 60% of professional time to clinical practice or teaching at accredited university.	No limitations.	**§29.12B.1-14.** Medical Liability Fund to assist in making malpractice insurance more readily available to specific health care providers.

States	Statutes of Limitation	Limits on Damage Awards	Pre-trial Screening and Arbitration	Joint and Several Liability	Expert Witnesses	Attorney Fees	Patient Compensation or Stabilization Fund
Wisconsin	**§893.55.** 3 years from injury or 1 year from discovery, not more than 5 years from act. Foreign object: 1 year from discovery or 3 years from act, whichever is later. Minors: by age 10 or standard provision, whichever is later.	**§895.04.** After 1995, $350,000 damage limit adjusted annually for inflation. **§893.55(4)(d).** $500,000 damage limit for death of a minor, and $350,000 damage limit for death of an adult.	**§655.42-4.** Voluntary. Mediation request must be made prior to court action and tolls statute of limitations until 30 days after the last day of mediation period.	**§895.045.(2).** Defendants are proportionally liable according to percentage of fault for damages awarded, unless found to be deliberately acting in concert with others or found more than 50% at fault.	No provisions.	**§655.013.** Sliding scale, not to exceed 1/3 of first $1 million, or 25% of first $1 million recovered if liability is stipulated within time limits, 20% of any amount exceeding $1 million.	**§655.27.** Injured Patients and Families Compensation Fund pays amounts in excess of statutorily prescribed future damages awards. Health care providers required to pay into fund annually.
Wyoming	**§1.3.107.** 2 years from injury or reasonable discovery. Minors: until age 18 or within 2 years, whichever is later. Legal disability: 1 year from removal.	**§97.3.027.** Limits prohibited. 2004 ballot measure to institute noneconomic damage limits rejected by voters.	**§9.2.1506.** Medical Review Panel to review all malpractice claims and render decision prior to claim being submitted to court. **Wyoming Ballot, 2004 Election. Legislative referendum adopted.** Allows legislature to create statutes requiring alternative dispute resolution or panel review prior to filing malpractice lawsuits.	**§1.1.109.** Defendants are proportionally liable according to percentage of fault for damages awarded.	No provisions.	**Ct. Rules, R. 5.** Recovery $1 million or less: 1/3 if claim settled prior to 60 days after filing; 40% if settled after 60 days or judgment; 30% over $1 million.	**§26.33.105.** Medical Liability Compensation Fund to provide malpractice insurance coverage in event of cause of action. Participating physicians pay surcharge.

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Additional Resources:

American Medical Association, Advocacy Resource Center, www.ama-assn.org, 800-621-8335
American Tort Reform Association, www.atra.org, 202-682-1163
National Academy for State Health Policy, www.nashp.org, 207-874-6524
National Association of Insurance Commissioners, www.naic.org, 816-842-3600
National Association of Mutual Insurance Companies, www.namic.org, 202-628-1558

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Testimony in Opposition to HB No. 1390
House Judiciary Committee
February 11, 2009

Chairman DeKrey and Committee Members. I'm Bruce Levi and I serve as the Executive Director of the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents and medical students.

The North Dakota Medical Association and other physician specialty organizations oppose HB 1390, which would repeal the $500,000 cap on non-economic damages in health care medical liability actions. HB 1390 would remove a ***proven solution*** to the problem of maintaining a stable medical liability insurance market in North Dakota for all health care professionals, hospitals, nursing homes, clinics and other health care providers.

North Dakota physicians believe that patients are entitled to prompt and fair compensation for injuries due to negligence. We support full payment for all reasonable out-of-pocket economic losses, including current and future medical expenses and wages, rehabilitation costs, and childcare expenses. We also support other strategies for improving the medical liability system and preventing patient injury, including pursuing patient safety initiatives, promoting open communication between patients and health care professionals, and recognizing the importance of an effective disciplinary process through the ND Board of Medical Examiners and other health professional boards. We also support a reasonable cap on non-economic damages for pain and suffering because these damages are subjective and unpredictable.

Insurance rates are based on the predictability of future losses. The North Dakota limitation on non-economic damages, first enacted in 1995, has made

the predictability of losses much more precise and, in turn, has contributed to the fact that medical professional liability rates in North Dakota are among the lowest in the country. You are all aware that we in North Dakota struggle to recruit and retain qualified health care professionals and face challenges in deploying resources to serve geographically dispersed communities, due to our geographic and resource disadvantages. HB 1390 would remove one of the key advantages we have in North Dakota for encouraging health care professionals to locate and remain in North Dakota – that is, a stable medical liability insurance market.

Several studies clearly demonstrate a link between caps on non-economic damages and lower premium rates and increased physician supply. Recent studies also show the positive impacts of caps on premium rate changes in Texas and Mississippi. We also know that caps that are too high, too unpredictable, or too exception-riddled are not effective.

With several decades of experience and thirty states with caps on damages, we know that if properly designed, caps are the most effective means to reduce the cost of an imperfect malpractice tort system, while preserving access to the courthouse for those who have meritorious malpractice claims.

HB 1390 would negatively impact the current stability in the medical liability insurance market in North Dakota, impacting both the availability and affordability of insurance and health care access and cost.

HB 1390 would only create a problem – not solve one. NDMA urges a Do Not Pass on HB 1390.

Talking Points
Opposition to HB 1390

HB 1390 Would Remove a Proven Solution to the Problem of Maintaining a Stable Medical Liability Insurance Market in North Dakota for all Health Care Professionals, Hospitals, Nursing Homes and Other Health Care Providers

•The limitation on non-economic damages in NDCC ch. 32-42 recognizes what a growing body of research has found: that these limitations (caps) are the single most effective means of reducing the cost of the malpractice tort system while ensuring that claimant patients are fully compensated for their economic damages. Economic analysis has demonstrated that a cap on non-economic damages can eliminate the incentive to litigate weak or meritless malpractice claims. Caps are particularly effective in reducing the cost of the medical malpractice tort system because they apply only to the most costly awards. Caps recognize the direct cause of instability in the medical liability insurance market: exploding liability premiums due to a national environment of escalating jury awards and settlements.

•With several decades of experience with limitations on non-economic damages, we know that, if properly designed, caps are the most effective means to reduce the cost of an imperfect malpractice tort system, while preserving access to the courthouse for those who have meritorious malpractice claims. Some of those system costs include:

- The long delays in getting compensation to claimants, and helping them begin their rehabilitation.
- The unnecessary tests and procedures that patients must endure, in order to reduce the health professional's exposure to liability.
- The time lost by physicians, nurses and other health professionals in defending themselves against malpractice claims.
- The loss of highly-trained health professionals from areas where they are sorely needed, including small towns and rural areas.

•North Dakota physicians believe that patients are entitled to prompt and fair compensation for injuries due to negligence. We support full payment for all reasonable out-of-pocket economic losses, including current and future medical expenses and wages, rehabilitation costs, and childcare expenses. We also support other strategies for improving the medical liability system and preventing patient injury, including pursuing patient safety initiatives, promoting open communication between patients and health care professionals, and recognizing the importance of an effective disciplinary process through the ND Board of Medical Examiners. We also support a reasonable cap on non-

economic damages for pain and suffering because these damages are subjective and unpredictable.

•Comprehensive medical liability reforms, based upon California's proven liability reform law known as MICRA, are being sought by states because we know that the evidence from the California experience ($250,000 cap on non-economic damages) shows that MICRA-style reforms reduce the incentive for patients and attorneys to litigate weak or marginal claims, reduce malpractice loss costs, hold down medical malpractice insurance premiums – both generally and for the specialties most vulnerable to malpractice suits, and accelerate the delivery of compensation to those with meritorious malpractice claims.

•Currently, thirty states have laws in place that limit non-economic or total damages in medical liability actions.

•We know that caps on non-economic damages can be effective in holding down costs and improving access if they are sufficiently *binding* to alter the behavior of both plaintiffs and defendants, are *predictable,* and are *comprehensive*. It is important to recognize that caps that are too high, too unpredictable, or too exception-riddled are not effective (Nevada experience).

•Several studies clearly demonstrate a link between caps on non-economic damages and lower premium rates. (C. Kane, PhD, D. Emmons, PhD, *The Impact of Caps on Damages: How are Markets for Medical Liability Insurance and Medical Services Affected?*). Recent studies also show the positive impacts of caps on premium rate changes in Texas and Mississippi (Physician Insurers Association of America).

•Studies demonstrate that tort reforms such as caps on damages increased physician supply by more than two percent relative to non-reform states. The impact of reforms on the supply of high-risk specialties is even greater; in emergency medicine the increase was 11.5 percent. As a rural state, North Dakota is likely to be particularly affected by the loss of physicians these studies suggest may occur if the cap is repealed.

HB 1390 Would Negatively Impact the Current Stability in the Medical Liability Insurance Market in North Dakota, Impacting Both the Availability and Affordability of Insurance and Health Care Access and Cost

•Insurance rates are based on the predictability of future losses. The North Dakota limitation on non-economic damages (NDCC ch. 32-42), first enacted in 1995, has made the predictability of losses much more precise and, in turn, has contributed to the fact that medical professional liability rates in North Dakota are among the lowest in the country. (Midwest Medical Insurance Company (MMIC))

•The medical malpractice insurance market in North Dakota through 2007 indicates a low competitive market (ND Insurance Department); placing the state at a level of vulnerability to national trends or decisions by medical liability companies to leave or reduce their volume of business in the North Dakota market. HB 1390 would substantially increase the potential for volatility in the North Dakota market by reducing the predictability of losses for those medical liability companies that do business or are considering doing business in North Dakota.

•For health systems that self fund medical liability risk, a reserve account must be funded based on the actuarially-defined estimated risk exposure. According to our self-funded health systems in North Dakota, HB 1390 would *significantly and negatively* impact the reserve account funding requirement necessary to meet that actuarially-defined estimated risk exposure.

•The repeal of NDCC 32-42-02 would result in increased professional liability insurance rates for physicians in North Dakota and may have a negative impact on the number of physicians willing to practice in the state, according to a major medical liability insurance carrier (MMIC). The passage of HB 1390 would make the goal to make professional liability insurance as affordable and available for physicians as possible much more difficult to achieve.

•The North Dakota limitation on non-economic damages applies to all "health care providers," and not only physicians, and the state's health care malpractice insurance market includes a variety of different types of risks: physician and surgeons, hospital/clinic professional, dentists, chiropractors, nurses and other allied healthcare providers.

•North Dakota struggles to recruit and retain qualified health care professionals and faces challenges in deploying resources to serve geographically dispersed communities, due to our geographic and resource disadvantages. HB 1390 would remove one of the key advantages we have to encourage health care professionals to locate and remain in North Dakota.

The North Dakota Legislative Assembly Must Protect Its Existing Liability Reforms as the Best Approach to Averting the Impacts of a National Problem

•The current medical liability crisis is a national problem - a problem North Dakota has been able to largely avert through proactive reforms adopted by the North Dakota Legislative Assembly. In the past several years nationally, medical liability premiums have exploded due to escalating jury awards and settlements –doubling and even tripling in some parts of the country. This has caused a significant financial strain on physicians trying to keep their doors open for their patients. The good news is that rates appear to be stabilizing; however, they are stabilizing nationally at very high levels.

•While physicians across the country have experienced huge increases in medical liability insurance premiums in the past several years, certain specialties have been hit especially hard. Many obstetrician/gynecologists and family practitioners have reported that they have stopped delivering babies. Also, specialties that perform advanced and high-risk procedures (such as neurosurgery and orthopedics) are affected. Emergency departments are losing staff and scaling back or eliminating certain services, including trauma units. North Dakota has not experienced these huge increases in premiums due to factors that include our medical liability reforms, including the cap on non-economic damages. HB 1390 would change all that.

HB 1390 Would Only Create a Problem – Not Solve One.

Defeat HB 1390.

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North Dakota Long Term Care Association | North Dakota Chapter ACP | NDHA North Dakota Healthcare Association | North Dakota Medical Association | MGMA | North Dakota | American Academy of Pediatrics | North Dakota Society of Obstetrics and Gynecology "Dedicated to Women's Health Care"

Several major professional and business organizations oppose HB No. 1390. These include the North Dakota Medical Association, North Dakota Healthcare Association, North Dakota Medical Group Management Association, North Dakota Chamber of Commerce, North Dakota Long Term Care Association, and the North Dakota Chiropractic Association. Many physician specialty organizations oppose the bill as well, including the ND Society of Obstetrics and Gynecology, the ND Chapter of the American Academy of Pediatrics, the ND Society of Eye Physicians and Surgeons, the ND Chapter of the American College of Physicians, the ND Chapter of the American College of Surgeons, the ND Society of Anesthesiologists, the ND Psychiatric Society, the ND Orthopaedic Society, and the ND Academy of Family Physicians.

The outpouring of concern is not surprising because HB 1390 would lead to higher medical costs and less access to health care for North Dakotans. HB 1390 would only create a problem – not solve one. The following facilities in North Dakota are represented by the ND Long Term Care Association, North Dakota Medical Association, North Dakota Medical Group Management Association, and North Dakota Healthcare Association:

1	Aneta	Aneta Parkview Health Center
2	Arthur	Good Samaritan Society – Arthur
3	Arthur	Prairie Villa
4	Ashley	AMC Clinic
5	Ashley	Ashley Clinic PC
[redacted]	Ashley	Ashley Medical Center
[redacted]	Ashley	Ashley Medical Center
8	Beach	Beach Medical Clinic
9	Belcourt	Quentin Burdick Memorial Hlthcare Facility
10	Beulah	Coal Country Community Health Center
11	Beulah	Sakakawea Beulah Clinic
12	Beulah	Knife River Care Center
13	Bismarck	Advanced Surgical Arts Center
14	Bismarck	Aesthetic Center of Plastic Surgery PC
15	Bismarck	Becker Plastic Surgery Ctr
16	Bismarck	Bismarck Cancer Center
17	Bismarck	Bismarck Health Center
18	Bismarck	Bismarck Radiology Associates
19	Bismarck	Bismarck VA Comm Based Outpatient Clinic
20	Bismarck	Bone Spine Sports Clinic
21	Bismarck	Center for Family Medicine-Bismarck
22	Bismarck	D Cynthia Cantwell MD
23	Bismarck	Dakota Ear Nose Throat PC
24	Bismarck	Dakota Eye Institute
25	Bismarck	Dakota Eye Institute-North
[redacted]	Bismarck	Dakota Foot and Ankle
[redacted]	Bismarck	Dakota Neurology
28	Bismarck	Dakota Osteoporosis
29	Bismarck	Denise Forte Pathroff MD PC
30	Bismarck	Face and Jaw Surgery Ctr
31	Bismarck	Family Foot and Ankle Clinic PC
32	Bismarck	FEKA Hematology-Oncology
33	Bismarck	Foot Care Associates
34	Bismarck	Healthways
35	Bismarck	Horizon Medical Services PC
36	Bismarck	Institute of Facial Surgery
37	Bismarck	Jay R Huber DO PC
38	Bismarck	Medcenter One Bismarck Family Clinic S
39	Bismarck	Medcenter One Family Medical Center N
40	Bismarck	Medcenter One Inc
41	Bismarck	Medcenter One Mental Health Ctr
42	Bismarck	Medcenter One Pain Clinic
43	Bismarck	Medcenter One Rehab Center
44	Bismarck	Medcenter One Walk-In Clinic
45	Bismarck	Medcenter One Walk-In Clinic North
46	Bismarck	Mid Dakota Clinic
47	Bismarck	Mid Dakota Clinic Gateway
48	Bismarck	Mid Dakota Clinic Kirkwood
49	Bismarck	Mid Dakota Clinic-Center for Women
50	Bismarck	Mid Dakota Clinic-U of Mary Student Hlth Cl
51	Bismarck	Mid Dakota Gateway Dermatology
52	Bismarck	Natural Journey
53	Bismarck	Oral Surgery Center of Bismarck
54	Bismarck	Pain Treatment Ctr Anesthesiologists PC
55	Bismarck	Pneumos Lung and Critical Care Institute
56	Bismarck	PrimeCare Pain Clinic
57	Bismarck	Q and R Clinic
58	Bismarck	Regional Neurological Ctr PC
59	Bismarck	Spine, Orthopedic, and Pain Center PC
60	Bismarck	St Alexius Arthritis Clinic

61	Bismarck	St Alexius Heart and Lung Clinic
62	Bismarck	St Alexius Medical Center
[redacted]	Bismarck	St Alexius Medical Center
[redacted]	Bismarck	St Alexius Neonatology Clinic
65	Bismarck	St Alexius Nephrology Clinic
66	Bismarck	St Alexius Neurology Clinic
67	Bismarck	St Alexius Neurosurgery Clinic
68	Bismarck	St Alexius Pain Clinic
69	Bismarck	St Alexius Physical Medicine Clinic
70	Bismarck	The Bone and Joint Center
71	Bismarck	The Center for Neurological Services
72	Bismarck	The Eye Clinic of ND
73	Bismarck	William E Cornatzer MD PC
74	Bismarck	Women's Medical Center
75	Bismarck	Baptist Home, Inc.
76	Bismarck	Edgewood Bismarck Senior Living
77	Bismarck	Maple View – East
78	Bismarck	Maple View – North
79	Bismarck	Medcenter One St. Vincent's
80	Bismarck	Medcenter One Subacute Unit
81	Bismarck	Missouri Slope Lutheran Care Center
82	Bismarck	Primrose Retirement Community
83	Bismarck	The Terrace
[redacted]	Bismarck	Valley View Heights
[redacted]	Bismarck	Waterford on West Century
86	Bottineau	St Andrews Bottineau Clinic
87	Bottineau	St Andrews Health Center
88	Bottineau	Good Samaritan Society – Bottineau
89	Bowbells	Bowbells Clinic
90	Bowman	Southwest Healthcare Services
91	Bowman	Southwest Medical Clinic
92	Bowman	West River Health Clinic
93	Bowman	Southwest Healthcare Services
94	Bowman	Sunrise Village
95	Cando	Towner County Medical Center
96	Cando	Towner County Medical Ctr Clinic
97	Cando	St. Francis Residence
98	Cando	Towner County Living Center
99	Carrington	Carrington Health Center
100	Carrington	Foster County Medical Center
101	Carrington	Golden Acres Manor
102	Carrington	Holy Family Villa
103	Casselton	Innovis Health Casselton
[redacted]	Cavalier	Altru Clinic-Cavalier
[redacted]	Cavalier	CliniCare
106	Cavalier	Pembina County Memorial Hospital
107	Cavalier	Wedgewood Manor
108	Center	Coal Country Community Health Ctr-Beulah
109	Center	Coal Country Community Health Ctr-Center
110	Columbus	Columbus Clinic
111	Cooperstown	Cooperstown Medical Center
112	Cooperstown	Cooperstown Medical Center Clinic
113	Cooperstown	Cooperstown Medical Center
114	Cooperstown	Park Place
115	Crosby	Crosby Clinic
116	Crosby	St Lukes Hospital
117	Crosby	Good Samaritan Society – Crosby
118	Devils Lake	Altru Clinic-Lake Region
119	Devils Lake	Devils Lake Community Clinic
120	Devils Lake	Medical Imaging Assoc Ltd
121	Devils Lake	Mercy Hospital of Devils Lake
122	Devils Lake	Northeast Eye Center
123	Devils Lake	Good Samaritan Society – Devils Lake
124	Devils Lake	GSS – Lake Country Manor
125	Devils Lake	Heartland Care Center
126	Devils Lake	Heartland Courts
127	Devils Lake	Odd Fellows Home
128	Dickinson	Adult Medicine of Dickinson
129	Dickinson	Advanced Orthopedics of ND
130	Dickinson	Arunava Das MD
131	Dickinson	Badlands Ear Nose and Throat Clinic
132	Dickinson	Dakota Bone and Joint
133	Dickinson	Dickinson Clinic
134	Dickinson	Great Plains Clinic
135	Dickinson	Prairie Imaging PC
136	Dickinson	St Josephs Hospital and Health Center
137	Dickinson	West River Foot and Ankle Clinic
138	Dickinson	Benedict Court
139	Dickinson	Dickinson Country House LLC
140	Dickinson	Evergreen
141	Dickinson	Hawks Point
142	Dickinson	Park Avenue Villa
143	Dickinson	St. Benedict's Health Center
144	Dickinson	St. Luke's Home
145	Drake	Central Dakota Clinic-Drake
146	Drayton	Altru Clinic-Drayton
147	Dunseith	Johnson Clinic PC
148	Dunseith	Dunseith Comm. Nursing Home
149	East Grand Forks	MeritCare Clinic East Grand Forks
150	Edgeley	MeritCare Clinic Edgeley
151	Edgeley	Manor St. Joseph
152	Edmore	Edmore Memorial Rest Home
153	Elgin	Elgin Community Clinic
154	Elgin	Jacobson Memorial Hospital Care Center
155	Elgin	Dakota Hill Housing

156	Elgin	Jacobson Memorial Hosp Cr Ctr
157	Ellendale	Avera United Clinic
[redacted]	Ellendale	Southeast Med Ctr-Ellendale
[redacted]	Ellendale	Evergreen Place
[redacted]	Ellendale	Prince of Peace Care Center
161	Enderlin	Hillcrest Medical Clinic
162	Enderlin	MeritCare Clinic Enderlin
163	Enderlin	Maryhill Manor
164	Fargo	Advanced Hand and Upper Extremity Ctr
165	Fargo	Allergy and Asthma Care Center
166	Fargo	Attentive Mind Corp
167	Fargo	Bergstrom Eye and Laser Clinic
168	Fargo	Catalyst Medical Center
169	Fargo	Center for Psychiatric Care
170	Fargo	Dermatology Associates
171	Fargo	Eye Professionals
172	Fargo	Face and Jaw Surgery Center PC
173	Fargo	Family HealthCare Center
174	Fargo	Fargo Disability Evaluation
175	Fargo	Fargo Gastroenterology & Hepatology Cl PC
176	Fargo	Fargo MEPS
177	Fargo	Fargo Psychiatric Clinic
178	Fargo	Fercho Cataract & Eye Clinic
[redacted]	Fargo	FM Orthopaedics
[redacted]	Fargo	Hogue Vein Institute
181	Fargo	Independent Family Doctors
182	Fargo	Independent Radiology Services Ltd
183	Fargo	Innovis Health LLC
184	Fargo	Innovis Health LLC
185	Fargo	Innovis Health Northport
186	Fargo	Innovis Health South University
187	Fargo	Innovis Health West Acres
188	Fargo	Institute of Diagnostic Imaging
189	Fargo	Internal Medicine Assoc Ltd
190	Fargo	James L Frisk MD Ltd
191	Fargo	Lamb Plastic Surgery Ctr PC
192	Fargo	Matthys Orthopaedic Center
193	Fargo	MeritCare Broadway Clinic
194	Fargo	MeritCare Broadway Health Center
195	Fargo	MeritCare Childrens Hospital
196	Fargo	MeritCare Childrens Southwest
197	Fargo	MeritCare Childrens Walk-In Southwest
198	Fargo	MeritCare Clinic N Fargo
[redacted]	Fargo	MeritCare Eye Clinic
[redacted]	Fargo	MeritCare Heart Center
201	Fargo	MeritCare Hospital
202	Fargo	MeritCare Internal Medicine Resident Clinic
203	Fargo	MeritCare Island Park
204	Fargo	MeritCare Neuroscience Center
205	Fargo	MeritCare Occupational Hlth Ctr
206	Fargo	MeritCare Pain Clinic
207	Fargo	MeritCare Professional Building
208	Fargo	MeritCare Psychiatry
209	Fargo	MeritCare Reproductive Medicine Institute
210	Fargo	MeritCare Roger Maris Cancer Ctr
211	Fargo	MeritCare Sleep Center-WCA
212	Fargo	MeritCare South University
213	Fargo	MeritCare Southpointe
214	Fargo	MeritCare Walk-In Clinic
215	Fargo	Neuropsychiatric Research Institute
216	Fargo	Orthopaedic Associates of Fargo
217	Fargo	Pediatric Arts Clinic
218	Fargo	Plains Medical Clinic
219	Fargo	Plastic Surgery Institute PC
220	Fargo	Prairie St John's
221	Fargo	Prairie St Johns Clinic-Fargo
222	Fargo	Precision Diagnostic Services
223	Fargo	RapidCare Urgent Care
224	Fargo	Red River Spine Associates
225	Fargo	Retina Associates PC
226	Fargo	Retina Consultants Ltd
227	Fargo	SCCI Hospital - Fargo
228	Fargo	TLC Laser Eye Center
229	Fargo	UrgentMed
230	Fargo	VA Medical Center
231	Fargo	Valley Anesthesia Assoc PC
232	Fargo	Valley Dermatology Clinic
233	Fargo	Valley Medical Clinic PC
234	Fargo	William C Porter MD
235	Fargo	Bethany Homes
236	Fargo	Bethany Towers I and II
237	Fargo	Edgewood Vista at Edgewood Village
238	Fargo	Elim – A Caring Community
239	Fargo	Good Samaritan Society – Fargo
240	Fargo	Manor Care of Fargo ND, LLC
241	Fargo	MeritCare Hospital TCU
242	Fargo	Pioneer House AL for Seniors
243	Fargo	Riverview Place
244	Fargo	Rosewood On Broadway
245	Fargo	Villa Maria
246	Fargo	Waterford at Harwood Groves
247	Fessenden	Central Dakota Clinic-Fessenden
248	Fessenden	Fessenden Community Clinic
249	Forman	Southeast Med Ctr-Forman
250	Forman	Four Seasons Healthcare Ctr Inc.

251	Fort Totten	Spirit Lake Health Center
252	Ft Yates	Standing Rock IHS Services
253	Gackle	Gackle Care Center
[redacted]	Garrison	Garrison Family Clinic
[redacted]	Garrison	Garrison Memorial Hospital
256	Garrison	Trinity Community Clinic-Garrison
257	Garrison	Benedictine Living Ctr of Garrison
258	Garrison	Garrison Memorial Hosp & NF
259	Glen Ullin	Glen Ullin Clinic
260	Glen Ullin	Glen Ullin Family Medical Center
261	Glen Ullin	Marian Manor HealthCare Center
262	Glenfield	Glenfield Community Clinic
263	Grafton	Grafton Family Clinic
264	Grafton	Unity Medical Center
265	Grafton	Veterans Administration Clinic
266	Grafton	Leisure Estates
267	Grafton	Lutheran Sunset Home
268	Grand Forks	Altru Cancer Center
269	Grand Forks	Altru Clinic
270	Grand Forks	Altru Clinic-Building 1
271	Grand Forks	Altru Clinic-Family Medicine Ctr
272	Grand Forks	Altru Hospital
273	Grand Forks	Altru Hospital Urgent Care
[redacted]	Grand Forks	Altru Rehabilitation Center
[redacted]	Grand Forks	Aurora Urgent Care LLC
276	Grand Forks	Cancer Center of North Dakota
277	Grand Forks	Carl John Fedyszyn MD PC
278	Grand Forks	Family Medicine Associates
279	Grand Forks	Frokjer Petersen Ltd
280	Grand Forks	Grand Forks Family Medicine-Residency
281	Grand Forks	Hogue Vein Institute
282	Grand Forks	ND Eye Clinic Ltd
283	Grand Forks	Northern Valley Obstetrics and Gynecology
284	Grand Forks	Red River Neurology Clinic Ltd
285	Grand Forks	Richard P Stadter Psychiatric Center
286	Grand Forks	Richard P Stadter Psychiatric Center
287	Grand Forks	Steven E Schultz MD PC
288	Grand Forks	The Heart Institute of North Dakota Ltd
289	Grand Forks	The Kidney and Hypertension Center
290	Grand Forks	Truyu Aesthetic Center
291	Grand Forks	UND Student Health Service
292	Grand Forks	Valley Bone and Joint Clinic
293	Grand Forks	Valley Oral & Facial Surgery
[redacted]	Grand Forks	Country Estates
[redacted]	Grand Forks	Parkwood Place
[redacted]	Grand Forks	St. Anne's Guest Home
297	Grand Forks	Tufte Manor
298	Grand Forks	Valley Eldercare Center
299	Grand Forks	Wheatland Terrace
300	Grand Forks	Woodside Village
301	Grand Forks AFB	319th Medical Group
302	Gwinner	Southeast Med Ctr-Gwinner
303	Halliday	Coal Country Comm Hlth Center-Halliday
304	Hankinson	Innovis Health Hankinson
305	Hankinson	St. Gerard's Com Nrsng Home
306	Harvey	Central Dakota Clinic
307	Harvey	St Aloisius Medical Center
308	Harvey	St Aloisius Medical Center Clinic
309	Harvey	St. Aloisius Medical Center
310	Hatton	Hatton Prairie Village
311	Hazen	Sakakawea Hazen Clinic
312	Hazen	Sakakawea Medical Center
313	Hazen	Sakakawea Medical Center Clinic
314	Hazen	Senior Suites at Sakakawea
315	Hebron	Hebron Community Clinic
316	Hettinger	West River Health Clinic
317	Hettinger	West River Regional Medical Center
318	Hettinger	Western Horizons Assisted Living
319	Hettinger	Western Horizons Care Center
320	Hillsboro	Hillsboro Medical Center Hospital
321	Hillsboro	MeritCare Clinic Hillsboro
322	Hillsboro	Comstock Corner
323	Hillsboro	Hillsboro Medical Center
324	Jamestown	Innovis Health Jamestown
325	Jamestown	Jamestown Hospital
326	Jamestown	Medcenter One Jamestown
327	Jamestown	MeritCare Clinic Jamestown
328	Jamestown	North Dakota State Hospital
329	Jamestown	Raymond L Larsen MD
330	Jamestown	Ave Maria Village
331	Jamestown	Bethel 4 Acres Ltd
332	Jamestown	Heritage Centre of Jamestown, Inc.
333	Jamestown	Hi-Acres Manor Nursing Center
334	Jamestown	Rock of Ages, Inc.
335	Jamestown	Roseadele
336	Kenmare	Kenmare Community Hospital
337	Kenmare	Kenmare Health Center
338	Kenmare	Baptist Home of Kenmare
339	Kenmare	Kenmare Comm Hosp–Trinity Hlth
340	Killdeer	Killdeer Medical Clinic
341	Killdeer	Hill Top Home of Comfort
342	Kulm	AMC Clinic-Kulm
343	Kulm	Kulm Community Clinic
344	Lakota	Altru Clinic-Lakota
345	Lakota	Lakota Health Center
346	Lakota	Good Samaritan Society – Lakota
347	Lakota	Good Samaritan Society – Prairie Rose

348	LaMoure	MeritCare Clinic LaMoure
349	LaMoure	Southeast Med Ctr-LaMoure
350	LaMoure	Rosewood Court Assisted Living
[redacted]	LaMoure	St. Rose Care Center
[redacted]	Langdon	Cavalier County Memorial Hospital
353	Langdon	Cavalier County Memorial Hospital Clinic
354	Langdon	Maple Manor Care Center
355	Larimore	Valley Community Health Center
356	Larimore	Good Samaritan Society – Larimore
357	Leeds	Johnson Clinic PC
358	Lidgerwood	Southeast Med Ctr-Lidgerwood
359	Lignite	Lignite Clinic
360	Linton	Linton Hospital
361	Linton	Linton Medical Center
362	Lisbon	Family Medical Clinic
363	Lisbon	Innovis Health Lisbon
364	Lisbon	Lisbon Area Health Services
365	Lisbon	Lisbon Area Health Services
366	Lisbon	Beverly Anne Assisted Living Center
367	Lisbon	North Dakota Veterans Home
368	Lisbon	Parkside Lutheran Home
369	Maddock	Johnson Clinic PC
370	Maddock	Maddock Memorial Home
371	Mandan	Q and R Clinic Mandan East
372	Mandan	Q and R Clinic Mandan North
373	Mandan	Regional Medical Center PC
374	Mandan	SCCI Hospital - Central Dakotas
[redacted]	Mandan	St Alexius Center for Family Medicine
[redacted]	Mandan	Dakota Alpha
377	Mandan	Dakota Pointe
378	Mandan	Medcenter One Mandan Care Center
379	Mayville	MeritCare Clinic Mayville
380	Mayville	Union Hospital
381	Mayville	Luther Memorial Home
382	Mayville	Sun Centers
383	McClusky	Northland Community Health Center
384	McVille	Nelson County Health System Clinic
385	Mcville	Nelson County Health Systems
386	McVille	Nelson Cty Hlth System Care Ctr
387	Medina	Innovis Health Medina
388	Michigan	Michigan Medical Community Clinic
389	Milnor	Milnor Clinic
390	Minot	Center for Family Medicine-Minot
391	Minot	Lloyd Mark Bell DO
392	Minot	Minot Health Center
393	Minot	Neck And Back Pain Clinic
394	Minot	Northwest Cancer Center
395	Minot	Orthopedic Associates
396	Minot	Pathology and Imaging Conslt
397	Minot	Pathology Services PC
398	Minot	Pediatric Associates
[redacted]	Minot	St Alexius Medical Clinic
[redacted]	Minot	Trinity - St Joseph's
401	Minot	Trinity CancerCare Center
402	Minot	Trinity Health Center-Centennial
403	Minot	Trinity Health Center-Medical Arts
404	Minot	Trinity Health Center-Riverside
405	Minot	Trinity Health Center-West
406	Minot	Trinity Health Ctr-Town & Country
407	Minot	Trinity Hospital
408	Minot	Trinity Regional Eyecare-Williams Ctr
409	Minot	Varicose Vein Clinic of Minot
410	Minot	Edgewood Minot Senior Living
411	Minot	Edgewood Vista Memory Care
412	Minot	Emerald Court
413	Minot	Manor Care of Minot ND, LLC
414	Minot	The View on Elk Drive
415	Minot	The Wellington
416	Minot	Trinity Homes
417	Minot AFB	5th Medical Group
418	Minot AFB	Veterans Administration Clinic
419	Mohall	Trinity Community Clinic-Mohall
420	Mohall	Good Samaritan Society – Mohall
421	Moorhead	Family HealthCare Ctr-Moorhead
422	Moorhead	Hendrix Health Center - MSUM
423	Moorhead	Innovis Health Moorhead
424	Moorhead	Lakeland Mental Health
425	Moorhead	MeritCare Clinic Moorhead
426	Moorhead	Prairie St Johns Clinic-Moorhead
427	Mott	West River Health Clinic
428	Mott	Good Samaritan Society – Mott
429	Mountain	Borg Pioneer Memorial Home
430	Napoleon	Napoleon Clinic
431	Napoleon	Napoleon Care Center
432	Napoleon	Napoleon Congregate/AL Apartments
433	New England	Rainy Butte Medical Clinic
434	New England	West River Health Clinic
435	New Rockford	Altru Clinic-New Rockford
436	New Rockford	Community Health Center
437	New Rockford	Heritage House
438	New Rockford	Luth Home of the Good Shep NH
439	New Salem	New Salem Community Clinic
440	New Salem	Elm Crest Assisted Living
441	New Salem	Elm Crest Manor
442	New Town	Minne Tohe Health Center Clinic
443	New Town	New Town Health Center
444	New Town	Trinity Community Clinic-New Town
445	New Town	Good Sam. Society – New Town
446	Northwood	Northwood Deaconess Hlth Ctr
447	Northwood	Valley Community Health Centers
448	Northwood	Northwood Deaconess Hlth Ctr
449	Oakes	Oakes Community Hospital
450	Oakes	Southeast Medical Center
451	Oakes	Good Sam. Society – Royal Oakes
452	Oakes	Good Samaritan Society – Oakes
453	Osnabrock	Good Samaritan Society – Osnabrock
454	Park River	Doctors Clinic
455	Park River	First Care Health Center
456	Park River	Good Samaritan Society – Park River
457	Parshall	Trinity Community Clinic-Parshall
458	Parshall	GSS – Rock View at Parshall
459	Powers Lake	Tioga Medical Center-Powers Lake

460	Ray	Tioga Medical Center-Ray
461	Richardton	Richardton Health Center
462	Richardton	Richardton Health Center Clinic
[redacted]	Rock Lake	Towner County Medical Center
[redacted]	Rolette	Northland Community Health Center
465	Rolette	Rolette Community Care Center
466	Rolla	Presentation Medical Center
467	Rolla	Rolla Clinic PC
468	Rolla	Park View Manor Assisted Living
469	Rugby	Heart Of America Medical Center
470	Rugby	Johnson Clinic PC
471	Rugby	Haaland Estates – Assisted Living
472	Rugby	Haaland Estates – Basic Care
473	Rugby	Heart Of America Medical Center
474	Scranton	West River Health Clinic
475	Sherwood	Trinity Community Clinic-Sherwood
476	Stanley	Mountrail County Medical Center
477	Stanley	Mountrail County Medical Center Clinic
478	Stanley	Patels Medical Clinic
479	Stanley	Mountrail Bethel Home
480	Steele	Kidder County Community Health Clinic
481	Steele	Prairie Health Clinic
482	Steele	Medcenter One Golden Manor
483	Strasburg	Strasburg Nursing Home
484	Tioga	Tioga Medical Center
485	Tioga	Tioga Medical Center Clinic
486	Tioga	Tioga Medical Center LTC
[redacted]	Towner	Johnson Clinic PC
[redacted]	Trenton	Trenton Community Clinic
489	Turtle Lake	Community Memorial Hospital
490	Turtle Lake	Northland Community Health Center
491	Underwood	Underwood Clinic
492	Underwood	Medcenter One Prairieview
493	Valley City	Innovis Health Valley City
494	Valley City	Mercy Hospital
495	Valley City	MeritCare Clinic Valley City
496	Valley City	MeritCare Valley City Eye Clinic
497	Valley City	HI Soaring Eagle Ranch
498	Valley City	Sheyenne Care Center
499	Velva	Trinity Community Clinic-Velva
500	Velva	Souris Valley Care Center
501	Velva	Valley View Manor
502	Wahpeton	Innovis Health Wahpeton
503	Wahpeton	Medical Arts Clinic
504	Wahpeton	MeritCare Clinic Wahpeton
505	Wahpeton	St. Catherine's Living Center
506	Wahpeton	The Leach Home
507	Walhalla	Walhalla Clinic
508	Walhalla	North Border Estates
509	Walhalla	Pembilier Nursing Center
510	Washburn	Washburn Clinic
[redacted]	Washburn	Washburn Family Clinic
[redacted]	Watford City	McKenzie County Clinic
513	Watford City	McKenzie County Health Systems Inc
514	Watford City	Horizon
515	Watford City	McKenzie Cty HC Systems
516	West Fargo	Innovis Health West Fargo
517	West Fargo	LilyCare Clinic
518	West Fargo	MeritCare Clinic West Fargo
519	West Fargo	Eventide Sheyenne Crossings
520	Westhope	Trinity Community Clinic-Westhope
521	Westhope	Westhope Home
522	Wildrose	Wildrose Clinic
523	Williston	Comprehensive Pediatric Care PC
524	Williston	Craven Hagan Clinic Ltd
525	Williston	Fairlight Medical Imaging
526	Williston	Great Plains Womens Health Center
527	Williston	Joseph E Adducci MD PC
528	Williston	Mercy Health Partners Specialty Group
529	Williston	Mercy Medical Center
530	Williston	Mercy Mental Health Clinic
531	Williston	Nelson Cancer Treatment Center
532	Williston	Salem S Shahin MD
533	Williston	Trinity Community Clinic-Western Dakota
534	Williston	Trinity Regional Eyecare-Williston Basin
535	Williston	Wayne L Anderson MD FACS
536	Williston	Williston Radiology Consultants
537	Williston	Williston VA Clinic
538	Williston	Bethel Lutheran Home
539	Williston	Kensington Williston LLC
540	Wilton	Redwood Village
541	Wishek	Wishek Community Clinic
542	Wishek	Wishek Community Hospital and Clinics
543	Wishek	Prairie Hills Assisted Living
544	Wishek	Wishek Home for the Aged
545	Zeeland	AMC Clinic-Zeeland

Urgent Medicine Associates, LLC

Kurt Kooyer, MD, FAAP
Internal Medicine and Pediatrics

February 10, 2009

Dear Legislative Committee,

I am a board-certified internist and pediatrician practicing in Fargo since 2002. Prior to that my wife and I (my wife is also a physician) spent eight years living and working among the poor in the Mississippi Delta. During that time, Mississippi witnessed an explosion of malpractice lawsuits. Hardest hit were specialties such as OB-GYN, neurosurgery and trauma surgery, though for a time, I did not know a private practice physician in my area who had not been sued. One gastroenterologist had been sued thirty times in frivolous prescription drug litigation.

As a result, the cost of malpractice insurance skyrocketed—and then became unavailable altogether. Family practice doctors were forced to stop delivering babies. Then obstetricians were stopped—or severely limited —from delivering babies. Mississippi's statewide trauma network crumbled for lack of trauma surgeons. There were terrible outcomes because patients with head injuries were deprived of timely access to a neurosurgeon. When I left the state in 2002, there were no more insurance companies writing malpractice policies. The state of Mississippi had to form a government sponsored risk-retention pool to cover many doctors who otherwise would not have had malpractice coverage. My own insurance company, Doctors Reciprocal out of Virginia, sold me a $24,000 tail policy so I could get out of Mississippi—a policy which became worthless five months later when the company went into receivership.

Many states suffered as Mississippi did until fair and reasonable tort reforms were instituted. As a result of meaningful tort reform—including caps on non-economic damages—Mississippi's malpractice climate is improving. While it is expected to take years to recover, physicians are coming back and access to health care is improving in many parts of Mississippi.

While there are those who say that we shouldn't put a limit on what someone's pain and suffering is worth, the fact is, in too many states without non-economic damage caps, the trial lawyers have shut the door on that discussion. Spurred by the potential for mega-verdicts and mind-boggling contingency fees, trial lawyers have mocked our courts by bringing forth cases where they know there has been no injury and where there has been no negligence—supposed essential elements in any tort claim. No state unprotected by tort reform is immune from this type of abuse. All it takes is one lawyer in one jurisdiction to start the ball rolling.

My wife and I left Mississippi because we learned that even one non-meritorious lawsuit is devastating. After six years in North Dakota, we find ourselves no longer overwhelmingly distracted by fears of frivolous lawsuits. We don't think for a minute, however, that lawsuit abuse could never happen in North Dakota. Abuse which would have a terrible impact on physicians, patients, and access to healthcare across our state. Abuse which could begin with the reversal of an important check on frivolous litigation.

I respectfully and strongly urge a DO-NOT-PASS on HB 1390.

Sincerely,

Kurt Kooyer MD

Kurt Kooyer, MD

3290 20th Street South, Fargo, ND 58104

(701) 232-9000, (701) 893-9057 fax

"It's like the lawyers are playing doctors there."
– **Dr. Kirk Kooyer,** Fargo doctor commenting on Mississippi

Doctor flees lawsuit-crazy Mississippi

He's national poster boy for medical tort reform

By Gerry Gilmour
ggilmour@forumcomm.com

In the case of Dr. Kirk Kooyer, Mississippi's loss is North Dakota's gain.

Disgusted with out-of-control litigation and astronomical jury awards, Kooyer recently pulled up stakes in the Mississippi Delta and moved to Fargo to join MeritCare Health Systems.

He's one of more than an estimated 100 physicians who have left Mississippi because of the rising cost of malpractice insurance and the risk of career-ending litigation.

"It's a crying shame we're losing another doctor – especially one of his talent," Dr. Chris Glick, a university hospital physician and president-elect of the National Perinatal Association, said Thursday from Jackson, Miss.

The Mississippi Legislature is meeting in special session this week to consider tort reform changes. "It looked like it was all but dead this morning," Glick said. "It looks like it won't happen. At least not this time."

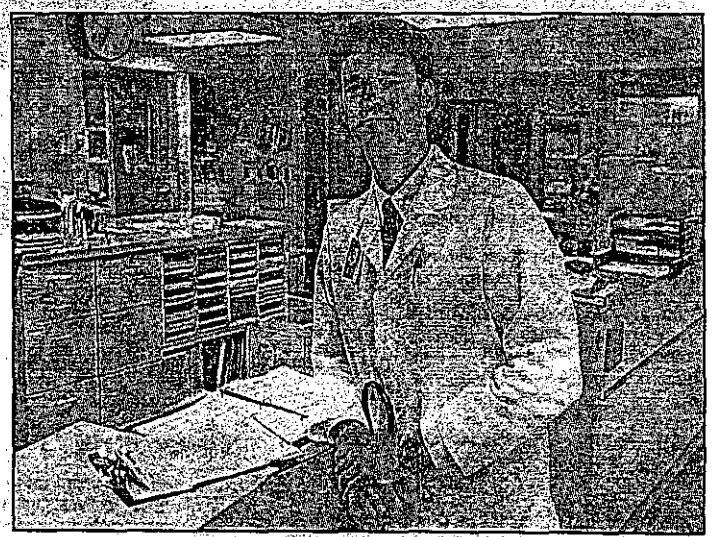
According to the Mississippi Medical Association, payouts in malpractice suits in the state the first quarter of this year totaled more than payouts in all of 2001. The association estimates 550 new malpractice lawsuits will be filed this year.

"It's like the lawyers are playing doctors there," Kooyer said Thursday morning during a stop at the MeritCare South University walk-in clinic. "It isn't ethical. It isn't moral. But it's legal."

Kooyer works at the MeritCare clinic full time, but Thursday was enjoying a day off – something he rarely had while serving as the only pediatrician in Sharkey and Issaquena counties, which are two of the nation's poorest.

Though it wasn't something he sought, Kooyer has become a national poster boy of sorts for medical tort reform. Thursday's day off included interviews by The Forum, Reuters News Service and Medical Economics magazine.

DOCTOR: Page A4



Bruce Crummy / The Forum

Dr. Kirk Kooyer works in the walk-in clinic at MeritCare in Fargo after serving the poor in Mississippi for many years.

DOCTOR: Medical peers sued to tune of millions

From Page A1

Kooyer has been featured on a national broadcast of FOX-News, been summoned to a tort reform roundtable by President Bush, and has been served up as an example of what's wrong with business in Mississippi in a Wall Street Journal editorial last week.

"Pediatrician Kirk Kooyer became so fed up he moved to North Dakota last month, saying he couldn't take 'the harassment of dealing with merit-less lawsuits,'" the Sept. 12 editorial said.

Change for the better

Truth be told, Kooyer, 40, likes it here. And it's not as though he threw a dart at a map of the nation to choose North Dakota. His wife, University of North Dakota School of Medicine graduate Dr. Maria Weller, is a native of Gwinner, N.D.

They've settled in nicely already in West Fargo with their 20-month-old daughter, Ella, and just two blocks from Eastwood Elementary School, where twin sons, Andrew and Will, attend separate first-grade classes.

Kooyer, a native of Grand Rapids, Mich., and Weller met while residents at Butterworth Hospital in Grand Rapids.

Having passed board examinations as a specialist in internal medicine and pediatrics, Kooyer had a lot of offers. He also heard a calling.

"I called it a Christian calling. I guess the president would call it a spirit of citizenship," Kooyer said.

Working with poor

In 1994 he became the staff physician at the Cary (Miss.) Christian Center. His first year there, he didn't take a salary. In fact, he took out a loan to pay his nurse and staff.

What he found was profound poverty and a predominantly black population. The counties his clinic served had the highest teen pregnancy and infant mortality rates in the state. Ninety percent of the black children were born to single mothers, some as young as 12 years of age.

"There are not a lot of father figures, and there is a lot of ignorance," Kooyer said. Recognizing a need, Kooyer introduced prenatal classes and instituted a home visit program for new mothers and their newborns. And, as a pediatrician – the only one in a 100-mile range – he was able to save some babies who otherwise might have died.

Kooyer oversaw hundreds of births at the Sharkey-Issaquena Community Hospital in Rolling Fork.

"Going into the area to practice, if your goal is to improve the plight of the people, you're going to be disappointed. You have to measure saves by individuals," he said.

During his time there, the infant mortality rate – once as high as 30 per thousand live births – was reduced by at least half. For his part in improving the health of mothers and babies, he was recognized in 2000 by the National Perinatal Association.

"You would be horrified if you saw the conditions people live in in those counties," Glick said. "The changes (Kooyer) made there are nothing short of miraculous in the face of that desperate poverty."

> *I was disgusted. I felt like a victim. Doctors don't stand a chance. It's not justice. It's extortion.*
>
> **Kirk Kooyer**
> New MeritCare physician

Victim of the system

While practicing, Kooyer became familiar with the people, culture, geography and history of the Mississippi Delta. He also watched in awe as his medical peers in the state were sued to the tune of millions.

Newspapers and political pundits in the state have come to call it "Jackpot Justice" and "Lawsuit Lottery."

Kooyer said he felt ashamed when his own attorney advised he settle, rather than risk losing at a jury trial, a wrongful death lawsuit filed after a patient died of a rapidly advancing infection.

"I was disgusted. I felt like a victim," Kooyer said. "Doctors don't stand a chance. It's not justice. It's extortion."

Kooyer said he denied one of his patients' requests for the now-banned diet combination drug fen-phen. She got the drug from another physician and later proudly showed Kooyer her $125,000 settlement check from a class action lawsuit. Ironically, Kooyer said, the woman has a healthy heart.

The pharmacist involved in the case, Kooyer said, ended up losing his business.

The last straw for Kooyer came the day after Easter. He was hit with a multimillion-dollar lawsuit from a patient who had taken Propulsid, a heartburn and anti-reflux drug the U.S. Food and Drug Administration has linked to 80 deaths nationally.

"Actually, I didn't get hurt by Propulsid," the patient later told Mississippi's Clarion-Ledger newspaper. Because she had taken the drug, she said she thought she could join a class-action lawsuit "and I might get a couple thousand dollars."

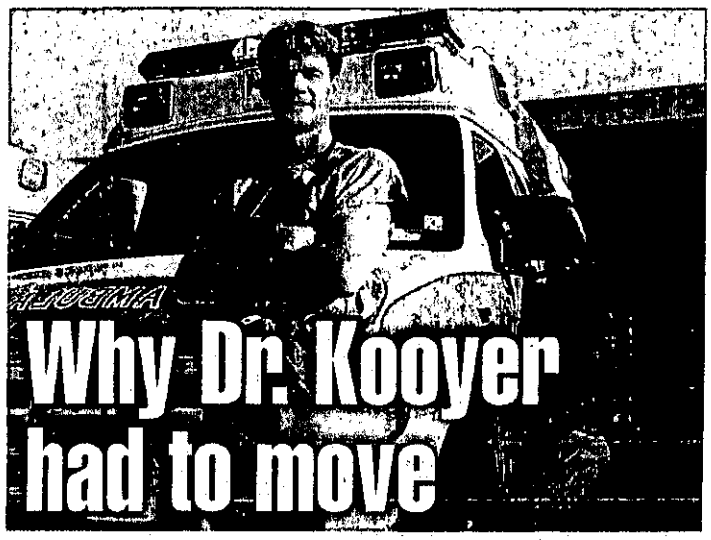
The woman went on to praise Kooyer's skill as a doctor. "It's ironic he's being run off because he's the kind of guy we need in the Delta," Glick said.

The day after he was served with the latest lawsuit, Kooyer booked a flight to Fargo and interviewed with a panel at MeritCare.

MeritCare was more than glad to hire him. In fact, MeritCare has hired Dr. Weller – who still faces a lawsuit in Mississippi – to begin working at the pediatric walk-in clinic later this year.

"We were very impressed with him as a physician and as an individual," said Paulette Amundson, MeritCare executive partner for regional and community care services. "His values fit well with MeritCare's values."

Readers can reach Forum Business Editor Gerry Gilmour at (701) 241-5560



Why Dr. Kooyer had to move

This doctor wanted to help the poor in the Mississippi Delta. The malpractice climate drove him away.

By Dorothy L. Pennachio
SENIOR EDITOR

When the malpractice crisis became unbearable in Rolling Fork, MS, pediatrician Kurt W. Kooyer, 40, headed toward the frontier but less litigious climate of North Dakota, where premiums are low, claims are few, awards are capped, and people, he says, are just plain nicer.

His story moved President Bush to cite him as an example of why tort reform is urgently needed.

Kooyer and his wife, pediatrician Maria L. Weller, both members of the Christian Reformed Church, came out of residency idealistic and wanting nothing more than to do good.

Board certified in pediatrics and internal medicine, Kooyer arrived in the Mississippi Delta in July 1993 to work at the Cary Christian Center Medical Clinic. He received no salary at first, but the clinic paid his malpractice premium—then $4,000.

After one year, Kooyer and fellow physician Andrew George founded the Delta Care Rural Health Center. Many patients had no insurance, but the clinic was entitled to cost-based reimbursement from the government for its Medicaid and Medicare patients. Kooyer's salary grew to $70,000—about half of what he could earn elsewhere. By 2000, he'd received the National Perinatal Association's Individual Recognition Award, acknowledging his work in one of the most medically challenged areas in the country.

It didn't take long for the litigation to start

Before he'd been in practice two years, Kooyer was named in a wrongful death suit in which a patient died of a rapidly advancing infection.

"We fought the allegations for more than two years," Kooyer says. "I attended the plaintiffs' depositions and could hardly believe the lies and orchestrations." In view of the fact that Kooyer's malpractice carrier had gone into bankruptcy, his attorney told

him he could not in good conscience let the case go to a jury trial. Kooyer reluctantly agreed to settle.

"It's not justice; it's extortion," he says. "Doctors who've done nothing wrong are settling suits. As a result, the National Practitioner Data Bank is losing its effectiveness as a policing tool. Instead, it's becoming a *Who's Who* of doctors in America."

It was a second lawsuit, this one involving Propulsid (cisapride), that convinced Kooyer and his wife to leave the state. By then, his malpractice premium had grown to $13,000.

"I was served by the sheriff on the day after Easter 2002," recalls Kooyer. "The complaint sought economic, noneconomic, and even punitive damages against me."

Propulsid has been shown to cause harm in patients with QT prolongation, according to the FDA. By the end of 1999, use of the drug had been associated with 341 cases of heart rhythm abnormalities, including 80 deaths. In July 2000, the manufacturer stopped marketing the drug.

In Kooyer's case, though, his patient hadn't suffered any negative consequences. "Actually, I didn't get hurt by Propulsid," plaintiff Hazel Norton told The [Jackson] Clarion-Ledger. Norton claimed she didn't know she was suing Kooyer.

"Hundreds of Mississippi doctors are being sued in mass tort drug cases now, and many times, the patients aren't even aware their doctors are named," says Kooyer. "Where's the shame? That kind of behavior's not ethical, but apparently it's legal in Mississippi." Due to Norton's objections, her attorney dismissed Kooyer from the case, but not before the doctor had made up his mind to go away from what he saw as an oppressive legal climate. Kooyer and his wife left Mississippi in August.

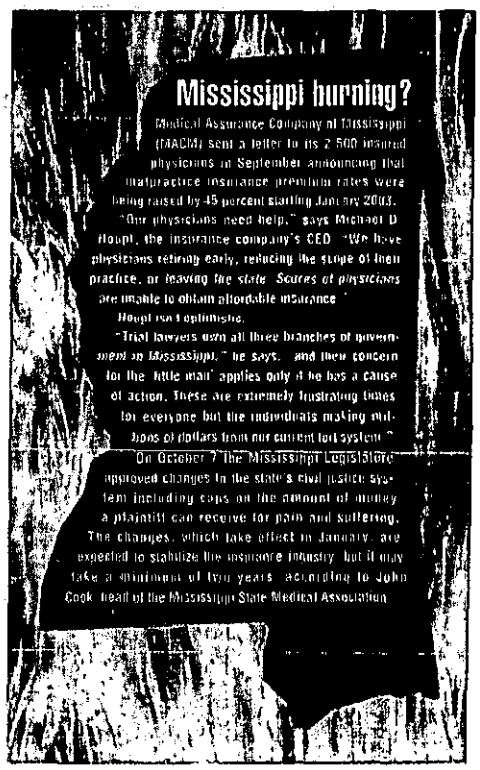
"Don't turn your red cross into a bull's eye"

When Kooyer was approached by *60 Minutes* earlier this year, he was tempted to tell his story, but his attorney advised him against it. He said, according to Kooyer, "Don't turn your red cross into a bull's eye." The attorney told him he'd only make himself a bigger target for litigation.

"Having to fear personal harm for speaking out about an injustice—isn't that an old tradition in Mississippi?" comments Kooyer.

He began to speak to the media only after he'd secured tail coverage. He feared that the premium would be much higher if the insurance company had perceived that his risk had increased. As it was, the tail is costing upward of $24,000.

"I don't care to practice any longer in a state where so many people are willing to behave unethically just because it benefits them financially," says Kooyer. "When you have patients who sue even though there's nothing wrong with them and lawyers who sue doctors who they know have done noth-



Mississippi burning?

Medical Assurance Company of Mississippi (MACM) sent a letter to its 2,500 insured physicians in September announcing that malpractice insurance premium rates were being raised by 45 percent starting January 2003.

"Our physicians need help," says Michael D. Houpt, the insurance company's CEO. "We have physicians retiring early, reducing the scope of their practice, or leaving the state. Scores of physicians are unable to obtain affordable insurance."

Houpt isn't optimistic.

"Trial lawyers own all three branches of government in Mississippi," he says, "and their concern for the 'little man' applies only if he has a cause of action. These are extremely frustrating times for everyone but the individuals making millions of dollars from our current tort system."

On October 7, the Mississippi Legislature approved changes in the state's civil justice system including caps on the amount of money a plaintiff can receive for pain and suffering. The changes, which take effect in January, are expected to stabilize the insurance industry, but it may take a minimum of two years, according to John Cook, head of the Mississippi State Medical Association.

ing wrong, that's a departure from personal ethics. It's not so much a crisis of tort as it is a crisis of character."

One person who learned of Kooyer's situation was President Bush. In August he cited the doctor in a speech about tort reform during a visit to Mississippi.

"[Kooyer's] got a heart," said the president. "But because of frivolous lawsuits, because every time he turns the corner, somebody might sue him, and because of his rising liability insurance premiums, he's leaving your state. He doesn't want to leave your state, he loves Mississippi, he loves helping those who need help . . . but he's had it."*

As a result of Kooyer's departure from Mississippi, Sharkey and Issaquena counties, two of the most impoverished in the country, are left without a pediatrician, and the community hospital is left with a staff of only two physicians. Administrator Winfred Wilkinson told The Clarion-Ledger that the loss of Kooyer would put a severe strain on that staff.

"It's going to be hard to replace him, and whoever comes will face the same thing," he said. "It's the patients who suffer." Since Kooyer arrived eight years ago, the counties' infant mortality rate declined from an average of 10 deaths per 1,000 live births to 3.4.

North Dakota: personal integrity and self-reliance

A commendable mind-set prevails in North Dakota and other upper Midwestern states, says Kooyer.

"It's simple. People are raised to do the right thing. For the most part, they don't accuse people unjustly or take things that don't belong to them. There's an emphasis on personal integrity and self-reliance. People know the difference between right and wrong."

And North Dakota laws reflect that. There's little focus on medical malpractice. As of Nov. 1, 2002, the National Practitioner Data Bank had received only 277 medical malpractice reports for the state. Mississippi has almost five times as many.

"When I arrived and asked doctors about the affordability of malpractice insurance in this state, they just looked at me blankly," says Kooyer. "They were pretty sure they had coverage, but they didn't think about it much. What a difference!"

Today Kooyer works for MeritCare Health Systems, a large, not-for-profit corporation in Fargo. His salary has nearly doubled. ■

*See "Special Report: A presidential boost for tort reform," Sept. 9, 2002 (also available at www.memag.com).

Coming soon

MEDICARE
Will patients pay the price?
Are doctors turning away Medicare patients because reimbursements have been cut, as some media accounts charge? We found out for ourselves.

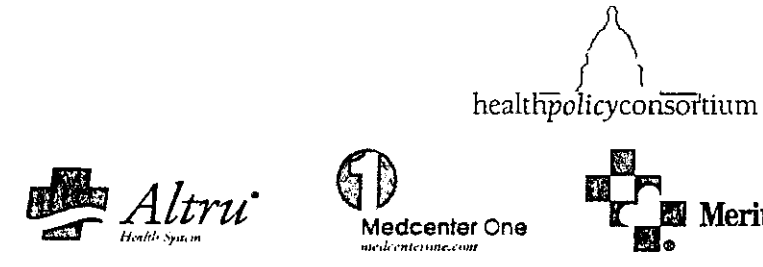
Frank words from the top
The outspoken CMS administrator says he's an advocate for physicians, but don't expect much good news any time soon.

Can your patient's victim sue you?
When you prescribe medication that can cause drowsiness, not warning patients about the effects can put *you* at risk.

Bone scans at the drugstore?
Pharmacy-based screenings can be a time saver. But are they accurate? And will you see the results?

PRACTICE POINTERS:
When you ask for payment, do it right
Clear wording, good design, and good timing will boost patient satisfaction—and collections, too.

FINANCIAL PROBLEM SOLVED
"My daughter wants a loan"
The start of a new feature series. You ask us the questions, a financial adviser answers them in a bit more depth than the quick takes you get in Money Management Q&As.



North Dakota 2009 Legislative Session
House – Judiciary Committee
Testimony on House Bill 1390
February 11, 2009

Chairman DeKrey and Members of the Judiciary Committee:

My name is Beverley Adams and I am the Executive Director of the Health Policy Consortium (HPC) which is comprised of the four largest integrated Health Systems in the State of North Dakota. They are Altru (Grand Forks), MedCenter One (Bismarck), MeritCare (Fargo) and Trinity (Minot). We strongly oppose HB 1390 to repeal the non-economic damages cap on medical malpractice cases.

Collectively, the HPC has over 800 employed physicians. The HPC members employ a large number of their physicians, rather than the traditional practice method where the physicians are a separate business group that has privileges to work at the hospital. We provide specialty and sub-specialty care in a number of medical services that we provide. The HPC members provide 80% of all healthcare services for the citizens of the State of North Dakota. The HPC members are also the Safety Net health care providers for the more complex medical needs of the citizens of the State. The HPC members provide the more advanced care such as comprehensive trauma centers, orthopedics, cardiology, children's hospital specialties, neonatology, organ transplants, nephrology, cancer treatments, dermatology and reproductive specialists.

The HPC members provide over $100 Million in charity care/community benefit in either the form of bad debt or charity care services each year on behalf of the patients that they serve. This includes providing healthcare services to the more than 60,000 under and uninsured North Dakotans.

Currently under North Dakota law there is no cap on economic damages. Those are damages that we can assign a dollar number to. For example, lost wages, past and future medical expenses, additional travel and child care expenses, etc. Non-economic damages are damages for pain and suffering,

emotional distress, loss of consortium or companionship, and other intangible injuries. These damages involve no direct economic loss and have no precise value. It is very difficult for juries to assign a dollar value to these losses, given the minimal guidance they customarily receive from the court. As a result, these awards tend to be erratic and because of the highly charged environment of personal injury trials, excessive.

In State civil justice systems that lack reasonable limits on liability, multi-million dollar jury awards and settlements in medical liability cases have forced many insurance companies, to either leave the market or substantially raise costs. Increasingly physicians in these states are choosing to stop practicing medicine, abandon high-risk parts of their practices like delivering babies and surgery or move their practices to one of the thirty states that has a cap on non-economic damages.

Three reasons why removal or increase of the non-economic damages will produce bad results:

1. Malpractice premiums will increase because of the unpredictability of awards for these types of claims;
2. Rural areas feel the effects of caps most acutely and more importantly the amount of the cap matters as it affects the supply of physicians;
3. Physicians will practice defensive medicine, which ultimately increases the cost of providing care and for million North Dakota that would mean approximately $58.4 in increased healthcare costs;

It is extremely unfortunate that all medical procedures don't have the greatest expected outcome. Physicans take an oath to do no harm to patients. However, they are human and unfortunately in rare circumstances a result is not positive. The HPC members have been acknowledged by the Dartmouth Group as some of the highest quality healthcare providers in the nation.

Removing the caps or increasing them will have an impact on malpractice premiums. The United States General Accounting Office completed a study in August of 2003 relating to Medical Malpractice and the Implications of Rising Premiums on Access to Health Care. Exhibit 1 is a slide that shows the average percentage growth in malpractice premium rates from 1996 to

2002. In 2002 alone the premiums rose 20% more in states that had no caps compared to states that had caps of $500,000.00 like North Dakota. Exhibit 2 is a side from the same GAO report that showed the increase in premium rates on three specialty practice areas, general surgery and internal medicine, and OB/GYN. General surgery malpractice premium rates were 22% higher than states with $500,000.00 caps in place in 2002.

Removing medical malpractice or increasing non-economic caps causes physicians to practice in other states that have caps. A study was completed by two senior economists for the Federal Agency for Healthcare Research and Quality, in 2005 and printed in the Health Tracking journal. The study concluded that rural areas feel the effects of caps most acutely and that the amount of the cap matters. Counties in states with a cap had 2.2 percent more physicians per capita because of the cap and rural counties in states with a cap had 3.2 percent more physicians per capita. Rural counties in states with a $250,000.00 cap had 5.4 percent more obstetrician-gynecologists and 5.5 percent more surgical specialists per capita than did rural counties in states with a cap above $250,000.00. Therefore even increasing the caps above $500,000.00 has a serious negative impact on the recruitment of surgeons and OB/GYN's in rural areas. Exhibit 3.

Removing malpractice caps or increasing them also causes physicians to practice defensive medicine. Defensive medicine means that more tests and procedures that are not medically necessary but protect doctors from lawsuits are completed. A study in 2006, published in the American Journal of Public Health by two senior economists associated with the Federal Agency for Healthcare Research and Quality, found that laws limiting malpractice payments lower state health care expenditures by between 3% and 4%, which equates to $92.00 per capita. According to that data, in North Dakota, removing the caps would result in an increase in health care expenditures by approximately $58.4 Million. The greatest irony is that defensive medicine may be counterproductive and actually increase malpractice risk.

Right now, North Dakota has the lowest premium rates in the nation. Exhibit 4 – 2008 Milliman Study comparing private insurance premiums and reimbursement with surrounding States, however, that will not exist if the non-economic damages cap is increased or removed.

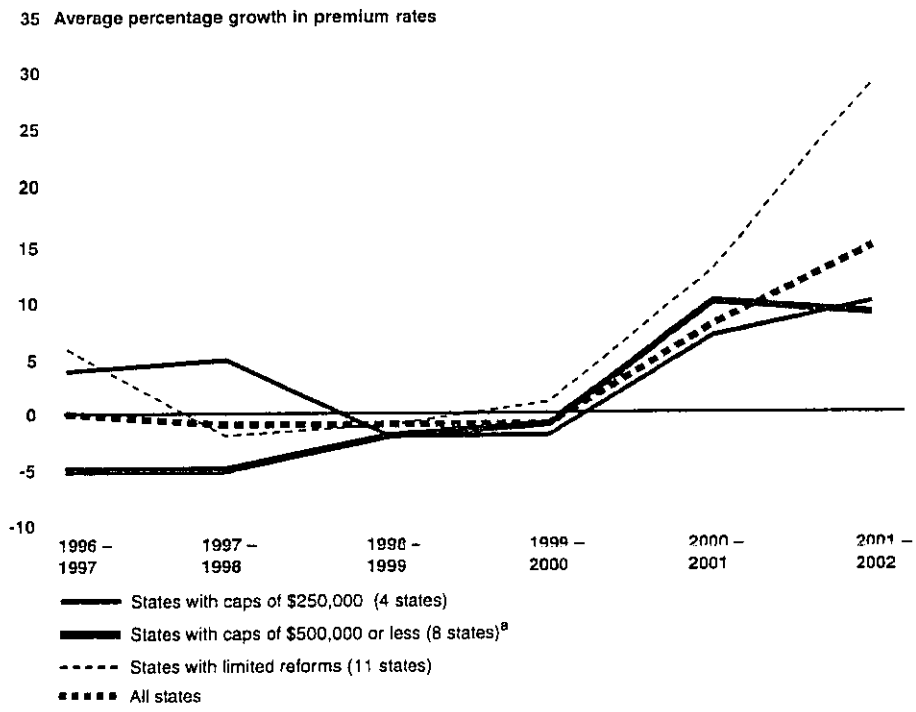
It makes no sense that while the rest of the nation is trying to lower healthcare costs and impose some type of caps that North Dakota would look at removing or even increasing caps. Also, the studies show that the amount of the caps make a difference in where physicans are willing to practice. Some states have caps as low as $250,000.00. A $500,000.00 non-economic damages cap is not unreasonable.

This Bill if passed would benefit personal injury trial lawyers and a very few plaintiffs to the detriment of every citizen of North Dakota, both from the cost of healthcare and the access to healthcare. To pass a law that benefits a few to a significant detriment of the many, is not wise policy.

I appreciate your time this morning. I want to reinforce our support for all of the arguments made this morning to defeat this bill. Our thousands of patients would be best-served if the current law is unchanged.

Please consider these comments as you deliberate on HB 1390. Chairman DeKrey and members of the Judiciary Committee, thank you for the time to speak to you today. I am available to answer any questions that you may have at this time.

Figure 5: Premium Rates for Three Physician Specialties Rose After 2000, but to a Lesser Extent in States with Noneconomic Damage Caps



Source: MLM.

Notes: GAO analysis of MLM base premium rates, excluding discounts, rebates, and surcharges, reported for the specialties of general surgery, internal medicine, and OB/GYN.

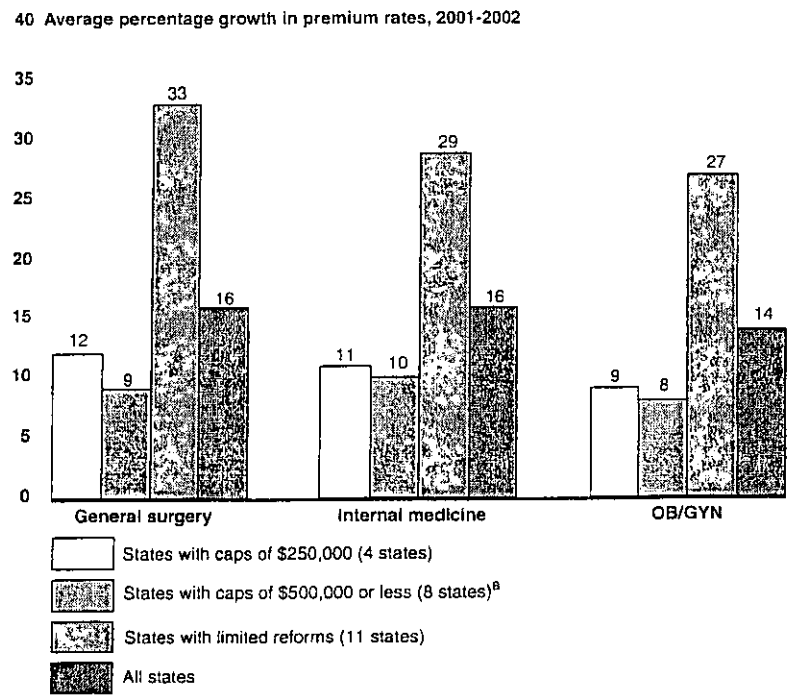
Premiums are adjusted for inflation to 2002 dollars.

[a]This category excludes states with caps of $250,000.

The recent increases in premium rates were also lower for each reported physician specialty in the states with these noneconomic damage caps. From 2001 to 2002, the average rates of premium growth for each specialty in the states with these noneconomic damage caps were consistently lower than the growth rates in the limited reform states. (See fig. 6.)

Exhibit 1

Figure 6: Recent Premium Growth Was Lower for Three Physician Specialties in States with Noneconomic Damage Caps



Source: MLM.

Note: GAO analysis of MLM base premium rates, excluding discounts, rebates, and surcharges, reported for the specialties of general surgery, internal medicine, and OB/GYN.

Premiums are adjusted for inflation to 2002 dollars.

[a]This category excludes states with caps of $250,000.

In addition to including rates for only three specialties, premium rates reported by MLM are subject to other limitations. First, because MLM relies on a voluntary survey, its data do not include all insurers that provide coverage in each state. Certain companies that may have a large market share in a particular state may not be included. MLM estimates that its 2002 survey may exclude about one-third of the total malpractice insurance market nationwide. Second, insurers that do report rates have not consistently done so across all the years, or have not consistently reported premiums in different geographic areas within each state. We generally excluded data from insurers that did not consistently report premium rates across most of the years studied. Third, premium rates do not reflect discounts, premium offsets, or rebates that may effectively reduce the actual premium rate, or surcharges that are assessed in certain

Exhibit 2

TRENDS

Have State Caps On Malpractice Awards Increased The Supply Of Physicians?

Data from U.S. counties indicate that rural areas feel the effects of caps most acutely and that the amount of the cap matters.

by William E. Encinosa and Fred J. Hellinger

ABSTRACT: Twenty-seven states have laws that cap payments for noneconomic damages in malpractice cases. In this study we examined whether these laws have increased the supply of physicians, using county-level data from all fifty states from 1985 to 2000. Counties in states with a cap had 2.2 percent more physicians per capita because of the cap, and rural counties in states with a cap had 3.2 percent more physicians per capita. Rural counties in states with a $250,000 cap had 5.4 percent more obstetrician-gynecologists and 5.5 percent more surgical specialists per capita than did rural counties in states with a cap above $250,000.

THERE IS MUCH EVIDENCE indicating that a state's legal environment influences the frequency and size of malpractice awards there.[1] Thus, it is reasonable to expect that the supply of physicians per capita and access to care would be greater in states with laws that limit payments in medical malpractice cases. Yet a recent report by the U.S. Government Accountability Office (GAO) did not find this to be the case.[2] However, the GAO report relied heavily on data from a relatively small number of interviews with providers in five states and on Medicare utilization data for only three procedures in these five states.

This study extends the findings of our earlier study examining how state laws that limit damages payments in malpractice cases affect the geographic distribution of physicians.[3] The earlier study was released by the Agency for Healthcare Research and Quality (AHRQ) in July 2003. Using county-specific data from 1996 and 2000 to explain the geographic distribution of physicians across counties, it found that counties in states with caps on damages awards had more physicians per person than counties in states without caps. However, this finding was only a picture of physician supply after caps had been in place for a while (twenty-two states already had caps in place by 1996).

In this study we expanded our county analyses to include data from years both before and after most states had adopted caps (1985–2000). Twenty states introduced caps during this period, so we could conduct a before-and-after analysis of the effects of caps within each county. Moreover, our expanded study examined the impact of the size of the caps on the supply of physicians, the differential impact of caps on physician supply in rural and urban areas, and the impact of caps on the supply of two types of physicians that have been particularly hard hit by the surge in medical mal-

William Encinosa (wencinos@ahrq.gov) and Fred Hellinger are senior economists in the Center for Delivery, Organization, and Markets, Agency for Healthcare Research and Quality (AHRQ), in Rockville, Maryland.

DOI 10.1377/hlthaff.W5.250

practice premiums: surgeons and obstetrician-gynecologists (OB-GYNs).

Background On Malpractice Award Caps

Proponents of legislation that caps malpractice damages awards maintain that high malpractice rates are driving physicians out of business or to states where such awards are capped. They also maintain that excessive jury awards for pain and suffering, and for punitive damages, vary widely because there is no accepted process by which juries assign dollar values to these concepts.

Opponents of tort reform legislation that caps damages awards in malpractice cases (principally, trial lawyers and some consumer groups) maintain that poor quality of care and poor investments by insurance companies are to blame for the recent spike in malpractice insurance premiums. Opponents argue that caps will harm those patients who suffer the most harm and who need help the most. Recent evidence suggests that caps may be regressive and hurt low-wage workers, women, and the elderly—those who rely on the noneconomic damages portion of malpractice awards for adequate compensation.[4] Opponents also maintain that medical malpractice claim payments are not the underlying cause of rapidly rising malpractice premiums.[5]

In March 2003 the U.S. House of Representatives passed a bill capping damages awards in medical malpractice cases (the Help Efficient, Accessible, Low-Cost, Timely Healthcare [HEALTH] Act of 2003, H.R. 5). However, on 9 July 2003, efforts to pass similar legislation in the U.S. Senate (the Patients First Act of 2003, S. 11) failed. Although President George W. Bush continues to support proposals that cap noneconomic damages payments at $250,000 in malpractice cases, Congress has not yet passed such legislation.

The effort to adopt a federal cap on malpractice awards is largely a response to recent increases in malpractice premiums.[6] Over the past two years, physicians in New Jersey, West Virginia, and Florida have carried out work stoppages in response to the rapid premium increases and to support state legislation limiting payments for noneconomic damages in malpractice cases.[7] Malpractice premium rates for internists, general surgeons, and OB-GYNs rose, on average, 25 percent, 25 percent, and 20 percent, respectively, in 2002.[8] In some states, a few specialties have seen premium increases of as much as 75 percent.

In response, legislation limiting noneconomic damages awards in malpractice cases was signed into law in Nevada and Mississippi in 2002; in Florida, Ohio, and Texas in 2003; in Oklahoma in 2004; and in South Carolina in 2005.[9] Twenty-seven states now have laws capping noneconomic damages or limiting total damages (Exhibit 1).[10]

Although there is relatively little information in the literature about the impact of caps on access, there are numerous studies of their impact on malpractice premiums. A number of studies based on data from the 1970s and 1980s have shown that tort reform laws that limit payments in malpractice cases result in lower premiums.[11] Moreover, a recent study by Kenneth Thorpe found that malpractice premiums in states with caps on malpractice awards are 17 percent lower on average than in states without caps.[12]

Indeed, malpractice premiums vary considerably across states. For example, in Florida, annual premiums for OB-GYNs ranged from $143,000 to $203,000 in 2001 (a year in which Florida had no cap). In contrast, in California, which has had a cap since 1975, annual premiums for OB-GYNs ranged from only $23,000 to $72,000. Similarly, annual premiums for surgeons in Florida ranged from $63,000 to $159,000, while in California they only ranged from $14,000 to $42,000.[13]

Such wide premium differences may eventually lead to disparities in access to physicians and particularly to surgeons and OB-GYNs.[14] This study examined whether or not state caps enacted during 1985–2000 have increased the supply of physicians, surgeons, and OB-GYNs.

EXHIBIT 1
States With Caps On Malpractice Awards For Noneconomic Damages, 1975–2005

State	Years with any cap	Years with $250,000 cap
Alabama	1987–1991	
Alaska	1986–	
California	1975–	1975–
Colorado	1986–	1988–2003
Florida	1988–1991, 2003–	
Hawaii	1986–	
Idaho	1990–	2003–
Illinois	1995–1997	
Indiana*	1975–	
Kansas	1988–	1988–
Louisiana*	1975–	
Maryland	1986–	
Massachusetts	1986–	
Michigan	1986–	
Mississippi	2002–	
Missouri	1986–	
Montana	1995–	1995–
Nevada	2002–	
New Hampshire	1977–1980	1977–1980
New Mexico*	1976–	
North Dakota	1995–	
Ohio	1975–1994, 1997–1999, 2003–	1975–1994
Oklahoma	2004–	
Oregon	1987–1999	
South Carolina	2005–	
South Dakota	1986–	
Texas	1977–1988, 2003–	
Utah	1986–	1986–2002
Virginia*	1976–	
Washington	1986–1988	
West Virginia	1986–	2003–
Wisconsin	1985–	

SOURCES: National Conference of State Legislatures, *State Medical Liability Laws Table* (Washington: NCSL, October 2002 and October 2004); American Tort Reform Association, *State Laws on Medical Liability: Medical Liability Reform* (Washington: American Tort Reform Association, October 2002 and 13 July 2004); and McCullough, Campbell, and Lane, "Summary of Medical Malpractice Law," www.mcandl.com/states.html (18 April 2005).

NOTE: The year 2005 includes only January through April.

*Cap on total damages.

Trends In Physician Supply Under Tort Reform

Our data on the supply of physicians in counties in all states from 1970 to 2000 are from the Area Resource Files (ARF). The ARF is maintained by the Health Resources and Services Administration (HRSA). The ARF obtained data on physician supply from the American Medical Association (AMA) Physician Masterfile, AMA distribution-of-physicians data, and the AMA Physician Specialty Microdata File.

Exhibit 2 examines trends in physician supply under the two eras of malpractice award caps. First, from Exhibit 1, there were seven states that enacted legislation capping

EXHIBIT 2
Trends In County Physician Supply For States With Caps On Malpractice Awards, 1970 (1975) And 2000

	Median number of doctors per 100,000 county residents		
All physicians	**1970 (75)**	**2000**	**Percent increase**
No cap before 2000	122.40	224.36	83
Cap adopted in 1975–1977	132.69	246.61	86
Cap adopted in 1985–1987	108.23	218.41	102
Surgical specialists[a]			
No cap before 2000	32.39	41.74	29
Cap adopted in 1975–1977	37.20	43.03	16
Cap adopted in 1985–1987	29.32	42.37	45
OB-GYNs[a,b]			
No cap before 2000	50.25	54.30	8
Cap adopted in 1975–1977	45.57	58.37	28
Cap adopted in 1985–1987	36.94	51.68	40

SOURCE: Area Resource File.

NOTES: Observations are weighted by the county population, except for the obstetrician-gynecologists (OB-GYNs) row, where observations are weighted by the county's female population ages 15–44.

[a] Data in the first column are for 1975.

[b] OB-GYN supply is the number of OB-GYNs per 100,000 female county residents ages 15–44.

awards in 1975, 1976, or 1977 in response to the medical malpractice crisis of the early 1970s (not including the overturned cap in New Hampshire). Second, there were thirteen states that enacted laws implementing damages caps in malpractice cases in 1985, 1986, or 1987 in response to the medical malpractice crisis of the early 1980s (not including the overturned caps in Alabama, Florida, and Washington).

We found that there was an 83 percent increase in the median number of physicians per 100,000 residents from 1970 to 2000 in the states that never had a cap on malpractice awards before 2000. For the states that enacted caps in the 1970s, physician supply grew 86 percent, compared with 102 percent in states that passed caps between 1985 and 1987. Thus, the caps responding to the malpractice crisis of the 1980s appear to have had a much greater effect on physician supply than the caps set in place during the 1970s malpractice crisis.

A similar effect occurred with the supply of surgical specialists and OB-GYNs from 1975 to 2000. The median number of surgical specialists per 100,000 residents rose 45 percent under the 1980 caps, compared with 16 percent under the 1970 caps and 29 percent in states without caps. The median number of OB-GYNs per 100,000 females ages 15–44 grew 40 percent under the 1980 caps, compared with 28 percent under the 1970 caps and 8 percent for states without caps. Thus, caps in both eras had a strong impact on the supply of OB-GYNs.

Exhibit 3 examines the trend in rural physician supply with respect to the monetary size of the cap. Between 1970 and 2005 only nine states had caps set at $250,000; all other caps were above that limit. Moreover, 40 percent of the population in states with caps faced a cap with a limit above $400,000. Between 1975 and 2000 the median number of physicians per 100,000 residents of rural counties rose 48 percent for states with $250,000 caps, compared

EXHIBIT 3
Trends In Rural-County Physician Supply In States With $250,000 Caps On Malpractice Awards, 1975 And 2000

	Median number of rural doctors per 100,000 county residents		
All rural physicians	**1975**	**2000**	**Percent increase**
Cap equals $250,000	60.61	89.65	48
Cap above $250,000	49.34	71.26	44
Rural surgical specialists			
Cap equals $250,000	19.23	27.09	41
Cap above $250,000	16.81	22.00	31
Rural OB-GYNs*			
Cap equals $250,000	23.87	38.30	61
Cap above $250,000	24.61	36.57	49

SOURCE: Area Resource File.

NOTE: Observations are weighted by the county population, except for the obstetrician-gynecologists (OB-GYNs) row, where observations are weighted by the county's female population ages 15–44.

*OB-GYN supply is the number of OB-GYNs per 100,000 female county residents ages 15–44.

with 44 percent in states with caps above $250,000. For surgical specialists the rates were 41 percent and 31 percent growth, respectively. For OB-GYNs (per 100,000 women ages 15–44), the rates were 61 percent and 49 percent growth, respectively.

Impact Of Malpractice Award Caps On Physician Supply

■ **Data.** We used data on county characteristics from the Area Resource Files. We used 23,593 county-year observations from eight years: 1985, 1986, 1990, 1994, 1995, 1998, 1999, and 2000, accounting for about 99 percent of the U.S. population. We excluded Alaska and the District of Columbia, and we examined three county-fixed-effects models of physician supply under tort reform.

■ **Methods.** First, following the work of Daniel Kessler and Mark McClellan on the effects of tort reform on defensive medicine spending, we used a difference-*in*-difference model to examine the "before" and "after" effects of state caps on overall physician supply and on rural physician supply.[15] Using county fixed effects, we regressed the log of physician supply on state dummies indicating whether or not the state had a cap during that year. Key results are presented in Exhibit 4. Because our data set began in 1985, we could not examine the impact of reforms adopted before that year. However, only five of the twenty-seven states with caps adopted their cap before 1985. In particular, we were able to examine the effects of the 1985–87 caps (passed during the second malpractice crisis) seen in Exhibit 2.

Second, as did Kessler and McClellan, we also employed a county-fixed-effects, dynamic model based on the time since adoption of the cap. Exhibit 4 shows (1) the effect of the first two years of a cap on the log of physician supply (compared with the omitted reference category—years without caps), and (2) the final effect of the remaining period of three or more years' experience with a cap.

Third, we used a county-fixed-effects difference-in-difference model to examine the effects of caps with a $250,000 limit on damages on the supply of surgical specialists and OB-GYNs. In all three models we also examined the impact of caps in rural counties. About 72 percent of counties were in our rural sample; they accounted for 20 percent of the U.S. population.

EXHIBIT 4
Impact Of Malpractice Award Caps On County Physician Supply, All Counties And Rural Counties, 1985–2000

	Within-county percent increase in physician supply due to cap	
	All counties	Rural counties
State has a cap	2.18 ($p < .01$)	3.24 ($p < .01$)
Time since adoption of cap		
Years 1 and 2 of cap	0.50 ($p = .75$)	1.07 ($p = .59$)
Additional effects of years 3+ of cap	2.11 ($p < .01$)	2.94 ($p < .01$)

SOURCE: Area Resource File.
NOTES: Regression results are available at www.ahrq.gov/research/statecaps. Statistical findings denote difference from zero.

In all three models we used the following controls. Since each county has its own idiosyncratic socioeconomic, cultural, and political factors; regulations (other than caps); and tax rates, which might influence the supply of physicians and access to them, we included county dummy variables to capture these factors. This allowed us to identify the within-county effect of introducing a cap in each state. Also, dummy variables for each of the eight years were included to capture time trends.

We also controlled for four other state malpractice reforms: (1) collateral source rule reform—prevents payments for losses that have been compensated from other sources, such as workers' compensation; (2) prejudgment interest reform—limits payments for interest accruing on losses between the time the medical mishap occurred and the time the trial judgment was made; (3) joint and several liability reform—when there are codefendants, this limits each defendant's payments to the percentage of the harm for which the defendant is responsible; and (4) caps on punitive damages—limits payments to punish a defendant for intentional or malicious misconduct.

Finally, we controlled for factors that might affect the demand for physicians: health maintenance organization (HMO) enrollment in the state; whether the county had a medical school; county Medicare enrollment; county unemployment rate; county personal income; percentage of county that is black; county birth rate among women ages 15–44; and county death rate for diseases such as heart disease, liver disease, cancer, influenza and pneumonia, and chronic obstructive pulmonary disease.[16]

■ **Empirical results.** Caps were responsible for a 2.18 percent within-county increase in the supply of physicians, or an increase of five physicians per 100,000 people (Exhibit 4). The effect of caps was larger in rural counties (3.24 percent). These effects occurred mainly three or more years after the cap had been in place. Other malpractice reforms, such as collateral source rule reform, prejudgment interest reform, joint and several liability reform, and caps on punitive damages, did not have an impact on the supply of doctors.

Compared with counties without caps, the caps with limits above $250,000 had no significant within-county effect on the overall supply and rural supply of surgical specialists and OB-GYNs (Exhibit 5). The $250,000 caps increased the overall supply of surgical specialists by 4.16 percent but had no effect on the overall supply of OB-GYNs.

The $250,000 caps had a larger impact on rural counties than others. Slightly more than 7 percent of the rural sample was under a $250,000 cap, and 28 percent of the rural sample was under a cap with a limit higher than $250,000. For the rural population in states with caps, nearly half faced caps with limits above $400,000. Caps with a $250,000 limit increased the number of rural surgical special-

EXHIBIT 5
Impact Of $250,000 Malpractice Award Caps On County Supply Of Surgical Specialists And Obstetrician-Gynecologists, 1985–2000

	Within-county percent increase in physician supply due to cap			
	Surgical specialists		OB-GYNs	
	All counties	Rural counties	All counties	Rural counties
Cap above $250,000	NS	NS	NS	NS
Cap equals $250,000	4.16 ($p = .01$)	5.51 ($p < .01$)	NS	5.42 ($p = .05$)

SOURCE: Area Resource File.

NOTES: Regression results are available at www.ahrq.gov/research/statecaps. Statistical findings denote difference from zero. NS is not significantly different from zero.

ists per residents by 5.51 percent compared with states without caps and those with caps above $250,000. Similarly, a $250,000 limit increased the number rural OB-GYN per female resident ages 15–44 by 5.42 percent compared to states without caps and those with caps above $250,000.

Conclusions And Policy Implications

In this study we found that state caps on noneconomic damages awards in malpractice suits between 1985 and 2000 increased the supply of physicians. Moreover, the caps had a larger impact on physician supply in rural counties, and caps limiting malpractice awards to $250,000 had a much larger effect on surgeons and OB-GYNs in rural areas than caps with limits above $250,000. Twenty-seven states have caps on malpractice awards, but only five have caps with a $250,000 limit on awards, and 40 percent of the U.S. population living in a state with a cap has one with a limit above $400,000. Thus, a federal cap set at $250,000 for noneconomic damages could have a beneficial impact on the supply of surgeons and OB-GYNs in rural areas.

■ **How robust are these results?** In a recent study of the impact of malpractice caps on physician supply, using state data from 1980–1998, Jonathan Klick and Thomas Stratmann similarly found that states that had adopted a cap had 3 percent more doctors per 100,000 residents than states that did not have caps.[17] However, their state-level analysis did not find any effect of $250,000 caps as our county-level analysis did. In a more recent study, David Matsa found that malpractice liability caps did not increase the overall supply of physicians in all counties with a cap using county data from 1970–2000.[18] However, he did find that malpractice caps increased physician supply by 3–5 percent from 1970 to 2000 for extremely rural areas (25 percent of counties, accounting for 3 percent of the population). We found effects for a much larger rural area (70 percent of counties, accounting for 20 percent of the population). Matsa's definition of *rural* was based on county population density, while ours was based on a U.S. Department of Agriculture measure. It is possible that Matsa found smaller effects of caps because he examined the impact of caps during both malpractice crises of the 1970s and 1980s combined, while we examined the impact of caps during the crisis of the 1980s only. Recall from Exhibit 2 that caps had a much larger effect on physician supply during the 1980s than in the 1970s. This lower impact of the 1970s caps might explain why Matsa found smaller effects than our analysis of 1985–2000.

We also found that other state malpractice laws did not affect physician supply. In particular, we found that the following laws (described earlier) did not have an effect: collateral source rule reform; prejudgment interest reforms; joint and several liability reform; and caps on punitive damages.

Although such laws may be related to physicians' decisions whether or not to practice in a given geographic area, they are not nearly as conspicuous as laws that cap payments. Moreover, three previous studies found laws that indirectly affect the level of malpractice damage awards (for example, laws permitting periodic payments or that abolish the common rule of joint and several liability) have less impact on the costs of defensive medicine and liability premiums than laws that directly limit malpractice damage awards.[19]

Finally, although the increased supply of physicians attributable to caps is likely to increase the availability of care for most residents, it is not clear what effect this has on the cost of care. Kessler and McClellan found that tort reforms such as reasonable limits on noneconomic damages can reduce health care costs by 5–9 percent without substantial effects on mortality or medical complications.[20] However, they examined only a few cardiac procedures for Medicare beneficiaries during three years (1984, 1987, and 1990). Thus, the impact of caps on noneconomic damages on health care costs should be the focus of future research.

This research was funded by the Agency for Healthcare Research and Quality (AHRQ). The views herein do not necessarily reflect the views or policies of AHRQ, or the U.S. Department of Health and Human Services.

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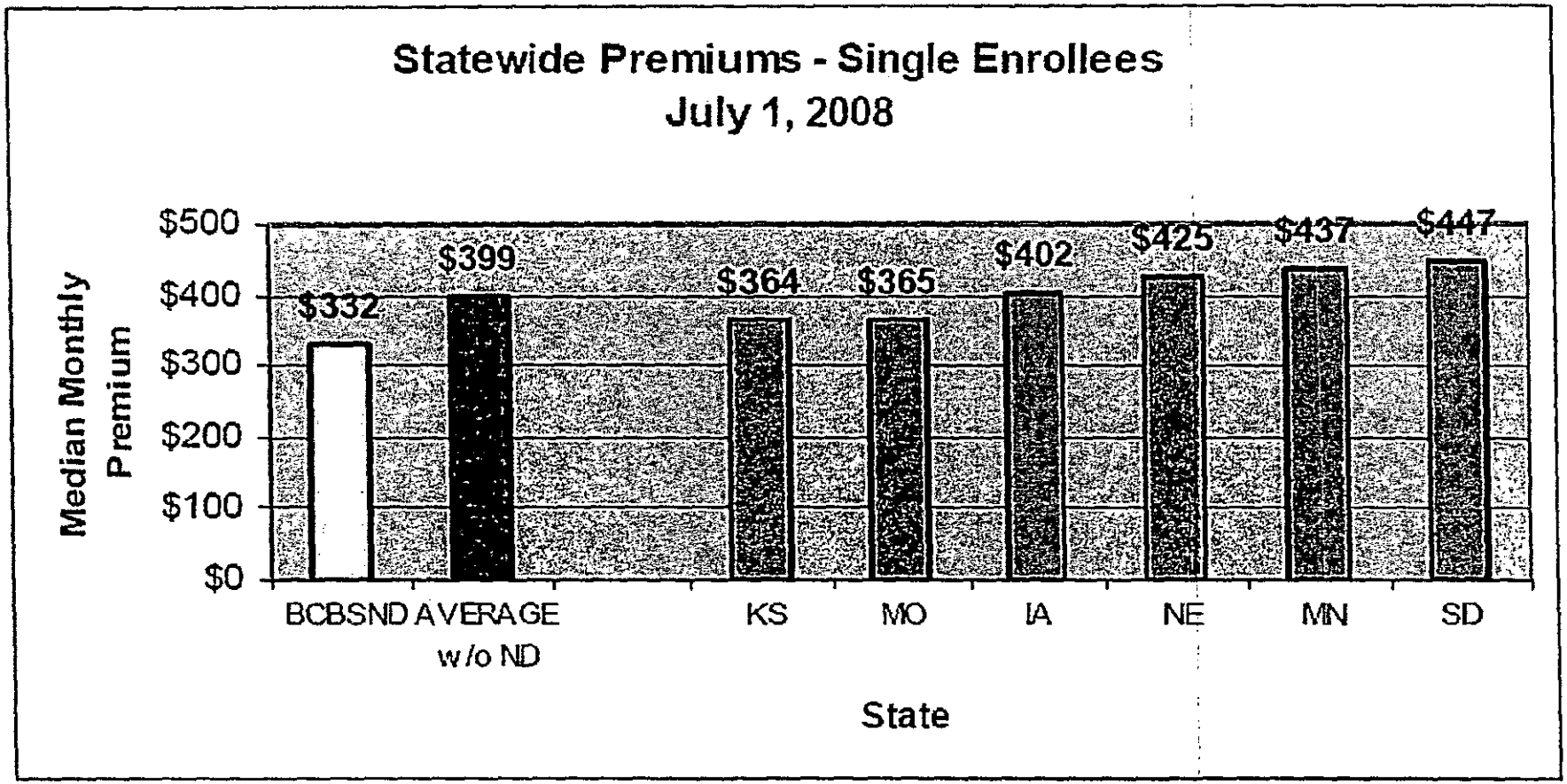
Exhibit 4



Milliman Private Insurer Study

Exhibit 4

NDHA
North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

Testimony on House Bill No. 1390
House Judiciary Committee
February 11, 2009

Chairman DeKrey, Members House Judiciary Committee. I am Arnold Thomas, President of the North Dakota Healthcare Association. I am here today to speak on House Bill 1390.

In a perfect world, negative outcomes would not exist. All births would be without complication - All surgeries would have positive outcomes - And all diagnoses would be completely accurate.

Sometimes, we do not live in a perfect world. Things go wrong - Human error -- Machine error -- or just plain unexplained fate.

Our legal system has long recognized that individuals who are harmed by medicine should receive a level of compensation. But - What is that level?

To those who have lost a spouse or a child - or who have suffered negative consequences at the hands of the medical profession, there is no amount of money that could ever serve as adequate compensation.

Having said that, it is also not appropriate to allow, encourage, or mandate exorbitant payoffs or payouts. That's the consequence of removing caps.

People drive past a hospital - especially one of our larger facilities -- and they see dollars. They see the ability to pay millions of dollars in compensation when something goes wrong.

Those of you who have been here a while understand that dollars have to come from somewhere. For every dollar more that we have to pay in malpractice insurance, that's a dollar that we can't put into upgrading or replacing equipment. For every dollar more that we have to pay in excessive legal awards, that's a dollar that we can't put into recruitment and retention of physicians and other medical personnel. That's a dollar that we can't put into patient care.

For every excessive settlement we have to enter into, we end up changing how we practice medicine. Tests will be run not for diagnostic reasons, but out of fear - fear of law suits. Tests cost money. Excessive and unnecessary tests cost a lot of money. Given the unwillingness of the state and federal governments to pay hospitals what it costs to care for Medicaid and Medicare patients, and given the pressure that Blue Cross is under not to raise its premiums, where does the money come from?

PO Box 7340 Bismarck, ND 58507-7340 Phone 701-224-9732 Fax 701-224-9529

Paying for medicine is a fine balancing act. Even obtaining medical services is a challenge of unbelievable proportions. I don't have to tell you that many of our communities did not make this year's top ten list of places for new medical school graduates to establish their practices. When you combine this state's wind chills with its lack of urban niceties, convincing people to come and practice here is not at all an easy task. One of the positives that we have been able to point to is our ability to obtain malpractice coverage and our ability to ensure that malpractice awards do not make national headlines because of their exorbitance.

When the caps were put in place, there was recognition of the fine balancing act that North Dakota needs to have in place in order to ensure the continuation of quality medical services for its citizens. Every now and then, an unfortunate event happens and it is suggested that the caps should be eliminated. It is suggested that you reward the few. Mr. Chairman, members of the committee, to do so would be at the expense of the many.

We therefore respectfully ask that you leave the current law in place and vote for a Do Not Pass on HB 1390.

Testimony of Jeb Oehlke
HB 1390
February 11, 2009

Mr. Chairman and committee members my name is Jeb Oehlke. I am here today representing the North Dakota Chamber of Commerce, the voice of North Dakota Business. Our organization is an economic and geographical cross section of North Dakota's private sector and also includes state associations, local chambers of commerce, development organizations, convention and visitors bureaus and public sector organizations. For purposes of this hearing we are also representing fifteen local chambers with total membership over 6,500 members. A list of those associations is attached. As a group we stand in opposition to HB 1390.

For several years the cost of healthcare and health insurance has been increasing rapidly. One of the few checks we as a state have on the rate of these increases is the fact that the premiums for medical professional liability insurance in North Dakota are among the lowest in the nation. The reason for this, in large part, is because we have capped the noneconomic damages available in medical malpractice cases at $500,000.

If this cap is removed the premiums for medical professional liability insurance will increase substantially. These increases cannot and will not be absorbed by the doctors and hospitals. They will be passed on to the patients in the form of higher costs for services. These higher costs will also be passed on to the health insurance companies who will, in turn, pass those costs on to the purchasers of health insurance in the form of increased premiums, increased co-pays, decreased coverage, and other cost shifting measures.

Adding these increases on top of the current annual increases of around 12 to 15% will soon put health insurance out of reach for most individuals and families as well as substantially diminishing the ability for businesses to provide coverage for their employees.

Repealing Section 32-42-02 of the North Dakota Century Code will, in the long term, create significant hardship, not only for this state's business community, but for its citizens as a whole. North Dakota's business community urges this committee to recommend a Do Not Pass on HB 1390. I am happy to answer any questions.

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www.ndchamber.com ndchamber@ndchamber.com

The following chambers are members of a coalition that support our 2009 Legislative Policy Statements:

Beulah Chamber of Commerce – 130 members

Bismarck-Mandan Chamber of Commerce – 1,200 members

Chamber of Commerce of Fargo Moorhead – 1,800 members

Devils Lake Area Chamber of Commerce

Grafton Area Chamber of Commerce

Greater Bottineau Area Chamber of Commerce – 155 members

Harvey Area Chamber of Commerce

Hettinger Area Chamber of Commerce – 145 members

Jamestown Area Chamber of Commerce – 360 members

Kenmare Association of Commerce

Minot Chamber of Commerce – 700 members

North Dakota Chamber of Commerce – 1100 members

Oakes Area Chamber of Commerce – 170 members

Wahpeton Breckenridge Chamber of Commerce – 290 members

Williston Chamber of Commerce – 450 members

Total Businesses Represented = 6,500 members

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Chairman DeKrey and Committee Members:

As per my testimony on behalf of the North Dakota Medical Association in opposition to HB 1390 last week, the following additional materials are provided based on requests from committee members. In our view, the information shows that the 1995 ND Legislative Assembly made a responsible decision in responding to concerns regarding the low competition in the medical liability insurance market in North Dakota and volatility in premiums in the decade prior to 1995. The law has never been challenged. The result has been a stable liability insurance market in our state for health care providers relative to states without limitations on non-economic damages.

We reiterate our view, and the view of the many health care organizations and community facilities across the state that oppose HB 1390, that this bill would only create a problem – not solve one.

The 1995 Law Will Continue to Stabilize Losses and Premiums

Clearly, the body of research on the impacts of tort reform shows that caps have resulted in lower growth in medical liability losses in states that passed caps than in states that did not. Caps also result in lower premium growth. Caps on non-economic damages also have a positive effect on the number of physicians per capita in a state. *E.g.*, Carol K. Kane, PhD, David W. Emmons, PhD, *The Impact of Caps on Damages. How are Markets for Medical Liability Insurance and Medical Services Affected?*, Policy Research Perspectives, AMA (2004).

NDMA and other organizations also oppose raising the current cap from $500,000 to a higher amount. The effectiveness of a cap in controlling medical liability costs is inversely related to the maximum award permitted for non-economic damages. William Hamm, PhD, Amit Bubna, PhD, *Key Components of Nevada's Assembly Bill 1: An Economic Analysis*, September 2002. Increasing the limitation creates additional

risk exposure that will impact losses and premiums and there is no information indicating a problem with the current amount or that the current cap is routinely or otherwise applied to reduce jury awards in our state.

North Dakota Claims Experience

Attached is ND Insurance Department data on claims, settlements, and judgments as compiled from reports filed by insurers and health care providers pursuant to NDCC 26.1-01-05 from 1984 to 2008. According to the Department the column "settlements" is a compilation of claims, settlements and judgments and the category is not broken down further, nor is there any Insurance Department information regarding the breakdown of economic, non-economic and punitive damages in ND jury awards. No other source was identified for such information. *Advocates of this bill have not identified any examples of cases in North Dakota in which a jury award of non-economic damages was reduced by the cap.* As noted by Mr. Pagel last week, there is no ready source of data identifying jury awards in medical liability cases in North Dakota breaking down the components of the award between economic, non-economic, punitive damages and costs.

From the Insurance Department information, there are 429 cases identified since 1984 totaling $93,553,785 in "settlements" with an average settlement of $218,074.09. The "settlements" range from $22 to $2,094,400. The data below uses the "year of closed date" to categorize the information by year:

Closed Date Year*	Total # of Settlements	Total $**	Avg. Settlement
2008	3	$1,400,000	$466,667
2007	15	$3,415,854	$227,724
2006	9	$3,437,500	$381,944
2005	21	$8,054,250	$383,536
2004	23	$12,481,472	$542,673
2003	26	$5,199,500	$199,981
2002	22	$3,467,250	$157,602
2001	27	$9,056,883	$335,440
2000	23	$6,309,824	$274,340
1999	19	$3,329,500	$175,237
1998	19	$5,477,053	$288,266
1997	19	$3,882,500	$204,342
1996	27	$3,005,329	$111,308
1995	15	$4,453,099	$296,873
1994	18	$1,905,210	$105,845
1993	33	$6,082,354	$184,314
1992	19	$2,939,383	$154,704
1991	10	$1,151,182	$115,118

1990	24	$4,188,117	$174,505
1989	16	$1,701,222	$106,326
1988	17	$1,360,866	$ 80,051
1987	14	$ 694,680	$ 49,620
1986	4	$ 28,180	$ 7,045

* 5 entries did not include a closed date
** Amounts are actual dollars; not adjusted

Another source of information is indemnity payment trends for medical specialties from the National Practitioner Data Bank Public Use File for North Dakota, which provided the following data which was provided to our Congressional Delegation in 2003:

Report Year	#Claims	Total Indemnity Pymts	Avg Pymt	Highest Pymt
1991	24	$2,340,000	$ 97,500	$ 295,000
1992	18	$1,975,500	$109,750	$ 945,000
1993	25	$5,083,500	$203,340	$ 995,000
1994	34	$3,237,050	$ 95,207	$ 665,000
1995	24	$4,602,750	$191,781	$ 995,000
1996	24	$3,120,000	$130,000	$ 335,000
1997	20	$3,557,500	$177,875	$ 475,000
1998	17	$3,605,250	$212,074	$1,050,000
1999	23	$4,315,250	$187,620	$ 825,000
2000	19	$4,672,750	$245,934	$1,450,000
2001	27	$8,966,000	$332,074	$1,950,000

North Dakota Premiums

These are statistics relating to the experience of one carrier (Midwest Medical Insurance Company or MMIC) based on Medical Liability Monitor national surveys:

Year	Internal Med	General Surgery	OBGYN	Change
1983				-10%
1984				12%
1985				22%
1986				48%
1987				45%
1988				8%
1989				21%
1990				-22%
1991				0
1992				-4%
1993				8%
1994				6%
1995				0%
1996				10%
1997	$4,968	$13,247	$22,769	*
1998	4,968	13,247	22,769	0%

1999	4,719	12,583	21,628	-5%
2000	4,719	12,583	21,628	0%
2001	4,719	12,583	21,628	0%
2002	5,430	14,479	24,886	15%
2003	5,701	17,103	26,129	5%
2004	6,086	18,258	27,894	6.8%
2005	6,681	20,044	30,623	9.8%
2006	6,681	20,044	30,623	0%
2007	6,681	20,044	30,623	0%
2008	6,021	18,063	27,596	-10%

In 2003, these premium statistics at the time were similar to what was reported by the U.S. Department of Health and Human Services for North Dakota for these three specialties. The HHS report indicated 2002 average premiums for North Dakota Internists of $6,609, for General Surgeons of $16,238, and Ob-GYNs of $24,971, compared to national averages of $12,355 for Internists, $36,564 for General Surgeons, and $49,530 for Ob-GYNs. The report used these 2002 average premiums for North Dakota, along with Indiana, South Dakota, Hawaii, Montana, Utah, New Mexico, California, and Michigan, for the proposition that "[w]ith few exceptions, *average premiums for states with reasonable limits on non-economic damages are lower than for the US as a whole*. This holds true for all three specialties." U.S. Department of Health and Human Services, *Special Update on Medical Liability Crisis,* September 25, 2002. The United States General Accounting Office (GAO) in August 2003 in a report to Congress made the following findings:

> "Limited available data indicate that rates of growth in malpractice premiums and claims payments have been slower on average in states that enacted certain caps on damages for pain and suffering – referred to as noneconomic damage caps – than in states with more limited reforms. Premium rates reported for the specialties of general surgery, internal medicine, and OB/GYN were relatively stable on average in most states from 1996 through the late 1990s and then began to rise, but *more slowly among states with certain noneconomic damage caps*. ...
>
> "After 2000, premium rates began to rise across most states on average, but more slowly among the states with certain noneconomic damage caps. In particular, from 2001 to 2002, the average rates of increase in the states with noneconomic damage caps of $250,000 and $500,000 or less were 10 and 9 percent, respectively, compared to 29 percent in the states with limited reforms.

> "Other studies have found a relationship between direct tort reforms that include noneconomic damage caps and lower rates of growth in premiums. For example, in a recent analysis of malpractice premiums in states with and without certain medical malpractice tort limitations, the Congressional Budget Office (CBO) estimated that certain caps on noneconomic damage awards in combination with other elements of proposed federal tort reform legislation would effectively reduce malpractice premiums on average by 25 to 30 percent over the 10-year period from 2004 through 2013." GAO, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care,* August 2003.

In 2003, physicians across the country were in the midst of advocating for medical liability reform including a $250,000 limitation on non-economic damages, which was successful in the U.S. House of Representatives but not the U.S. Senate [*E.g.*, HEALTH Act HR 5.passed by the U.S. House of Representatives on March 13, 2003, and supported by Rep. Earl Pomeroy would have limited attorneys' contingent fees on a sliding scale and capped non-economic damages at $250,000; Rep. Pomeroy later supported a similar bill, HEALTH Act of 2005, on July 28, 2005]. Studies by the US General Accounting Office (GAO) and Congressional Budget Office (CBO) prepared during this timeframe regarding the federal legislation reported that rates of growth in malpractice premiums and claims payments have been slower on average in states that enacted caps on non-economic damages.

Attached is the Medical Liability Monitor State-By-State Rate Survey, October 2008, showing state-by-state differences in liability premiums. While states have experienced some stabilization in rates, those rates have stabilized at high levels in many states.

For health systems that self fund medical liability risk, a reserve account must be funded based on the actuarially-defined estimated risk exposure. These larger health systems typically shoulder the burden of substantial deductibles and other risk sharing in order to avoid higher premiums. According to our self-funded health systems in North Dakota, HB 1390 would *significantly and negatively* impact the reserve account funding requirement necessary to meet that actuarially-defined estimated risk exposure. Innovis Health reported that removal of the cap as proposed in HB 1390 "would conservatively impact (increase) our reserve account funding requirement by 7-9% annually." Altru

Health System reports that it spends $2,000,000 per year to fund the professional liability component – averaging approximately $20,000 per physician.

It is appropriate to limit non-economic damages to a reasonable amount to provide predictability and stability in the medical liability insurance market. This would continue to ensure access for North Dakota people to high quality health care and services provided by not only physicians but all other health care professionals and nursing homes, hospitals and clinics across our state. Not a single problem has been cited regarding the current limitation. If we remove the cap, our predictability is lost and North Dakota is again subject to unsettling national trends and cycles.

While we're holding our own at the state level, we have always been concerned that these national trends may impact North Dakota. Many states have been mired in true liability crises in which the lack of affordable coverage directly impacted patients' access to health care. Physicians were and are leaving states in which liability premiums have spiraled out of control and many have discontinued doing high-risk procedures. According to the American College of Obstetricians and Gynecologists, one in twelve obstetricians nationally had stopped delivering babies in 2003; 75% of neurosurgeons reported in 2005 they no longer operate on children because of the liability crisis. One only needs to review the Medical Liability Monitor state-by-state survey of premium rates to see what is occurring nationally and what North Dakota has avoided.

Experience has shown that the liability climate of any state can deteriorate rapidly and unexpectedly. We urge a "Do Not Pass" on HB 1390.

-Bruce Levi

License Number	Claim Number	Accident Date	NATURE_OF_CLAIM	Closed Date	Settlemen	Entry Date
P2988	111642-1	3/17/2004	patient died frompulmonary embolism.	2/22/2008	$725,000	4/16/2008
P9323	111429-1	8/12/2004	Patient death from complication after femoral popliteal bypass surgery.	1/22/2008	$250,000	39505
P5227	111847-2	7/26/2005	Failure to treat abdominal aortic aneurysm.	1/18/2008	$425,000	39505
P4178	107607-1	11/27/2001	Missed fracture.	12/21/2007	$149,000	39485
P4593	27993	9/22/2003	Abdominal Surgery: Pain & suffering due to foreign object left in patients abdomen.	11/30/2007	$23,000	12/12/2007
P5641	18875	9/17/2004	failure to diagnois MI resulted in death	11/21/2007	$165,000	39553.51316
P3604	107292-1	9/20/2002	Pathology inaccurately interpreted as cancer when it was actually benign.	11/14/2007	$43,750	12/12/2007
P4396	107292-2	9/20/2002	Pathology inaccurately interpreted as cancer when it was actually benign.	11/14/2007	$43,750	12/12/2007
P8708	107292-3	9/20/2002	Pathology inaccurately interpreted as cancer when it was actually benign.	11/14/2007	$87,500	12/12/2007
P9432	0606060082644.01	6/13/2006	Died due to complication.	11/12/2007	$150,000	12/3/2007
P9385	110228-1	7/18/2003	Alleging patient not given anticoagulated medication following surgery resulting in Pulmonary Embolism death.	7/17/2007	$225,000	5/10/2005
P8649	276461	4/2/2004	Alleged suture through peroneal nerve resulting in partial foot drop	5/2/2007	$326,927	39367.51046
P8649	276461	4/2/2004	Alleged Improper Treatment resulted in pain and suffering	5/2/2007	$326,927	5/15/2007
P7646	106456-1	3/5/2003	Alleged negligent panniculectomy	4/13/2007	$1,200,000	39217
P4177	16418	8/31/2001	failure to timely diagnose & treat breast cancer.	3/14/2007	$225,000	4/15/2008
P3492	17806	6/27/2003	Underwent Laporotomy & salping-ovphorectomy. Colon damaged during procedure resulting in permanent colostomy.	2/13/2007	$225,000	39553.49927
P5664	1-0303-1501	12/17/2001	A condition known as shoulder dystocia developed during the delivery of infant, which resulted in the death of the infant. During the delivery of the infant, the mother suffered a fourth degree laceration & rectal vaginal fistula which were subsequently	2/1/2007	$75,000	3/12/2007
P6201	SC-05-38272	4/27/2004	Fir to perform on all areas of back r/l additional surgery	1/11/2007	$150,000	39170
P7646	107510-1	11/14/2001	Complications following reduction mammoplasty.	10/17/2006	$110,000	12/1/2004
P4571	0402040053251.01	2/2/2006	Percutaneous biopsy of kidney resulted in bleeding. Dr. Khota called in to assit. Removed right kidney. Patient expired three days later.	8/29/2006	$300,000	38966.49741
P5659	105914-2	2/9/2003	Paralysis following surgery	6/6/2006	$182,500	38911.50686
P6399	DM0661991733A02 2/GM00123	4/9/1998	Alleged failure to diagnose and treat complication resulting from cardiac bypass surgery.	5/9/2006	$200,000	38883.36223
P5505	102430-1	11/17/1997	Complications following intubation	3/31/2006	$1,900,000	4/19/2006
P7851	269952	2/6/2002	Plaintiff Came for routine chest check up x-ray was done alleges negligent interpreation which resulted in delayed treatment and diagnosis carcinoma.	3/9/2006	$200,000	38327.36567
P6619	106996-1	9/18/2002	Addition knee surgery required due to equipment failure.	2/24/2006	$20,000	38784
P8445	107683-2	11/16/2003	Delay in doing appendicits.	2/3/2006	$262,500	38784
P6117	107683-1	11/16/2003	Delay in doing appendicitis.	2/3/2006	$262,500	3/8/2006
P8544	104858-1	4/25/2002	Laminectomy resulting in spinal cord injury	11/28/2005	$1,600,000	38694
P3492	105489-1	7/14/2002	Negligent treatment	11/8/2005	$155,000	12/8/2005
P5321	106427-1	5/26/2001	Alleged negligent arthroscopic knee surgery	10/4/2005	$150,000	38660
P7503	102204-1	8/29/2000	patient had cardiac arrest and is in vegetative state after c-section	9/16/2005	$2,094,400	10/19/2005
P4886	102204-2	8/29/2000	Patient had cardiac arrest and is in vegetative state after C-section	9/16/2005	$261,800	10/19/2005
P4575	102204-3	8/29/2000	Patient had cardiac arrest and is in vegetative state after C-Section.	9/16/2005	$261,800	38644
P7585	105942-2	1/17/2001	Failure to administer and monitor radiation therapy properly	7/15/2005	$600,000	38568
P4990	MM0009058433A01 4	4/4/2001	Patient allegedly suffered cardiac arrest during operation to stabilize spine (auto accident injury)	6/22/2005	$225,000	38565

License Number	Claim Number	Accident Date	NATURE_OF_CLAIM	Closed Date	Settlement	Entry Date
P8895	106663-2	10/31/2001	Patient death.	5/31/2005	$118,750	38523.57557
P7916	103274-2	8/5/2001	Alleged failure to diagnose ROP in left eye.	5/24/2005	$130,000	38335.63603
P6722	104482-1	3/18/2002	Alleged damage to optic nerve from surgery	5/10/2005	$240,000	37452.63715
P3838	0201030004147.00	1/3/2002	Patient had right ovary removed due to abscess. A few months later came back to insured surgeon c/o pain on left side. CT scan indicated that drain left in right side.	5/3/2005	$70,000	38482.35571
P8195	MM0009058433A009/OH00895	5/25/2000	serious birth trauma (shoulder dystocia with resulting brachial plexus injury requiring corrective surgery).	4/28/2005	$325,000	6/3/2005
P5691	104816-1	8/22/2000	Delay in diagnosing subarachnoid hemorrage	4/22/2005	$690,000	37497.59616
P3838	0201030004147.00	1/3/2002	surgeon care of pain on left side. CT scan indicated that drain left in right side. Dr does not know if it has been removed.	4/6/2005	$70,000	10/3/2005
P5530	108419-1	10/22/2003	NRE excision done on wrong site	4/1/2005	$25,000	6/30/2004
P8616	DM0662939322S001	6/12/2001	Alleged improper performance of surgery to repair bladder	3/31/2005	$72,500	6/19/2003
P6219	106392-1	5/5/2002	Failure to diagnose tumor resulting in death.	2/22/2005	$130,000	6/19/2003
P8792	DM0663460933A002/QW11358	3/2/2002	Alleged mismanagement of lower abdominal pain, resulting in loss of both ovearies and sterility in a 34-year old female.	2/4/2005	$35,000	3/9/2005
P7886	DM0661991733A047	3/21/2002	Alleged complications from appendectomy resulting in death.	2/2/2005	$500,000	4/25/2003
P3932	105384-1	11/9/2000	Wrong level surgery	2/1/2005	$300,000	37644.60005
P3817	106250-2	9/28/2002	Patient death	12/17/2004	$425,000	4/28/2003
P5860	106250-1	9/28/2002	Patient death	12/17/2004	$425,000	4/28/2003
P4576	102157	11/2/1998	Delay in diagnosing sinus mass	10/22/2004	$237,500	36943
P8598	106121-1	2/28/2001	Complications following surgery	10/5/2004	$200,000	4/28/2003
P6722	106708-1	12/27/2001	Alleging insured left tumor and removed pituitary gland.	9/10/2004	$237,500	11/30/2004
P6943	MM0009058433A007	6/7/1999	Alleged misdiagnosis of Hirschsprung's disease	9/3/2004	$200,000	37791.63072
P4826	104431-1	9/23/1997	Brain damage baby	9/3/2004	$1,875,000	7/15/2002
P4826	104430-1	9/23/1997	Brain damage baby	9/3/2004	$1,875,000	7/15/2002
P8036	44794	5/19/1999	Alleged bone was not set properly following traumatic injury resulting in decreased function.	8/12/2004	$10,000	10/28/2004
P7646	107293-1	1/27/2003	Negligently performed reduction mammoplasty	6/29/2004	$6,472	38288.59782
P6594	103743-4	3/29/2001	Patient death	6/18/2004	$87,500	38288
P6952	103743-1	3/29/2001	Patient death	6/18/2004	$87,500	10/28/2004
P4536	MM0009058422M002/SF11598	4/12/1999	Alleged failure to properly perform bypass surgery; mammary artery was allegedly anastomosed to the diagonal branch	6/17/2004	$200,000	38288
P4372	108101-1	7/30/2003	Negligent prescription of Acutane	6/4/2004	$40,000	38288
P7434	MM0009058422M001/HP11657	4/15/1998	Alleged complications arising out of surgery to repair deviated septum.	6/4/2004	$2,000,000	38288
P4396	0504JA015233A035/FK11164	7/11/1997	Alleged delay in diagnosis of prostate cancer	5/5/2004	$400,000	38167
P5076	DM0662939333A006/GU011	10/10/2000	Insured performed 6 laparoscopies in 8 years on patiet with chronic pelvic pain and biopsy-proven endometriosis. Plaintiff alleged that surgeries caused infertility and pelvic pain, but admits pain was pre-existing.	4/7/2004	$50,000	7/6/2004

License Number	Claim Number	Accident Date	NATURE_OF_CLAIM	Closed Date	Settlement	Entry Date
P618	08-HM-IL-ND-544700	3/13/2000	Alleges that a portion of the common bile duct was removed during a laparascopic cholecystectomy because it was not identified correctly. This required additional surgery to repair and a prolonged hospitalization and recovery period.	4/2/2004	$265,000	38170.63913
P8350	204648A	1/13/1999	Endoscopic anterior diskectomy T9-10 performed by insured on 1-13-99, during which spinal cord signals were lost. Insured stopped the procedure immediately. Postop nerve deficits included partial paraplegia from the level of surgery down.	3/16/2004	$2,000,000	7/6/2004
P3908	105391	2/8/2001	Patient death	2/24/2004	$90,000	38174
P5985	104819-1	11/7/2000	Patient death	2/17/2004	$1,170,000	38174
P4728	104787-1	7/14/2001	Patient death	2/17/2004	$300,000	38174
P4917	DM0661991733A04 3/DF01188	9/27/1999	Alleged failure to timely diagnose ovarian cancer, resulting in 17month delay in treatment	2/9/2004	$300,000	38174.69762
P3803	105475-1	1/1/2001	Alleged misdiagnosis of breast cancer	12/2/2003	$425,000	3/8/2004
P2818	103770-1	4/23/2000	Failure to diagnose coronary artery disease; death.	12/2/2003	$750,000	3/8/2004
P5070	0504JA015233A007 /EN00815	8/25/1999	Alleged delay in referral of fracture of lower extremity	12/1/2003	$82,500	3/9/2004
P5649	103098-1	12/6/1999	Delay in diagnosis	11/7/2003	$250,000	3/8/2004
P4976	MM0008408644538 0	5/1/2000	During surgical procedure Dr. Clayburgh allegedly fused the wrong finger. Patient marking of the finger was not clear.	11/3/2003	$65,000	38054.621
P7003		1/29/2001	Patient with sever osteolysis presented for a right total hip revision. The plan was to remove the loose components and cement and do the revision with cementless components. Pre-operative x-rays did not reveal that there was little bone present on the	11/3/2003	$225,000	38055.38295
P4575	105487-1	1/2/2002	Clip left in ureter following surgery	10/22/2003	$45,000	3/8/2004
P3908	105487-2	1/2/2002	Clip left in ureter following surgery	10/22/2003	$45,000	38054.60512
P5659	105028-1	9/13/2000	Right femoral component used in left knee.	9/26/2003	$25,000	3/8/2004
P4776	MM0009058433A01 1	1/6/2000	Alleged burn to abdomen during liposuction	8/25/2003	$50,000	11/7/2003
P3604	105520-2	9/19/2002	Alleged unnecessary mastectomy	8/12/2003	$575,000	37746.6356
P5813	103378-1	9/16/2000	patient alleges tubal reversal was not done correctly	8/12/2003	$125,000	38055
P3872	97273	8/14/2002	Condition was uterine fibroid. Treatment given was surgery. Alleges improper treatment, which resulted in pain and suffering.	8/7/2003	$70,000	38054.59299
P7071	103387-1	8/21/2001	Alleging superficial femeral vein inadvertently dissected during vein ligation procedure	5/23/2003	$12,000	11/6/2003
P3131	221285A	6/7/1999	On 6/7/99 the male patient underwent cervical diskectomy and fusion at C5-6 and C6-7 and anterior fixation C5-7 by insured. Patient underwent refusion C5-6 and re-plating C5-7 in November 99 by insured. 5/28/2000, insured performed a posterior cervical	5/20/2003	$850,000	37791
P7353	105195-1	2/12/2002	Complications following achilles tendon injury	5/6/2003	$165,000	6/19/2003
P6435	103069-2	2/9/2000	Wrongful death	4/1/2003	$250,000	4/25/2003
P3068	8-HP-ND-566710	7/24/2000	Alleged injury to bile duct and improper placement of T-tube during an exploratory laparotomy, cholecystectomy with common bile duct and insertion of T-tube	3/13/2003	$85,000	37762.64833
P7537	104133-1	6/8/2000	Allege failure to diagnose coronary artery arthroselerosis	2/28/2003	$750,000	37739
P4178	103483-1	1/31/2001	Failure to diagnose fracture	2/21/2003	$30,000	4/28/2003
PAC02	0504JA015233A024	9/26/2000	Alleged failure to diagnose and treat cardiac condition in ER, resulting in death	2/18/2003	$60,000	3/27/2003

License Number	Claim Number	Accident Date	NATURE_OF_CLAIM	Closed Date	Settlement	Entry Date
P6644	0504JA015233A024	9/26/2000	Alleged failure to diagnose and treat cardiac condition in ER, resulting in death	2/18/2003	$40,000	37707.65074
P6556	104479-2	1/14/2002	Alleged negligent treatment	2/11/2003	$117,250	37739
P3908	104479-1	1/14/2002	Alleged negligent treatment	2/11/2003	$57,750	4/28/2003
P4966	ND-441376	2/21/1997	Alleged lack of informed consent for performance of varicose vein stripping of the leg	1/17/2003	$35,000	37762
P3696	ND-492284	4/17/1997	herniated extruded disc resulting in psuedomeningocele-also negligence in handling of post surgical care	1/17/2003	$15,000	37762.63883
P3055	101120-1	9/29/1999	Common duct injury during lap chole	12/31/2002	$12,000	37707.66293
P5835	103567-1	12/28/1999	Patient died following coronary bypass surgery	12/20/2002	$35,000	37707
P3388	103567-2	12/28/1999	Patient died following coronary bypass surgery	12/20/2002	$70,000	37707
P7827	45-HM-IL-ND-47577	8/27/1998	Alleged delay in diagnosing, providing treatment and transferring a newborn to another facility resulting in the infant's death.	12/9/2002	$100,000	5/21/2003
P4264	MM/100	4/8/2002	Negligent medical treatment of mother in that Dr. Baird failed to discuss treatment option (performing a bronchoscopy) with patient and her family and failure to perform drainage of the right pleural effusion for relief of symptoms at the time of death.	12/6/2002	$10,000	1/23/2003
P6156	101947-1	8/15/2000	Complications following surgery	11/26/2002	$1,250,000	37643
P7431	100365-1	3/22/1999	Common bile duct injury following lap cholecystecomy	11/19/2002	$150,000	37643
P5382	MM0009058433A005	5/11/1999	Alleged improper procedures were used to change code status - leaving no attempt to resussitate patient who died.	11/13/2002	$58,750	3/27/2003
P6117	102341-1	12/3/2000	Complications following surgery	11/13/2002	$250,000	37643
P4396	MM0000438424687 1	10/26/1998	Alleged failure to diagnose cancer from pap smear	11/11/2002	$37,500	37707.67118
P7000	104917-1	7/2/2002	Patient given medication overdose	11/8/2002	$30,000	1/22/2003
P7617	23-836-45709	1/15/2000	Laceration to left ear & scalp of newborn during c-section	10/31/2002	$5,000	11/4/2002
P6131	216971A	10/13/2001	ON 10/12/01, the 76-year-old female in-patient underwent re-do mitro valve and coronary artery bypass graft surgery, by employees of the insured. Post-surgery patient's blood pressure spiked, she was returned to surgery. The ventilator was turned on, th	10/23/2002	$325,000	37572.45005
P7219	DM06622497-33A002	8/1/1998	Alleged failure to diagnose cancer on an X-ray	8/30/2002	$137,500	38168.44484
P2802	8-HP-ND-539508	3/23/2000	MIR of lumbar spine on 3/23/2000 read as normal. Second MRI on 9/22/2000 revealed a mass invading the left psoas muscle. In hindsight, the first MRI showed presence of the mass (metastasis from lung cancer). Plaintiff concurs that patient outcome would	8/28/2002	$20,000	10/3/2002
P5739	205673	9/20/1995	The 47-year-old inpatient with a history of angina and MI underwent a cardiac cath and CABG by the insured. Insured intended to bypass two branches, but did two grafts on the posterior distal artery. Patient has had two subsequent cardiac surgeries and	8/15/2002	$75,000	8/29/2002
P5643	103857-1	8/16/2001	Patient death	6/17/2002	$64,000	37707.61683
P6125	DM0661991733A044	7/17/2001	Alleged complication arising out of knee surgery	6/3/2002	$7,500	3/27/2003
P4110	DM06619917 - 33A036	7/3/2000	Alleged failure to diagnose and treat cardiac condition resulting in heart damage.	3/29/2002	$406,000	10/4/2002
PA	HK0660027233A048	7/3/2000	Alleged failure to diagnose cardiac problems resulting in heart damage	3/29/2002	$174,000	37533.59788
P7979	HMO27277-11	5/11/2000	Alleged injury to the common bile duct during laparoscopic cholecystectomy surgery	3/6/2002	$50,000	7/16/2002

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P4828	92871	9/20/1999	of left breast.	2/4/2002	$200,000	38170
P3922	HM027418-11	3/24/1998	Death due to an alleged failure to properly treat pneumonia	11/14/2001	$65,000	3/2/2005
P3282	6084-01	9/12/1994	Negligent mishandling of transference	9/28/2001	$65,000	11/6/2001
P5315	101438-1	4/8/1997	Involuntary hospitalization	9/7/2001	$385,000	37201.65221
P3492	MM00076421-436693	12/29/1998	Transection of the common bile duct during laparoscopic surgery	9/7/2001	$72,500	3/12/2002
P3031	102834-1	5/1/2001	Infection - following procedure	8/28/2001	$7,500	11/5/2001
P2943	DMO6619917-33A031	10/29/1998	Alleged damage to teeth during surgery	8/24/2001	$5,000	11/6/2001
P7408	DMO6619917-33A011	3/9/1997	Alleged improper management of labor & delivery resulting in shoulder dystocia	7/31/2001	$190,000	37201.54731
P4884	DMO661768133A010/BZ00101	3/10/1998	Alleged prescription of macrodantin contributed to possible lung damage	7/31/2001	$20,000	37113.56693
P7492	MM0000714610542 1/TF00965	4/20/1998	Alleged failure to diagnose and treat fracture to finger	7/25/2001	$15,000	37113.57282
P3838	MM00004765-105495	1/6/1999	Alleged failure to diagnose complications from surgery	7/18/2001	$125,000	37201.57214
P7617	MM0009058664947 2/CC00956	9/16/1999	During C-Section delivery the patient allegedly suffered a cut to the forehead.	7/2/2001	$20,000	37084.40205
P3520	100448-1	4/3/1996	Inappropriate nasal surgery	6/26/2001	$700,000	37090.58928
P5719	MM00085355-105164	1/20/2000	Alleged complications resulting from placement of suprapublic catheter	5/18/2001	$550,000	11/6/2001
P3800	MM0000438424364 3/AO00923	8/18/1999	Alleged delay in performing a pregnancy test resulting in increased loss of blood and additional medical expense	5/16/2001	$15,934	7/12/2001
P3080	DM0661207333A005/NM00102	5/1/1997	Alleged complications arising out of LASIK surgery	5/7/2001	$200,000	37084.41406
P3106	6757-2	2/14/1997	Vision problems due to prematurity	4/24/2001	$2,000,000	37090
P7512	101775-1	8/18/1998	Artery allegedly punctured during surgery	4/20/2001	$225,000	7/18/2001
P6971	101953-1	12/30/1997	Allege patient burned during procedure	4/3/2001	$900,000	37090
P7646	101642-1	2/13/1999	Patient unhappy with breast reduction. Needs revision	3/27/2001	$40,000	7/18/2001
P7092	DM0661991733A015/ZA00104	11/3/1996	Alleged failure to properly place a fermoral rod resulting in a further breakdown in the femoral head	2/19/2001	$243,836	37084.40425
P4374	HMO20762-11	1/28/1998	Brain damage and comatose state in 32 year old female allegedly due to a failure to diagnose and treat a pending mi/heart attack	2/12/2001	$2,000,000	7/18/2001
P7486	ND-485210	2/26/1997	Alleged removed median nerve of right wrist instead of the palmaris longus tendon	1/29/2001	$162,500	36972.60668
P2668	DM0661991733A013	8/1/1998	Improper placement of wire prosthesis in ear...	1/23/2001	$67,500	7/18/2001
P3696	ND-509270	10/7/1997	Alleged failure to remove all of the C3-4 disc during surgery	1/23/2001	$85,000	3/22/2001
P5078	7394-1	10/1/1997	Difficult delivery. Alleged C-Section neuro damage	1/22/2001	$300,000	36969.60131
P4565	100316-1	5/11/1997	Improper discharge from emergency room	1/12/2001	$591,113	3/19/2001
P7766	207033	12/19/1997	Breast scarring - The 24 year old femail outpatient underwent bilateral breast reduction for a dx of chronic back pain. One year later she experienced left breast pain. Mammogram revealed a broken off blake drain in her let breast. Two days later the i	1/9/2001	$6,000	5/16/2000

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P3817	MM0008408544328 9/OQ00820	11/12/1999	Alleged failure to place feeding tube into proper position which may have contributed to the patient's death.	12/12/2000	$325,000	37084.41971
P4966	ND-454265	5/1/1996	Extensive pain and serious disfigurement of right hand	12/1/2000	$30,000	1/16/2001
P4612	HM001861-11	9/1/1994	Plaintiff alleges during RCT a bleach irrigant caused severe reaction	10/19/2000	$75,000	36858.59419
P3464	DM0661991733A01 9/YO00152	6/28/1999	Alleged improper contact with plaintiff	10/5/2000	$15,000	36972.69534
P5878	23-836-29121	9/17/1996	organ failure	9/22/2000	$700,000	10/4/2000
P4905	6955-01	3/11/1997	Surgery terminated due to surgeon's becoming ill	8/25/2000	$15,000	3/22/2001
P3388	HM022576-11	6/27/1996	Complications allegedly following gastric bypass surgery	8/22/2000	$50,000	10/4/2000
P3696	ND-483393	4/13/1998	lumbar laminectomy for a herniated disc - post op developed leak of spinal fluid	8/21/2000	$45,000	12/4/2000
P7050	ND-451642	4/5/1996	unaware of 2nd baby when delivering resulting in severe brain damage	6/27/2000	$1,175,000	9/13/2000
P4057	6721-03	9/20/1996	Delay in diagnosis of bowel injury	6/13/2000	$137,500	9/13/2000
P4765	249399	2/23/1995	Failure to diagnose arotic aneurysm	5/25/2000	$20,000	8/15/2000
P6591	HM009881-11	9/19/1997	Death due to an alleged failure to recognize pulmonary problem.	5/22/2000	$200,000	7/24/2000
P5445	DM0661991733A00 9/GF00105	2/23/1995	Alleged failure to diagnose aortic anyuerism	5/18/2000	$125,000	8/3/2000
P4388	100257-1	11/2/1998	Complications following laparoscopic surgery	5/16/2000	$350,000	11/28/2000
P3700	BP00102	10/8/1997	Failure to notice tumor in x-ray	5/3/2000	$45,000	5/15/2000
P7651	100213-1	3/18/1997	Artery cut during surgery, followed by complications	3/31/2000	$30,000	36662
P2706	HMO23192-11	10/30/1998	Death of 29 y/o. Alleged failure to DX pulmonary emboli	3/15/2000	$600,000	36685.40703
P2582	HMO23192-11	10/30/1998	Death of 29 y/o. Alleged failure to DX pulmonary emboli	3/15/2000	$600,000	36685.40703
P4721	7297-1	5/17/1994	birth aspayria suffered by C-section baby	1/28/2000	$1,499,324	
P3803	6013-01	12/6/1989	Delivery complications of large baby	1/11/2000	$150,000	36641
P7884	ND-496643	1/15/1999	Right lung was punctured during needle aspiration of right breast	1/10/2000	$8,000	3/29/2000
P3206	100216-1	11/18/1998	Complications following cataract removal	1/7/2000	$105,000	4/25/2000
P6515	ND-378845	12/13/1995	Failure to properly monitor and assess a patient	1/7/2000	$10,000	
P7646	100346-1	3/23/1998	Patient unhappy with results of surgery	12/10/1999	$75,000	
P5988	108539A	11/19/1994	Patient treated for left femur fracture. Fracture treated with traction. Patient alleges 4 cm leg length discrepancy which required subsequent leg lengthening surgery	12/2/1999	$675,000	
P4856	130056A	1/11/1994	Decreased life expectancy. Patient underwent PAP smear interpreted by insured as showing benign cellular changes. 18 months later patient had abnormal pap smear and was diagnosed with invasive squamos carcinoma, for which she underwent modified radical	11/17/1999	$80,000	
P7997	100749-1	8/16/1999	Patient given prescription despite alleged sensitivity	11/12/1999	$2,387	
P6901	100746-1	9/17/1996	Complications & scarring after tattoo removal	11/5/1999	$1,897	
P5243	HM022571	9/26/1996	Diminished life expectancy due to an alleged failure to diag	7/29/1999	$450,000	
P4267	HM011358	9/5/1998	Lost portion of thumb following self-inflicted injection of hydraulic fluid injury as a result of failure to timely refer to specialist	7/19/1999	$22,500	
P6404	100217-1	6/26/1998	Failure to timely treat hearing loss	7/16/1999	$50,000	
P3584	7236-01	2/24/1997	Complications following knee surgery	6/18/1999	$75,000	
P6016	7318-1	10/20/1997	Complications with rod placement resulting in shortened femu	6/18/1999	$75,000	
P6116	107869A	4/3/1996	Unnecessary mastectomy and lymph node removal.	6/9/1999	$240,000	
P6592	109851A/109852A	9/26/1995	Skull revision surgery. Post surgery, patient went into res	5/26/1999	$400,000	
P4242	3631-01	7/5/1990	DELAY IN DIAGNOSING RETAINED SPONGE	4/27/1999	$75,000	
P5860	6408-01	10/10/1994	Improperly closed reduction of right colles fracture and man	4/19/1999	$45,000	

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P6407	ND-337590	1/18/1995	Surgeon fused wrong discs together	2/2/1999	$72,216	
P4242	6796-01	6/5/1997	Nerve damage during cervical node biopsy	2/2/1999	$20,500	
P7921	7202-01	6/15/1998	Acid burn during wart removal	1/22/1999	$20,000	
P4888	784G1111	5/18/1994	Death of newborn due to failure to diagnose a breech present	1/22/1999	$125,000	
P4726	109852	9/26/1995	Patient underwent skull revision surgery with anesthesia pro	1/6/1999	$825,000	
P3921	HM002822	10/5/1993	cerebral palsy and birth trauma following uterine rupture du	12/15/1998	$540,000	
P4768	5909-01	9/29/1995	Common bile duct was clipped during laparoscopic choleoystec	10/16/1998	$450,000	
P7798	23-836-26893	6/27/1997	Post-Natal infection. Inability to breastfeed and possible	9/23/1998	$5,000	
P4905	6605-01	1/24/1997	Transected uretha-ureters during surgery to remove rectal ma	9/22/1998	$1,090,000	
P4888	784-2-G1111	5/21/1994	Death due to alleged failure to diagnose fetal distress	9/15/1998	$125,000	
P5699	5879-01	5/4/1994	Failure to diagnose Kawasaki's disease	8/4/1998	$650,000	
P6615	6880-01	9/23/1996	Nerve injury during ganglion cystectomy	8/1/1998	$26,000	
P2738	DM06610274-33A001	5/2/1996	Failure to properly monitor narcotic medication	7/29/1998	$35,000	
P7291	10-342-00671	10/25/1996	Surgical injury from laparascopic cholecystectomy. Patient	7/15/1998	$550,000	
P4117	6704-01	6/25/1997	Delivery complications	7/14/1998	$5,000	
P5076	DM06617681-33A006	12/12/1996	Failure to diagnose preeclampsia	7/9/1998	$100,000	
P6515	ND-331351	7/14/1993	improper surgical technique caused complications from staple	7/1/1998	$8,553	
P7086	9503970002064.00	3/7/1995	Unnecessary surgery. Patient underwent a Nissen Fundoplicat	6/30/1998	$115,000	
P3492	244462	11/17/1994	Attempted 2 vasectomies, both unsuccessful	5/6/1998	$35,000	
P3449	784G1498	6/19/1995	Pain and suffering as result of hemilaminectomy	4/29/1998	$90,000	
P3057	5202-01	8/7/1992	Failure to diagnose and treat cholestetoma	4/24/1998	$95,000	
P5485	751A5213/A5214	3/26/1993	Severly neurologically impaired infant due to alleged failur	4/20/1998	$50,000	
P6515	ND-331350	5/11/1993	improper surgical technique caused extensive bleeding and in	4/6/1998	$7,500	
P3603	91129-01	1/12/1990	Failure to diagnose haemophillea influenza Type B meningitis	3/11/1998	$1,500,000	
P7086	9301960001797.00	4/3/1995	Failure to timely diagnose and treat complications arising o	12/23/1997	$250,000	
P3551	ND-419238	6/19/1996	Failure to diagnose	12/22/1997	$7,500	
P5227	4466-01	1/6/1993	Complications following patient ductus surgery	12/19/1997	$850,000	
P4465	32-374668	10/8/1993	Unnecessary appendectomy & negligent laparoscopy, punctured	11/18/1997	$95,000	
P2342	DM06608470-33A001	11/29/1995	Complications resulting from removal of Norplant	10/17/1997	$30,000	
P3822	5356-01	8/10/1993	Failure to recognize symptoms following fall.	9/19/1997	$250,000	
P6221	6566-01	12/9/1995	Bile & hepatic ducts severed during lap chole.	8/8/1997	$120,000	
P3790	5145-02	6/8/1990	Jaundice following delivery. Developmental delays	8/8/1997	$200,000	
P2615	HM005730	4/16/1996	Breast cancer due to alleged failure to read positive mamogr	6/26/1997	$275,000	
P5212	5415-02	8/4/1993	Seizure disorder following birth	6/9/1997	$300,000	
P9254	751A5283	1/20/1995	Additional surgery due to an alleged failure to properly per	5/24/1997	$75,000	
P2837	6285-02	8/12/1994	Negligent care of right ankle fracture caused charcot joint	5/2/1997	$175,000	
P5522	5190-02	7/31/1992	Exploratory laparatomy to biopsy mass, but biopsied kidney i	4/4/1997	$165,000	
P4538	784G1748	1/6/1994	Death due to alleged failure to diagnose & treat lung cancer	3/22/1997	$55,000	
P5227	5393-01	11/20/1992	Failure to diagnose heparin sensitivity	2/18/1997	$325,000	

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P4435	5665-01	4/1/1995	Improper surgical technque and excessive surgery	1/24/1997	$225,000	
P4966	DM06302728-33A012	10/1/1992	Substandard facial surgery	1/22/1997	$10,000	
P6221	5573-01	9/7/1994	Biliary leak/ascites secondary to laparoscopic cholecystecto	1/10/1997	$175,000	
P3724	4885-03	10/1/1992	Patient Death	1/10/1997	$300,000	
P7091	DM06621795-33A001	8/9/1995	Claimant unhappy with outcome of earlobe revision	12/16/1996	$10,000	
P5203	DM06301827-33A001	4/4/1990	Infiltration of dye during venogram procedure	12/3/1996	$75,000	
P4435	6114-01	3/26/1993	Inappropriate/superficially performed surgical procedure	11/15/1996	$10,000	
P4435	6248-01	8/16/1995	Wrong size component in right total knee arthoplasty	10/31/1996	$15,000	
P4435	3447-02	1/21/1990	Failure to diagnose fractured tibia	10/31/1996	$100,000	
P4435	5965-01	2/5/1991	Non-union of sternoclavicular joint	10/31/1996	$280,000	
P4435	4662-01	2/5/1992	Fraud, misprepresentation - shoulder surgery	10/25/1996	$80,000	
P4435	6115-01	2/11/1992	Inappropriate/superficially performed surgical procedure	10/25/1996	$100,000	
P4435	5758-01	3/4/1991	Negligent performance of left knee arthoscopy	10/22/1996	$60,000	
P4435	5993-01	12/16/1993	Patient not satisfied with care rendered for fracture of rig	10/22/1996	$200,000	
P4435	5468-01	9/24/1992	Complications follwing knee surgery	10/22/1996	$225,000	
P4435	5894-01	8/17/1992	Complications following knee surgery	10/8/1996	$62,500	
P4245	6225-01	2/21/1994	Delayed diagnosis of hole in bladder subsequent to hysterect	9/24/1996	$9,079	
P5552	DM06608444-33A001	8/10/1993	Failure to diagnose cancer on Xray film	9/18/1996	$150,000	
P6370	784-3-G1229	10/28/1993	Scar due to improper removal of moles from face.	8/5/1996	$40,000	
P3388	784G1474	6/28/1994	Delayed recovery and septic shock due to alleged negligently	6/25/1996	$70,000	
P5812	DM06301991-33A001	7/26/1990	Complications developed after cataract surgery	6/12/1996	$35,000	
P4856	88932A	1/22/1992	Pap Smear. Lab tech misread, later diagnosis: Cervical Canc	6/5/1996	$58,750	
P3622	5452-01	9/13/1994	Negligent performance of subclavian artery aneurysm surgery	5/24/1996	$250,000	
P5809	5484-03	12/9/1993	Negligent care after hip surgery	5/10/1996	$150,000	
P4476	751D1196	5/31/1995	Packing materials left in patient after surgery	5/10/1996	$5,000	
P6333	5313-01	8/12/1993	Failure to diagnose fractured foot.	4/2/1996	$225,000	
P3862	4212-01	11/7/1990	NEGLIGENT BOWEL SURGERY	3/13/1996	$150,000	
P5510	7847G1155	5/3/1994	Thrombosis due to alleged improper placement of central veno	2/12/1996	$10,000	
P3103	566XM0950 33A041	8/5/1992	Failure to diagnose & treat obstructed drainage shunt	1/29/1996	$70,000	
P3898	4774-02	2/11/1992	inadequate instruction on trach tube maintenance	1/2/1996	$282,500	
P3057	4774-01	2/11/1992	inadequate instruction on trach tube maintenance	1/2/1996	$282,500	
P5709	ND-197734	8/15/1993	Fracture resulting in forearm fracture-closed	12/1/1995	$1,499	
P6194	4791-02	12/15/1991	Wrongful death	10/31/1995	$1,000,000	
P2891	751-4-D1181	3/10/1993	Failure to diagnose and treat cardiac condition	10/30/1995	$900,000	
P4776	4235-01	7/10/1992	Negligent mastectomies	10/16/1995	$277,500	
P5541	4449-01	4/18/1991	Failure to diagnose acute myocardial infarction	9/29/1995	$1,000,000	
P3379	DM06302728-33A017	6/3/1993	Complication during nephrectomy surgery	9/25/1995	$80,000	

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P5670	4374-01	1/31/1991	Negligent oopharectomy	9/5/1995	$1,800	
P5160	5536-01	4/14/1993	Negligent care resulted in suicide	8/31/1995	$660,000	
P2708	DM06619917 33A001	9/28/1992	Negligent in surgery to repair fracture of right arm.	8/7/1995	$108,000	
P4245	4926-01	4/16/1993	Baby delivered with respiratory distress resulting in perman	6/9/1995	$180,000	
P3782	5274-01	5/9/1994	Arthroscopy performed on wrong knee	6/2/1995	$20,000	
P4456	3217-01	3/29/1990	Retained sponge	4/25/1995	$100,000	
P4733	3948	3/22/1990	Contraindication for Birth Control Pills	4/25/1995	$85,000	
P3011	4812-01	7/3/1993	Surgery was started on wrong ankle	3/14/1995	$27,300	
P5009	ND-205012	5/12/1993	Retained foreign object resulting in Genital area infection	1/6/1995	$12,000	
P4826	4749-01	11/25/1992	Nicked ureter during hysterectomy	12/29/1994	$70,000	
P3622	4032-01	9/25/1991	Negligent performance of laparoscopic cholecystectomy	11/4/1994	$220,000	
P4156	5007-02	12/1/1993	misdiagnosis and inappropriate therapy	10/20/1994	$25,000	
P5524	4484-01	1/19/1993	Negligent removal of anticoagulant therapy	10/18/1994	$20,000	
P4214	566XM0753 33A006	12/1/1990	Failure to place screws in fixation device, causing poplitea	9/27/1994	$131,652	
P4417	5235-01	5/26/1993	Patient had 2nd breast biopsy because mass was not removed d	9/19/1994	$3,400	
P5078	4537-01	7/24/1992	Failure to diagnose breast cancer	8/4/1994	$135,000	
P5321	3142-01	4/20/1988	PARALYSIS FOLLOWING BACK SURGERY	7/8/1994	$289,758	
P5130	90347A	7/29/1993	Prescribed Methotrexate. Toxic reaction. Developed Pneumon	6/8/1994	$65,000	
P5321	4819-01	5/23/1991	Unnecessary surgery caused loss of use of hand	5/26/1994	$5,000	
P4985	3987-01	8/7/1989	PERFORATION OF CECUM DURING SURGERY	5/3/1994	$185,000	
P6635	91840A	7/15/1993	Negligent Cataract Surgery	4/26/1994	$120,000	
P6436	23-425-11370	3/15/1993	Nerve damage following a lymph node biopsy	1/27/1994	$67,900	
P4071	3943	4/10/1990	Hemorrage following eye surgery	1/21/1994	$125,000	
P5792	32-367870	4/2/1993	claimant hospitalized after taking incorrect medication amou	1/19/1994	$30,000	
P5985	DM06301547 33A001	2/28/1992	Death during surgery to adjust pacemaker	1/18/1994	$360,000	
P5394	4569-01	6/11/1991	complications during laparoscopic cholecystectomy	1/18/1994	$30,000	
P2134	3300-01	8/19/1988	COMPLICATION DURING ABORTION	1/14/1994	$22,500	
P5218	4672-01	1/12/1993	Delay in diagnosis of distal fibular non-union	12/21/1993	$10,000	
P6045	3989-01	4/22/1992	INFECTION FOLLOWING BACK SURGERY	12/15/1993	$300,000	
P4828	DM06301814	8/4/1989	Claimant alleged incorrect diagnosis of medical condition	11/19/1993	$3,000	
P4917	3552-01	4/4/1989	URETER DAMAGE DURING LAPAROSCOPY	10/22/1993	$165,000	
P6303	4506-01	10/6/1992	Negligent performance of laparoscopic cholecystectomy	10/14/1993	$60,000	
P4976	4620-01	7/1/1991	Surgery on wrong finger	10/1/1993	$2,000	
P5186	3539-01	3/29/1991	Perforated aorta during back surgery	9/21/1993	$75,000	
P4435	4342-01	9/26/1991	Drill bit broke inside patient's knee.	9/8/1993	$35,000	
P5082	DM06301765 33A005	9/7/1991	Wrongful death	8/2/1993	$290,000	
P4456	4133-01	6/10/1991	Bowel perforation during Laparoscopy	7/30/1993	$324,871	
P6286	4463-01	2/20/1993	Improper stitching of finger.	7/21/1993	$22	
P4284	32-321784	12/16/1988	Fetal distress during C-section. Neurological impairment	7/8/1993	$285,000	

License Number	Claim Number	Accident Date	NATURE_OF_CLAIM	Closed Date	Settlement	Entry Date
P5670	32-321784	12/16/1988	Fetal distress during C-section. Neurological impairment	7/8/1993	$285,000	
P2743	3791-01	10/23/1991	Inadvertant incision into iliac artery	6/30/1993	$150,000	
P5242	3677-01	1/25/1990	PERINATAL ASPHYXIA	6/25/1993	$999,675	
P5801	ND-169597	6/26/1991	IV/Blood-Other resulting in Leg deformity	6/25/1993	$200,000	
P5311	3422-01	8/21/1990	COMPLICATIONS FOLLOWING NASAL SURGERY	6/15/1993	$25,000	
P3068	3546-01	9/12/1990	FAILURE TO DIAGNOSE CANCER	4/28/1993	$150,000	
P5487	3813-01	9/9/1991	FAILURE TO DIAGNOSE BROKEN HARRINGTON RODs	4/6/1993	$12,000	
P3068	3881-01	7/31/1991	Retained Sponge	4/5/1993	$20,000	
P4528	4057-01	4/3/1991	RH factor complications	3/26/1993	$300,000	
P4245	32-280167	8/13/1986	BIRTH COMP CAUSED CEREBRAL PALSY	3/10/1993	$25,000	
P4560	32-280167	8/13/1986	BIRTH COMP CAUSED CEREBRAL PALSY	3/10/1993	$25,000	
P3047	DM06302261/33A001	7/24/1991	DOCTOR FAILED TO PERFORM SPHENOID SINUSOtomy; intercerebal h	2/26/1993	$600,000	
P3492	566XM0950 33A005	10/15/1990	Negligent treatment of cancer	2/8/1993	$35,000	
P4417	3176-01	7/18/1989	DEATH FOLLOWING HYSTERECTOMY	2/4/1993	$213,000	
P4403	3752-01	7/26/1991	INADVERTENT INJECTION INTO RETINA SPACE	2/3/1993	$208,000	
P3520	4210-01	8/23/1990	Treatment failed to relieve Nasal problem.	2/3/1993	$4,100	
P5833	DM06302560 33A006	1/2/1990	Blood vessel to testical accidentally cut during vasectomy	1/28/1993	$20,000	
P2836	3426-01	1/1/1989	EXCESSIVE MEDICATION	1/26/1993	$900,000	
P4097	DM06301323 33B001	1/2/1987	improper treatment of finger laceration	1/25/1993	$150,000	
P3492	4007-01	6/2/1990	COMPLICATIONS FOLLOWING BOWEL SURGERY	1/8/1993	$188,686	
P2660	566XM0543/33A006	8/21/1989	FAILURE TO DIAGNOSE LUKEMIA	1/7/1993	$22,000	
P3379	DM06302728 33A003	5/8/1992	Incorrect diagnosis of cancer of prostate	12/18/1992	$10,000	
P3782	4246-01	8/27/1991	Failure to properly treat infection	12/15/1992	$11,000	
P5321	3306-01	6/21/1989	FAILURE TO DIAGNOSE COMPARTMENT SYNDROME	12/10/1992	$425,000	
P6221	4065-01	5/6/1992	Injury to neck caused by multiple attempts to start CVP line	12/2/1992	$20,000	
P3131	3506-01	2/24/1989	COMPLICATIONS FOLLOWING BACK SURGERY. Patient operated on f	8/28/1992	$48,158	
P3932	3324-01	9/30/1988	IMPAIRED MOTOR FUNCTION FOLLOWING LAMINEctomy	8/4/1992	$210,000	
P3696	DM06302560	2/21/1991	DOCTOR REMOVED WRONG DISC DURING SURGERY	7/27/1992	$159,978	
P4917	32-280255 G2	6/11/1987	COMPLICATIONS AFTER SURGERY	7/13/1992	$4,138	
P4645	32-318767 G9	8/13/1987	FAILED TUBAL LIGATION	6/25/1992	$85,000	
P3131	2915-01	9/24/1988	FAILURE TO TREAT fractured vertebra	6/12/1992	$950,000	
P3287	3803-01	2/22/1991	FAILURE TO REMOVE STENT	5/1/1992	$12,000	
P5571	3585-01	5/17/1990	SEXUAL EXPLOITATION	4/21/1992	$100,000	
P4917	2936-01	7/26/1989	MISCARRIAGE AFTER AMNIOCENTESIS	4/16/1992	$30,000	
P3007	3601-01	2/15/1991	FAILURE TO DIAGNOSE BREAST CANCER	3/13/1992	$265,000	
P3855	ND-81854	1/2/1987	ALLEGED IMPROPER CARE-FINGER DISLOCATION	3/12/1992	$491,109	
P5715	3264-01	3/6/1990	BACK SURGERY AT WRONG LEVEL	2/27/1992	$25,000	
P4822	3618-01	3/29/1989	PATIENT DEVELOPED STAPH INFECTION FOLLOW	2/11/1992	$35,000	

License Number	Claim Number	Accident Date	NATURE_OF_CLAIM	Closed Date	Settlement	Entry Date
P3511	32-336381-G6	12/31/1990	WRONG DROPS USED IN PATIENT'S EYE. CAUS	1/27/1992	$8,000	
P2836	3424-01	10/12/1989	EXCESSIVE MEDICATION	1/14/1992	$50,000	
P4578	ND-67612	9/20/1986	COMPLICATIONS DURING DELIVERY RESULTING	12/19/1991	$70,000	
P4087	32-311619-G6	10/15/1986	FAILURE TO DIAGNOSE CANCER LED TO PATIEN	10/10/1991	$490,000	
P5306	1895-01	7/29/1986	WRONGFUL DEATH	8/15/1991	$40,000	
P5805	DM06301718/33A001	1/30/1990	FAILURE TO DIAGNOSE CANCER	8/13/1991	$27,682	
P2836	3194-01	3/21/1990	EXCESSIVE MEDICATION CAUSED DEATH	7/30/1991	$225,000	
P5354	3505-01	9/19/1989	INJURY DURING CYSTOSCOPY	7/25/1991	$50,000	
P4043	DM06300340	4/10/1989	SERRATIA MARCESENS INFECTION OF RT BREAS	7/19/1991	$90,000	
P5355	2806-02	4/30/1988	RENAL FAILURE AFTER CHEMOTHERAPY OVERDOS	7/15/1991	$90,000	
P2461	3030-01	2/27/1989	FAILURE TO TREAT FINGER FRACTURE	6/26/1991	$65,000	
P4757	DM06301508/33A001	9/4/1988	FAILURE TO DIAGNOSE FOREARM FRACTURE	4/3/1991	$3,500	
P2729	034-OAD 454	12/13/1984	REMOVING PATELLA; IMPROPER DIAGNOSIS	11/29/1990	$300,000	
P3817	3068-01	3/23/1989	ALLEGED NEGLIGENT REMOVAL OF CAST - SCAR	11/19/1990	$1,500	
P3510	3017-01	5/20/1986	IMPROPER DIAGNOSIS OF CANCER	11/2/1990	$40,490	
P3911	2756-01	3/23/1980	ALLEG DELAY IN DX/TREAT & INAPPROP TREAT	10/5/1990	$250,000	
P2895	566XM0395	11/25/1985	WIRE LEFT IN BREAST	8/31/1990	$5,000	
P2895	566XMO395	11/25/1985	WIRE LEFT IN BREAST	8/31/1990	$5,000	
P3834	32-273126-G6	6/23/1986	NICKED ILIAC ARTERY DURING SURGERY. PAT	8/23/1990	$150,000	
P4753	32-299555	4/29/1985	MERSILENE STRAP WORKED THROUGH BLADDER D	8/23/1990	$35,000	
P2837	32-259773-G6	5/15/1985	BACK SURGERY PERFORMED AT WRONG LEVEL	8/21/1990	$110,029	
P4856	76106A	11/21/1989	EMOTIONAL DISTRESS DUE TO MIS DIAGNOSIS	8/14/1990	$6,500	
P4973	3224-01	6/11/1990	WRONGFUL DISCLOSURE OF INFORMATION	7/31/1990	$15,000	
P3361	2109-01	5/27/1986	PATIENT DIED FOLLOWING GALL BLADDER SURG	7/30/1990	$10,000	
P4930	2570-01	9/22/1989	FAILURE TO TREAT EYE INJURY RESULTED IN	7/16/1990	$256,000	
P4930	2570-01	9/22/1987	FAILURE TO TREAT EYE INJ RESULTED IN BLI	7/16/1990	$256,000	
P5226	32-286805	9/30/1988	LOSS OF CONSORTIUM: LACK OF OXYGEN SUPP	6/28/1990	$1,188,598	
P2433	4702 201220 01 1	6/29/1972	ALLERGIC REACTION TO ANESTHESIA	5/14/1990	$126,000	
P3711	583JG5363	9/21/1983	IMPROPER PROCEDURE TO DIAGNOSE AND TREAT	5/2/1990	$15,000	
P3834	034-1AB525	7/13/1984	ALLEGED SURGICAL PROCEDURE NOT APPROPRIA	4/9/1990	$85,000	
P3007	32-264403	4/1/1985	LOSS OF CONSORTIUM DUE TO COMPLICATIONS	3/2/1990	$560,000	
P2035	436-0012-829	8/18/1983	SURGICAL SPONGE LEFT IN ABDOMEN	2/27/1990	$25,000	
P4284	32-302087	6/1/1989	INJURY TO UTERINE TUBE DURING EXPLORATOR	2/23/1990	$25,000	
P3834	32-272875-G6	6/25/1986	COMPLICATIONS DURING SURGERY	2/6/1990	$700,000	
P5289	32-276750-G1	2/22/1986	DR GARBER CUT ARTERY DURING C-SECTION SU	1/30/1990	$20,000	
P2813	32-269848	5/9/1987	MENTAL ANGUISH OVER POSSIBLE DIAGNOSIS	1/30/1990	$3,000	
P5028	2449-01	7/17/1988	RH PROBLEM RESULT IN PREMATURITY RENAL/K	12/27/1989	$1,496	
P5354	2343-01	11/25/1986	ALLEG NEG PERFORMANCE OF HYPOSPADIAS REP	12/4/1989	$25,000	
P4966	DM06301847 22M-005	7/2/1987	FAILURE OF BLEPHAROPLASTY	10/31/1989	$10,000	
P4284	32-277585-G6	6/2/1986	ALLEG MD'S FAILED TO DIAG CERVICAL OBSTR	8/16/1989	$25,000	
P3511	32-277585-G6	6/2/1986	ALLEG MD'S FAILED TO DIAG CERVICAL OBSTR	8/16/1989	$25,000	

License Number	Claim Number	Accident Date	NATURE_OF_CLAIM	Closed Date	Settlement	Entry Date
P4057	32-255729	1/15/1985	POOR RESULT FROM TREATMENT OF WRIST FRAC	6/30/1989	$10,000	
P2342	D630TA80175 33B 001	1/6/1985	MISDIAGNOSIS RESULTING IN DEATH	6/1/1989	$100,000	
P5196	1070 33B 001	12/7/1987	ALLEG REMOVAL OF WRONG KIDNEY	5/23/1989	$300,000	
P2545	034-2AB831	9/1/1974	ALLEG FAILURE TO DIAG. SEPTIC HIP	5/2/1989	$250,994	
P2676	034-2AB831	9/1/1974	ALLEG FAILURE TO DIAG. SEPTIC HIP	5/2/1989	$250,994	
P2919	034-2AB831	9/1/1974	ALLEG FAILURE TO DIAG. SEPTIC HIP	5/2/1989	$250,994	
P3511	32-272338	12/12/1985	esophagus perforated during gastroscopy. Not warned of risk	5/1/1989	$6,000	
P4644	0838 33B 001	9/5/1985	ALLEG IMPROPER TREATMENT OF WRIST FRACTU	4/24/1989	$50,000	
P3699	32-249854	9/15/1984	CLT ALLEGES FAILURE TO DIAGNOSE C6, C7 F	4/18/1989	$24,500	
P3629	2368-02	4/3/1987	FAILURE TO DIAGNOSE TUMOR	3/16/1989	$364,744	
P2629	32-253748	12/27/1984	FAILURE TO DIAGNOSE ACHILLES TENDON	1/5/1989	$6,500	
P3978	1316-01	8/9/1984	LINEAR ACCEL. CT STEREOTOXIC RADIA. RESU	12/13/1988	$90,000	
P2734	566XM0395	7/6/1988	ATROPHY TO LEFT BUTTOCK FROM INJECTION	11/8/1988	$23,000	
P5379	563JN7040-33A305	10/21/1986	PREPARED C-SEC. BABY BORN VAGINALLY WITH	10/24/1988	$47,500	
P3183	0251 33J300	1/30/1976	ALLEG FETAL DISTRESS	9/30/1988	$150,000	
P2072	034 9AD 068	1/30/1976	ALLEG FETEAL DISTRESS NOT RECOG PRIOR TO	9/27/1988	$100,000	
P3183	034 9AD 068	1/30/1976	ALLEG FETEAL DISTRESS NOT RECOG PRIOR TO	9/27/1988	$100,000	
P4918	7396 33B 008	11/1/1984	PARTIAL BACK FUSION	8/25/1988	$43,000	
P4190	32-264102-G1	12/28/1984	ALLEG INSUFFICIENT TREATMENT LEAD TO CLM	8/22/1988	$20,000	
P4757	32-264748	5/7/1985	FAILURE TO REFER FOR HEART SURGERY	6/29/1988	$148,000	
P4918	594JC7396 33B-001	1/7/1985	ALLEG NEGLIGENT SURGERY	6/22/1988	$70,000	
P4178	22RM205014/33A00 1	9/5/1987	BONES NOT JOINED CORRECTLY IN LEFT ARM	6/21/1988	$7,000	
P4918	594JC7396	11/21/1983	NEG CARE OF LEFT FRONT	3/25/1988	$100,000	
P4918	594JC7396	10/9/1985	NEG TREAT RT TIBIA FIBULA FRACTURE	3/15/1988	$47,500	
P4971	1834-01	12/20/1983	COMPLICATIONS FOLLOWING HYSTERECTOMY	3/9/1988	$134,789	
P3695	1834-02	12/20/1983	LOSS OF KIDNEY FOLLOWING HYSTERECTOMY	3/9/1988	$270,077	
P4916	4020 33B 007	2/16/1985	ALLERGIC REACTION TO NEMBUTAL	1/8/1988	$3,500	
P4916	08-M-ND-60294	12/18/1985	ADV REACTION TO MEDICATION; RESULTING FI	1/7/1988	$6,500	
P3492	563TA0122-33A300	1/12/1986	CLMT TREATED IN ER W/MAALOX, SENT HOME D	12/18/1987	$55,000	
P4994	21-M-ND-63146	10/22/1985	COMPLICATIONS FOLLOWING SURGERY RESULTIN	12/8/1987	$5,000	
P4994	1934-01	10/21/1985	RETAINED FRAGMENT OF PENNSE DRAIN	11/23/1987	$10,000	
P4918	587JC7211 33B001	7/6/1983	INFECTION	11/16/1987	$25,000	
P2721	4430 33B 008	9/17/1985	FAILURE TO DIAGNOSE TEAR IN ESOPHAGUS	9/17/1987	$2,500	
P5196	563 TA 3322 33B 001	10/28/1985	POST OP SURGERY COMPLICATIONS	9/8/1987	$17,500	
P1578	32-267054-G9	4/22/1987	CLMT SWALLOWED IMPRESSION MATERIAL	6/6/1987	$884	
P1976	32-244600	9/28/1982	FAILURE TO DIAGNOSE SHOULDER DISLOCATION	5/26/1987	$112,324	
P2779	32-244600	9/28/1982	FAILURE TO DIAGNOSE SHOULDER DISLOCATION	5/26/1987	$112,324	

License Number	Claim Number	Accident Date	NATURE_OF_CLAIM	Closed Date	Settlement	Entry Date
P4378	563JN7040-33A304	1/22/1985	ALLEG DRS DAMAGED LEFT URETER DURING SUR	5/26/1987	$27,250	
P3369	32-244600	9/28/1982	FAILURE TO DIAGNOSE SHOULDER DISLOCATION	5/26/1987	$112,324	
P4057	32-244600	9/28/1982	FAILURE TO DIAGNOSE SHOULDER DISLOCATION	5/26/1987	$112,324	
P3908	563JN7040-33A304	1/22/1985	ALLEG DRS DAMAGED LEFT URETER DURING SUR	5/26/1987	$27,250	
P3945	563-TA-2005 33B00	12/11/1982	ALLEG INFECTION IMROP TREATED, SUBSEQU	3/10/1987	$75,000	
P3320	1632-01	12/16/1985	FAILURE TO DIAGNOSE/TREAT ECTOPIC PREGNA	12/30/1986	$6,000	
P2869	563TA3270 33B 001	2/14/1985	FAILURE TO DIAGNOSE	12/19/1986	$2,000	
P2905	582JH7304-33B003	12/24/1981	CLMT UNDERWENT BYPASS SURG. HAD A STROKE	8/11/1986	$18,800	
P4421	ND-37893	7/9/1984	Complications during delivery resulting in fatality	8/11/1986	$1,380	
P4284	747 L 68384	11/19/1982	perforation of bladder during laparoscopy	4/23/1984	$6,000	
P7924	107436-1	9/23/2003	Unauthorized release of information.		$20,000	12/1/2004
P2581	248990	3/2/1995	Chest x-ray on 3/2/95 for pre-op exam for hysterectomy & diagnosis was made on 6/4/96. Alleged failure to diagnose lung cancer resulting in death.		$137,500	7/2/2004
P3361	2109-01	5/25/1986	PT DIED FOLLOWING GALL BLADDER SURGERY		$270,077	
P3080	MD06300308 33A001	8/21/1990	improper diagnosis of condition following eye surgery		$10,000	
P4465	DM06302206/33A00 7	7/31/1989	INSURED SUTURED RIGHT URETER DURING HYST		$30,000	

Medical Liability Reforms Reduce Premiums

Medical Liability Insurance Premiums

Rate Changes for Texas Medical Liability Trust Since Reform Enacted in 2003

2004	2005	2006	2007	2008	2009
-12%	-5%	-5%	-7.5%	-6.5%	-4.7%

Dividends for Policy Holders of Texas Medical Liability Trust Since Reform Enacted in 2003

2005	2006	2007	2008
5%	20%	22%	22.5%
$10 million	$35 million	$30 million	$30 million

Dividend Credits since 2005 total approximately $105 million

Rate Changes for Medical Assurance Company of Mississippi Since Reform Enacted in 2004

2005	2006	2007	2008	2009
0%	-5%	-10%	-15.5%	-20%

Refunds for Policy Holders of Medical Assurance Company of Mississippi

Since Reform Enacted in 2004

2005	2006	2007	2008
15%	20%	25%	20%

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Policy Research Perspectives

The Impact of Caps on Damages. How are Markets for Medical Liability Insurance and Medical Services Affected?

By Carol K. Kane, PhD and David W. Emmons, PhD

Introduction

The current crisis in the medical liability insurance market has been characterized by insurer exits and rapidly escalating premiums in certain states and specialties.[1] As a result, many physicians have reported that they have moved or plan to move to states where liability premiums are lower, or that they have stopped or intend to stop providing certain services so that they fall into lower risk classifications and are able to pay lower premiums.[2]

To stem the rise in premiums, many physician organizations including the American Medical Association have called for state or federal tort reform similar to the package of reforms included in California's Medical Injury Compensation Reform Act of 1975 (MICRA). The 1970s and 1980s were also marked by insurance crises in medical liability, and California and other affected states enacted a variety of tort reforms in response. Much of the current debate over medical liability reform is focused on whether MICRA-like reforms – in particular, a cap on non-economic damages – would reduce the growth in both indemnity amounts (insurer losses) and premiums paid by physicians in the future if enacted either at the federal level or in other states today.

Existing research on the impact of caps on non-economic damages on medical liability losses and premiums relies on data from the earlier periods of crisis because it offers the opportunity to compare states that enacted a cap with those that did not, and to compare states that enacted a cap before and after it became effective. This Policy Research Perspective provides a summary of research on the impact of caps including those on punitive and total[3] damages in addition to those that apply only to non-economic damages. Our focus is on those papers that employ statistical techniques to control for potentially competing explanations of changes that are observed when simple descriptive statistics are used.

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[1] American Medical Association (2004).
[2] American Medical Association, Division of Market Research (2004).
[3] Total damages include non-economic and economic damages.

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The literature clearly shows that caps reduce losses relative to what losses would have been without caps. Although premiums are ultimately linked to losses,[4] it has been more difficult to empirically establish the link between caps and premiums than it has the link between caps and losses – however, more recent papers looking at the impacts of caps on premiums have found an effect.[5] Finally, two studies published in 2005 reported positive impacts associated with caps on damages on physician supply.

The research summarized in this report measures the average impact of caps that differ in several dimensions including the amount of the cap and whether there are exceptions to the cap for certain types of medical outcomes. States also vary in the manner in which the cap applies to a claim. In some states a single cap applies regardless of the number of defendants named while in others the cap is per defendant. Similarly, in some states a single cap applies regardless of the number of causes of action on which the claim is based or the number of persons claiming damages and in others it is applied per cause of action and per person claiming damages.

Impact of Caps on Losses and Premiums

One branch of this literature relies on data from the end-of-year annual statements filed by insurers with state insurance departments. Those data are not on a per-claim basis or a per-physician basis. Rather, they reflect the aggregate medical liability losses and revenues of each insurer across all insured physicians and filed claims. Some researchers have used the data at the state-insurer level, where the losses and revenues of each insurer in the state remain distinct from one another. Others further aggregate the data so that it is at the state-level—the losses and revenues of each insurer in the state are added together.

- Viscusi and Born (2005) studied the impacts of reforms on premium revenues and incurred losses using state-insurer specific NAIC data for the period 1984 to 1991.[6] They found that insurers in states that enacted caps on non-economic damages had losses 17% lower than those of insurers in other states and that earned premiums were 6% lower. In addition, losses and premiums of insurers in states where punitive damages were not allowed (i.e., in the case of states with zero dollar caps on punitive damages) were 16% and 8% lower than losses and premiums of insurers in states that allowed punitive damages. Viscusi and Born also reported the more general finding that states with a non-zero cap on punitive damages had incurred losses that were 7% lower than other states. They did not find a corresponding effect on premiums for the more general measure, however.

- Thorpe (2004) studied impacts of reforms on premium revenues and incurred losses using state-specific NAIC data for the period 1985 to 2001. Thorpe found that premium

[4] Both the General Accounting Office (2003) and the National Association of Insurance Commissioners (Nordman, Cermak, and McDaniel, 2004) issued comprehensive reports that found losses to be the key driver of premiums.

[5] A number of factors make it difficult to find premium impacts. For one, there may be initial uncertainty about the impact of a cap on losses. As claims subject to a new cap are closed, this uncertainty lessens and insurers are better able to predict how losses will be affected and can appropriately reflect that change in their premiums. In addition, there may be uncertainty as to whether the constitutionality of the cap will withstand judicial scrutiny, and thus whether immediate impacts on losses will continue into the future.

[6] Earlier papers by Viscusi, Born, and several co-authors have reached similar conclusions. Because the research has evolved over time and the results are robust to the changes in methodology, we have summarized only the 2005 paper which is the most recent. Earlier research includes Viscusi and Born (1995), Viscusi, Zeckhauser, Born, and Blackmon (1993), and Blackmon and Zeckhauser (1991).

revenue was between 13% and 17% lower in states that capped non-economic or total damages than in states that did not. Thorpe also reported a 13% reduction in loss ratios associated with discretionary collateral offset rules. Unlike Viscusi and Born (2005), Thorpe did not find any impacts that were attributable to limitations on punitive damages.

Other papers used per-physician premium data from surveys of insurers conducted by the Health Care Financing Administration.[7]

- Zuckerman, Bovbjerg, and Sloan (1990) examined the impact of a variety of tort reforms on premiums and claim severity using base-rate premium data and average (per-claim) indemnity data from 1975 to 1986. They found that capping physician liability (but not caps on non-economic damages) reduced premiums for general surgeons, general practitioners, and obstetricians and gynecologists on the order of 13% in the year following enactment of a cap and by 34% over the long term. Across all specialties, they found that caps on non-economic damages (but not caps on physician liability) decreased the average indemnity per paid claim (claim severity).[8]

- Sloan (1985) relied on the same source of information on premiums for his analysis but focused on the period 1974 to 1978. Sloan examined premiums paid by general practitioners, ophthalmologists, and orthopedic surgeons. He was unable to find any impact on premiums from either plaintiff recovery limitations or provider liability limitations.

In response to the crisis of the 1970s, the NAIC developed a national database of closed claims. The GAO conducted a similar study of claims closed in 1984.[9] The following paper uses that information.

- Sloan, Mergenhagen, and Bovbjerg (1989) looked at the impact of tort reform using closed claim data for 1975 through 1978 and 1984. They found that caps on non-economic damages reduced insurer payouts by 31% and reduced payouts-plus-expenses by 23%. The impacts of caps on total damages were somewhat larger, 38% and 39%, respectively.

In a series of papers Daniel Kessler and coauthors examined the impact of "direct" and "indirect" tort reforms of the mid to late 1980s on the markets for medical liability insurance and health care services. Direct reforms include but are not limited to caps on non-economic damages.[10] Viewed as a whole, the authors' research shows that direct tort reforms reduce a variety of costs associated with the medical liability system.

- Kessler and McClellan (1996) compared hospital expenditures on Medicare beneficiaries with heart disease in states with direct, indirect, and no tort reforms. They concluded that states adopting direct reforms in the late 1980s exhibited reductions in hospital

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[7] HCFA's name was changed to the Centers for Medicare & Medicaid Services in 2001.

[8] The authors were not able to resolve the different impacts that caps on physician liability and caps on non-economic damages had on premiums and losses.

[9] In 2004 the GAO's legal name became the Government Accountability Office.

[10] Direct reforms include caps on economic, non-economic, or total damages, abolition of punitive damages, no mandatory prejudgment interest, and collateral source rule reform. Indirect reforms include limits on contingency fees, mandatory periodic payments, joint and several liability reform, statute of limitations reform, and existence of a patient compensation fund.

expenditures of 5% to 9% within three to five years without substantial adverse affects on mortality or complications. Because outcomes were not affected, they attributed the cost difference to defensive medicine. If their results are applied to all medical spending, this would have amounted to an $83.9 to $151.1 billion reduction in national health spending in 2003.

- Kessler and McClellan (1997) examined "malpractice pressure," measured by liability premiums and claim frequency, and how that pressure was affected by tort reform. Both the premium and frequency data were from 1985 through 1993 surveys of physicians conducted by the AMA. They found that direct reforms reduced premiums by 8.4% within the first three years after a reform, and reduced the likelihood that a physician would be sued by 2.1%.

A number of literature reviews have also concluded that caps on non-economic damages work to reduce claim severity and premiums.

- Using a variety of data sources, Hamm, Wazzan, and Frech (2005) concluded that MICRA has led to a reduction in medical liability costs both through a reduction in the filing of weak claims and a reduction in the severity of paid claims. After comparing claim frequency in California to that in other states they also concluded that MICRA did not reduce access to the courts.

- The Congressional Budget Office (1998) concluded that caps on non-economic damages were one of two reforms that "have been found extremely effective in reducing the amount of claims paid and medical liability premiums." The other reform was collateral source offset provisions.

- The Office of Technology Assessment (1993) concluded that "caps on damage awards were the only type of State tort reform that consistently showed significant results in reducing the malpractice cost indicators."[11]

The research summarized in this report controls for state differences in a wide variety of factors. For this reason it is more credible than reports which simply compare unadjusted state averages in premiums, losses, or physician supply. Nevertheless, sometimes a simple comparison speaks directly and clearly to the heart of the matter.

- A comparison of annual data on insurers' earned premium revenues shows that while premiums in California increased by 282% between 1976 and 2003, they increased by 920% in the rest of the country (National Association of Insurance Commissioners, 2004).

Impact on Physician Supply

Debate has also focused on whether physicians respond to premium increases by moving to lower-premium states or by retiring early. This question is not easy to answer because of the difficulty of tracking the movements of nearly 700,000 patient care physicians in "real time." The American Medical Association's Physician Masterfile, the sole national, annual source of

[11] The OTA was nonpartisan analytical agency that provided assistance to the U.S. Congress for 23 years through 1995.

demographic information on physicians, should only be used to look at longer term changes in physician supply. Two recent papers have used the Masterfile data to do just that.

- Kessler, Sage, and Becker (2005) examined physician supply from 1985 to 2001. They found that direct tort reforms increased physician supply by 2.4% relative to non-reform states. They also looked at the impact on a number of high-risk specialties and found that the impact on emergency physicians was particularly large, 11.5%.

- Encinosa and Hellinger's paper (2005) also looked at the impact of caps on physician supply. They looked specifically at the impact of caps on non-economic damages from 1985 to 2000. They concluded that caps increased the supply of physicians per capita by 2.2% relative to states without caps.

Conclusion

The impacts from caps summarized in this report are average effects found in analyses that have implemented statistical controls for other factors (or potentially competing explanations) for the changes being studied. They measure the average impact of caps that were set at different levels and implemented in states with different pre-cap payment (loss) distributions. The actual impact of a cap in any particular state may be higher or lower than the impacts found in this literature.

Clearly, the body of research on the impacts of tort reform shows that caps have resulted in lower growth in medical liability losses in states that passed caps than in states that did not. The more recent literature on premium effects has found that caps result in lower premium growth. And, two very recent papers based on sufficiently many years of the AMA's Masterfile data have found that non-economic caps and direct tort reforms more generally have a positive effect on the number of physicians per capita in a state.

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United States General Accounting Office

GAO

Report to Congressional Requesters

August 2003

MEDICAL MALPRACTICE

Implications of Rising Premiums on Access to Health Care

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GAO-03-836

North Dakota
Insurance Department

Adam W. Hamm, Commissioner

Memo

To: Chairman Dekrey , House Judiciary Committee

From: Larry Maslowski, North Dakota Insurance Department

Date: February 12, 2009

Reason: HB 1390 – Report requested by the committee from the Medical Malpractice Claims Reporting database.

The database originated in 1983 according to NDCC 26.1-01-05. The information we are providing includes reported claims from 1983 to present.

From the database we have compiled the following:

- A separate report for:
  - Physicians
  - Health Care Institutions (hospitals, clinics, etc)
  - Others Health Care Providers (dentists, chiropractors, nurses etc)
- Each report shows the following by year:
  - The number of claims in which payment was made.
    - The amount of payment/settlement for each individual paid claim.
    - The amount of loss adjusting expense (LAE) for each individual paid claim.
  - The number of claims in which no payment was made (LAE is shown).
- A summary report by year for each category and a summary of all categories combined.

For the committees reference you will also find attached a copy of the current Form SFN 17118 used by health care providers or insurance carriers in making the report to the department. Page two shows the statutory reference NDCC 26.1-01-05 for this process.

Please note the report does not identify whether the payment to the plaintiff is for economic, non economic or punitive damages. It reports only the aggregate amount paid to the plaintiff, and the Loss Adjusting Expenses (defense and other expenses combined).

Should you need further input from me I can be reached at 328-4976 or lmaslows@nd.gov

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NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

CLAIMS VS PHYSICIANS

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS PHYSICIANS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1983				
Claims w Payment		0	$0	$0
Claims w/o Payment		1	$0	$34,500
1983 Total		1	$0	$34,500
1984				
	1		$112,324	$0
	68		$75,000	$34,973
	203		$18,800	$24,396
	975		$6,000	$2,650
Claims w Payment		4	$212,124	$62,019
Claims w/o Payment		3	$0	$55,070
1984 Total		7	$212,124	$117,089
1985				
	113		$90,000	$66,725
	204		$25,000	$11,477
	336		$24,500	$10,568
	401		$15,000	$28,669
	342		$6,500	$22,759
	201		$2,000	$13,025
Claims w Payment		6	$163,000	$153,223
Claims w/o Payment		12	$0	$137,238
1985 Total		18	$163,000	$290,461
1986				
	36		$270,077	$36,115
	105		$250,994	$36,708
	49		$150,000	$0
	95		$148,000	$16,404
	121		$134,789	$3,186
	549		$110,029	$62,235
	502		$100,000	$40,633
	4		$85,000	$115,691
	207		$70,000	$35,314
	67		$55,000	$0
	69		$17,500	$10,490
	346		$10,000	$4,464
	115		$6,000	$0
	18		$3,500	$6,228
	883		$1,380	$0
Claims w Payment		15	$1,412,269	$367,468
Claims w/o Payment		28	$0	$350,708
1986 Total		43	$1,412,269	$718,176

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS PHYSICIANS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1987				
	548		$700,000	$30,417
	543		$560,000	$33,134
	34		$300,000	$35,163
	129		$270,077	$36,115
	108		$100,000	$6,204
	50		$50,000	$30,456
	205		$47,500	$17,942
	168		$47,500	$0
	211		$43,000	$4,160
	474		$40,000	$21,840
	63		$27,250	$4,852
	22		$20,000	$15,538
	124		$10,000	$312
	247		$10,000	$13,779
	56		$7,000	$0
	250		$6,500	$3,056
	27		$6,000	$3,009
	13		$5,000	$2,460
	331		$3,000	$10,880
	61		$2,500	$70
	316		$884	$0
Claims w Payment		21	$2,256,211	$269,387
Claims w/o Payment		57	$0	$63,584
1987 Total		**78**	**$2,256,211**	**$332,971**
1988				
	544		$1,188,598	$20,742
	131		$364,744	$748
	158		$300,000	$96,523
	136		$256,000	$380
	251		$256,000	$380
	545		$150,000	$25,015
	962		$150,000	$0
	559		$126,000	$11,525
	14		$70,000	$10,171
	38		$25,000	$4,707
	100		$25,000	$10,149
	30		$25,000	$68,882
	1		$20,000	$21,301
	102		$4,138	$19,400
	133		$1,496	$376
Claims w Payment		15	$2,961,976	$290,299
Claims w/o Payment		25	$0	$127,225
1988 Total		**40**	**$2,961,976**	**$417,524**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS PHYSICIANS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1989				
	145		$950,000	$62,833
	141		$250,000	$44,234
	538		$213,000	$40,294
	46		$90,000	$8,228
	540		$85,000	$14,174
	546		$35,000	$9,841
	246		$30,000	$33,021
	547		$25,000	$1,945
	95		$25,000	$136
	71		$23,000	$0
	90		$10,000	$500
	73		$5,000	$1,400
	422		$5,000	$1,400
Claims w Payment		13	$1,746,000	$218,006
Claims w/o Payment		36	$0	$76,779
1989 Total		**49**	**$1,746,000**	**$294,784**
1990				
	605		$900,000	$1,241,919
	280		$491,109	$26,937
	465		$490,000	$24,941
	536		$425,000	$800
	42		$289,758	$36,340
	775		$285,000	$149,787
	239		$225,000	$77,423
	535		$210,000	$90,986
	944		$100,000	$74,352
	1218		$75,000	$55,923
	252		$65,000	$8,137
	453		$50,000	$2,189
	259		$40,490	$9,803
	509		$27,682	$0
	451		$25,000	$348
	611		$25,000	$13,336
	241		$22,500	$88,320
	516		$22,000	$0
	238		$15,000	$0
	533		$6,500	$0
	515		$3,500	$300
	255		$1,500	$201
Claims w Payment		22	$3,795,039	$1,902,042
Claims w/o Payment		45	$0	$264,832
1990 Total		**67**	**$3,795,039**	**$2,166,874**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS PHYSICIANS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1991				
	434		$999,675	$17,216
	580		$600,000	$0
	934		$290,000	$0
	442		$265,000	$405
	429		$208,000	$312
	588		$165,000	$23,292
	598		$159,978	$5,638
	610		$150,000	$14,957
	756		$150,000	$14,428
	868		$131,652	$0
	496		$100,000	$0
	818		$75,000	$3,171
	590		$75,000	$10,590
	585		$50,000	$0
	582		$48,158	$250
	452		$35,000	$198
	565		$30,000	$0
	939		$20,000	$0
	431		$12,000	$16
	436		$12,000	$0
	940		$10,000	$0
	454		$8,000	$1,404
	935		$3,000	$0
Claims w Payment		23	$3,597,463	$91,877
Claims w/o Payment		37	$0	$201,887
1991 Total		**60**	**$3,597,463**	**$293,764**
1992				
	937		$360,000	$0
	660		$324,871	$1,016
	628		$300,000	$0
	649		$300,000	$975
	859		$277,500	$10,789
	745		$220,000	$21,050
	636		$200,000	$2,309
	652		$188,686	$8,777
	648		$185,000	$35,388
	645		$150,000	$19,258
	662		$125,000	$11,358
	661		$85,000	$18,800
	1065		$35,000	$78,562
	663		$20,000	$9,355
	720		$20,000	$0
	666		$11,000	$0
	936		$10,000	$0
	721		$4,100	$0
Claims w Payment		18	$2,816,157	$217,637
Claims w/o Payment		36	$0	$820,479
1992 Total		**54**	**$2,816,157**	**$1,038,116**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS PHYSICIANS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1993				
	748		$1,000,000	$75,771
	800		$1,000,000	$66,726
	841		$850,000	$20,239
	798		$282,500	$19,494
	797		$282,500	$19,262
	831		$135,000	$7,123
	769		$120,000	$1,210
	734		$80,000	$13,834
	1021		$80,000	$4,438
	803		$70,000	$577
	791		$67,900	$0
	768		$65,000	$2,000
	832		$60,000	$720
	766		$58,750	$30,037
	726		$35,000	$2,824
	733		$30,000	$144
	786		$30,000	$5,154
	987		$27,300	$150
	845		$20,000	$600
	746		$10,000	$600
	1145		$10,000	$0
	801		$5,000	$95
	744		$2,000	$0
	728		$1,800	$17,725
	764		$1,499	$0
	722		$22	$0
Claims w Payment		26	$4,324,271	$288,722
Claims w/o Payment		45	$0	$305,147
1993 Total		**71**	**$4,324,271**	**$593,869**
1994				
	998		$325,000	$7,298
	860		$300,000	$11,138
	1123		$300,000	$23,551
	993		$250,000	$13,880
	1057		$250,000	$11,251
	1029		$225,000	$2,522
	1119		$200,000	$18,723
	945		$180,000	$18,750
	854		$165,000	$12,668
	1157		$150,000	$99,176
	1018		$108,000	$874
	866		$95,000	$41,284
	1053		$70,000	$26,959
	862		$25,000	$377
	980		$20,000	$200
	795		$12,000	$4,538
	830		$3,400	$0
Claims w/Payment		17	$2,678,400	$293,188
Claims w/o Payment		35	$0	$209,653
1994 Total		**52**	**$2,678,400**	**$502,841**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS PHYSICIANS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1995				
	1032		$900,000	$1,157
	948		$660,000	$25,249
	1062		$650,000	$76,112
	1134		$450,000	$20,192
	1122		$280,000	$240
	947		$225,000	$6,210
	1146		$225,000	$5,958
	1113		$200,000	$3,930
	1060		$175,000	$12,071
	1016		$150,000	$1,713
	1159		$150,000	$141,314
	1041		$125,000	$41,258
	1347		$125,000	$40,691
	1230		$75,000	$3,102
	1613		$75,000	$30,674
	1006		$72,216	$46,507
	1108		$62,500	$6,467
	982		$60,000	$159
	1288		$50,000	$43,694
	1043		$40,000	$4,400
	1148		$10,000	$3,041
	955		$8,553	$21,448
	954		$7,500	$25,386
	1293		$5,000	$1,242
Claims w Payment		24	$4,780,768	$562,214
Claims w/o Payment		37	$0	$318,455
1995 Total		**61**	**$4,780,768**	**$880,669**
1996				
	1110		$1,500,000	$179,386
	1346		$540,000	$53,603
	1204		$175,000	$300
	1260		$137,500	$21,947
	1126		$100,000	$240
	1079		$100,000	$240
	1294		$90,000	$17,819
	1464		$80,000	$6,294
	1229		$70,000	$12,390
	1116		$65,000	$229,491
	1228		$55,000	$20,111
	1078		$45,000	$400
	1220		$35,000	$13,023
	1234		$30,000	$100
	1100		$15,000	$750
	1132		$10,000	$1,632
	1172		$10,000	$11,483
	1128		$10,000	$0
	1099		$9,079	$0
Claims w Payment		19	$3,076,579	$569,210
Claims w/o Payment		31	$0	$424,880
1996 Total		**50**	**$3,076,579**	**$994,089**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS PHYSICIANS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1997				
	1630		$2,000,000	$15,490
	1246		$1,090,000	$637
	1348		$825,000	$53,000
	1257		$700,000	$74,145
	1144		$675,000	$21,066
	1227		$550,000	$5,070
	1198		$400,000	$138,000
	1231		$275,000	$10,648
	1248		$250,000	$9,315
	1222		$240,000	$2,688
	1562		$200,000	$15,087
	1274		$137,500	$0
	1201		$120,000	$700
	1283		$115,000	$29,173
	1278		$100,000	$6,863
	1581		$50,000	$165,256
	1277		$35,000	$235
	1256		$35,000	$0
	1247		$26,000	$434
	1240		$20,500	$359
	1209		$7,500	$0
	1306		$5,000	$460
Claims w Payment		22	$7,856,500	$548,625
Claims w/o Payment		23	$0	$269,326
1997 Total		**45**	**$7,856,500**	**$817,951**
1998				
	1435		$2,000,000	$35,339
	1376		$1,499,324	$4,298
	1286		$1,175,000	$45,087
	1539		$600,000	$8,740
	1397		$450,000	$12,466
	1374		$300,000	$94,867
	1714		$190,000	$100,298
	1568		$125,000	$52,684
	1404		$75,000	$534
	1304		$75,000	$3,248
	1265		$30,000	$22,213
	1275		$20,000	$47,709
	1305		$20,000	$39
	1252		$15,000	$4,866
	1284		$5,000	$1,160
Claims w Payment		15	$6,579,324	$433,549
Claims w/o Payment		51	$0	$125,593
1998 Total		**66**	**$6,579,324**	**$559,142**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS PHYSICIANS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1999				
	2048		$2,000,000	$74,833
	1406		$700,000	$79,245
	1323		$591,113	$1,142
	1319		$350,000	$250
	1666		$243,836	$162,674
	1670		$200,000	$15,081
	2232		$200,000	$154,330
	1373		$162,500	$10,685
	1642		$150,000	$20,153
	1318		$105,000	$0
	1471		$85,000	$4,880
	1393		$75,000	$250
	1453		$75,000	$45,000
	1330		$72,500	$32,499
	1674		$67,500	$22,198
	2129		$65,000	$40,368
	1314		$50,000	$0
	1369		$45,000	$18,355
	1521		$45,000	$1,165
	1315		$30,000	$21,501
	1388		$22,500	$0
	1698		$20,000	$25,906
	1326		$15,000	$0
	1658		$15,000	$36,658
	1899		$12,000	$28,995
	1481		$8,000	$0
	1445		$2,387	$0
	1444		$1,897	$0
Claims w Payment		28	$5,409,233	$796,167
Claims w/o Payment		56	$0	$385,555
1999 Total		**84**	**$5,409,233**	**$1,181,722**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS PHYSICIANS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
2000				
	1736		$2,094,400	$288,979
	1708		$1,250,000	$61,861
	1659		$900,000	$16,770
	1716		$550,000	$17,624
	1739		$385,000	$87,372
	1673		$325,000	$5,748
	2120		$261,800	$0
	2119		$261,800	$0
	1765		$250,000	$31,159
	1628		$237,500	$171,645
	1579		$225,000	$7,389
	1640		$200,000	$0
	2015		$137,500	$28,060
	1720		$125,000	$16,997
	1569		$65,000	$22,729
	1803		$50,000	$6,211
	1563		$40,000	$0
	1903		$37,500	$16,185
	1671		$15,934	$10,552
	1700		$15,000	$7,356
	1525		$6,000	$975
	1558		$5,000	$0
	1740		$5,000	$3,761
Claims w Payment		23	$7,442,434	$801,372
Claims w/o Payment		43	$0	$277,186
2000 Total		**66**	**$7,442,434**	**$1,078,558**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS PHYSICIANS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
2001				
	1637		$1,900,000	$150,595
	2004		$750,000	$69,209
	1830		$406,000	$67,189
	2145		$325,000	$74,838
	1846		$325,000	$10,864
	1728		$250,000	$1,054
	1731		$250,000	$1,956
	1923		$225,000	$0
	1962		$200,000	$46,807
	2110		$130,000	$34,899
	1735		$125,000	$1,086
	1942		$87,500	$875
	1883		$87,500	$3,987
	2008		$82,500	$1,783
	1745		$70,000	$146
	1901		$58,750	$51,423
	1977		$50,000	$14,002
	1763		$35,000	$1,395
	1925		$30,000	$1,000
	1665		$20,000	$0
	1738		$12,000	$0
	2056		$10,000	$48,895
	1696		$7,500	$0
Claims w Payment		23	$5,436,750	$582,001
Claims w/o Payment		41	$0	$919,705
2001 Total		**64**	**$5,436,750**	**$1,501,706**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS PHYSICIANS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
2002				
	1779		$1,875,000	$225,285
	1780		$1,875,000	$92,888
	1932		$1,600,000	$69,008
	1816		$1,170,000	$23,959
	1797		$850,000	$35,121
	1799		$750,000	$465
	1815		$690,000	$166,797
	1937		$575,000	$1,311
	1863		$425,000	$2,331
	2055		$300,000	$95,147
	1812		$300,000	$13,845
	1862		$300,000	$17,928
	1781		$240,000	$1,039
	2242		$182,500	$10,513
	1882		$165,000	$545
	1935		$155,000	$5,221
	1853		$117,250	$750
	1851		$90,000	$0
	1880		$64,000	$0
	1782		$57,750	$35
	2050		$50,000	$23,622
	2005		$45,000	$0
	1852		$45,000	$0
	1895		$40,000	$1,887
	1819		$30,000	$0
	1818		$25,000	$1,468
	1825		$20,000	$5,439
	1867		$10,000	$347
	1887		$7,500	$0
Claims w/Payment		29	$12,054,000	$794,951
Claims w/o Payment		68	$0	$1,092,913
2002 Total		**97**	**$12,054,000**	**$1,887,864**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS PHYSICIANS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
2003				
	1991		$1,200,000	$3,523
	2053		$600,000	$6,672
	1915		$500,000	$60,503
	1920		$425,000	$4,136
	1919		$425,000	$7,151
	1978		$400,000	$15,883
	2136		$262,500	$6,702
	2190		$262,500	$4,612
	2061		$237,500	$20,469
	2007		$225,000	$0
	1933		$200,000	$28,088
	1950		$150,000	$38,315
	2108		$149,000	$62,924
	1949		$130,000	$16,213
	2151		$118,750	$0
	2087		$110,000	$76,702
	1943		$100,000	$0
	3231		$87,500	$0
	1944		$85,000	$0
	1961		$72,500	$10,245
	2003		$70,000	$0
	2140		$70,000	$16,352
	2186		$70,000	$16,352
	3229		$43,750	$89,841
	3230		$43,750	$0
	2117		$20,000	$5,503
	2084		$20,000	$48,506
	2057		$6,472	$1,126
Claims w Payment		28	$6,084,222	$539,819
Claims w/o Payment		39	$0	$421,218
2003 Total		**67**	**$6,084,222**	**$961,037**
2004				
	2011		$2,000,000	$54,316
	2032		$265,000	$0
	3275		$225,000	$99,818
	2094		$200,000	$62,260
	2012		$200,000	$0
	2040		$40,000	$7
	2132		$35,000	$21,602
	2010		$25,000	$0
Claims w Payment		8	$2,990,000	$238,003
Claims w/o Payment		24	$0	$445,101
2004 Total		**32**	**$2,990,000**	**$683,104**
2005				
	2255		$300,000	$12,717
	2203		$250,000	$21,004
	2144		$225,000	$37,230
	3276		$225,000	$70,593
	2284		$150,000	$23,105
Claims w Payment		5	$1,150,000	$164,649
Claims w/o Payment		16	$0	$245,002
2005 Total		**21**	**$1,150,000**	**$409,651**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS PHYSICIANS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
2006				
	3285		$725,000	$17,120
	2229		$425,000	$0
	3215		$326,927	$44,063
	2243		$326,927	$4,990
	3336		$275,000	$124,724
	3284		$165,000	$28,768
	3225		$150,000	$8,550
	3227		$23,000	$0
Claims w Payment		8	$2,416,854	$228,215
Claims w/o Payment		27	$0	$197,757
2006 Total		**35**	**$2,416,854**	**$425,971**
2007				
Claims w Payment		0	$0	$0
Claims w/o Payment		28	$0	$54,093
2007 Total		**28**	**$0**	**$54,093**
2008				
	3304		$3,868	$425
Claims w Payment		1	$3,868	$425
Claims w/o Payment		13	$0	$0
2008 Total		**14**	**$3,868**	**$425**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

CLAIMS VS HEALTH CARE INSTITUTIONS

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS HEALTH CARE INSTITUTIONS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1983				
	400		$10,000	$46,624
Claims w Payment		1	$10,000	$46,624
Claims w/o Payment		1	$0	$73,919
1983 Total		2	$10,000	$120,543
1984				
	1519		$275,000	$18,854
	411		$35,000	$2,451
	1515		$33,333	$6,405
Claims w Payment		3	$343,333	$27,710
Claims w/o Payment		0	$0	$0
1984 Total		3	$343,333	$27,710
1985				
	1190		$275,000	$8,034
	906		$235,000	$5,085
	398		$160,000	$0
	350		$150,000	$51,039
	288		$103,800	$28,187
	554		$56,000	$1,784
	319		$55,000	$11,067
	256		$50,000	$37,386
	262		$25,000	$19,417
	169		$16,500	$3,900
	1520		$12,500	$3,260
	397		$10,630	$3,941
	893		$10,000	$69,101
	399		$10,000	$34,605
	1516		$10,000	$10,372
	161		$8,550	$9,114
	1300		$1,000	$85
Claims w Payment		17	$1,188,980	$296,378
Claims w/o Payment		9	$0	$69,100
1985 Total		26	$1,188,980	$365,478

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS HEALTH CARE INSTITUTIONS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1986				
	330		$400,000	$20,438
	1072		$300,000	$872
	1419		$57,000	$5,860
	1513		$33,333	$7,697
	267		$6,300	$15,534
	1083		$5,000	$0
	334		$4,500	$70
	1073		$2,000	$67
	1617		$600	$0
Claims w Payment		9	$808,733	$50,538
Claims w/o Payment		23	$0	$290,842
1986 Total		**32**	**$808,733**	**$341,380**
1987				
	406		$441,093	$225,963
	404		$238,819	$1,550
	1531		$85,479	$40,548
	1150		$75,000	$12,160
	1420		$50,000	$111,389
	405		$20,000	$18,262
	1321		$16,000	$39,224
	907		$10,000	$13,661
	304		$4,000	$10
	908		$1,500	$7,883
	21		$500	$0
Claims w Payment		11	$942,391	$470,650
Claims w/o Payment		48	$0	$1,286,401
1987 Total		**59**	**$942,391**	**$1,757,051**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS HEALTH CARE INSTITUTIONS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1988				
	179		$290,260	$0
	329		$130,000	$0
	25		$100,000	$11,079
	344		$63,000	$11,525
	1340		$61,959	$29,915
	517		$40,000	$63,875
	1535		$35,000	$21,403
	228		$10,000	$11
	294		$7,600	$0
	222		$5,000	$15
	1077		$3,250	$0
	788		$2,637	$0
	1082		$500	$0
Claims w Payment		13	$749,206	$137,823
Claims w/o Payment		22	$0	$306,079
1988 Total		**35**	**$749,206**	**$443,902**
1989				
	916		$1,500,000	$129,624
	1412		$56,250	$11,114
	341		$32,500	$0
	1037		$25,000	$500
	1500		$14,789	$905
	1343		$13,500	$11,193
	1540		$10,000	$10,256
	158		$10,000	$559
	1087		$4,000	$3,683
	785		$1,083	$0
	1196		$650	$0
Claims w Payment		11	$1,667,772	$167,834
Claims w/o Payment		34	$0	$154,716
1989 Total		**45**	**$1,667,772**	**$322,550**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS HEALTH CARE INSTITUTIONS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1990				
	1344		$170,000	$1,454
	1352		$87,500	$17,977
	1067		$70,000	$1,659
	1574		$25,000	$0
	1345		$15,362	$3,186
	1086		$3,500	$7,121
	490		$3,250	$0
	1068		$1,664	$0
	1317		$1,500	$6,208
	1550		$1,250	$2,455
	903		$80	$0
Claims w Payment		11	$379,106	$40,060
Claims w/o Payment		23	$0	$385,362
1990 Total		**34**	**$379,106**	**$425,422**
1991				
	318		$185,000	$113,328
	1367		$142,500	$2,285
	1137		$130,000	$23,242
	1098		$80,000	$29,453
	1378		$75,000	$8,632
	385		$25,000	$0
	686		$25,000	$48,522
	1549		$10,000	$0
	917		$2,500	$0
	921		$2,017	$21,321
	341		$624	$0
Claims w Payment		11	$677,641	$246,783
Claims w/o Payment		20	$0	$66,092
1991 Total		**31**	**$677,641**	**$312,874**
1992				
	924		$500,000	$0
	1355		$262,500	$34,893
	409		$237,500	$0
	1111		$130,000	$10
	364		$50,000	$0
	425		$25,000	$16,233
	361		$20,000	$9,929
	1312		$10,000	$24,462
	1105		$8,000	$118
	1114		$7,500	$0
	379		$7,500	$0
Claims w Payment		11	$1,258,000	$85,644
Claims w/o Payment		36	$0	$228,392
1992 Total		**47**	**$1,258,000**	**$314,036**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS HEALTH CARE INSTITUTIONS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1993				
	1570		$665,000	$45,485
	1788		$575,000	$266,026
	422		$500,000	$6,306
	414		$180,000	$0
	94		$150,000	$3,442
	420		$67,250	$462
	1138		$65,000	$190
	1136		$37,000	$124
	371		$32,970	$1,358
	1553		$25,000	$62,672
	1575		$20,250	$1,859
	1392		$12,500	$3,139
	1573		$4,000	$0
	383		$1,500	$0
	373		$102	$0
Claims w Payment		15	$2,335,572	$391,062
Claims w/o Payment		24	$0	$165,466
1993 Total		**39**	**$2,335,572**	**$556,528**
1994				
	417		$75,000	$0
	930		$63,337	$0
	1289		$50,000	$20,106
	320		$39,500	$21,571
	1496		$35,000	$16,534
	1586		$17,500	$0
	1510		$10,000	$0
	418		$10,000	$970
	895		$7,500	$29,522
Claims w Payment		9	$307,837	$88,703
Claims w/o Payment		29	$0	$169,967
1994 Total		**38**	**$307,837**	**$258,669**
1995				
	553		$725,000	$0
	1423		$125,000	$41,258
	491		$50,000	$59,468
	1499		$28,000	$4,990
	902		$12,500	$0
	315		$11,140	$0
	684		$9,000	$4,706
Claims w Payment		7	$960,640	$110,422
Claims w/o Payment		47	$0	$702,281
1995 Total		**54**	**$960,640**	**$812,702**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS HEALTH CARE INSTITUTIONS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1996				
	974		$375,000	$832
	882		$289,956	$8,047
	969		$150,000	$134,800
	484		$80,000	$14,846
	333		$60,000	$102,785
	782		$15,000	$24,970
	1588		$10,000	$0
	1501		$10,000	$2,611
	1428		$5,000	$4,110
Claims w Payment		9	$994,956	$293,001
Claims w/o Payment		31	$0	$181,081
1996 Total		**40**	**$994,956**	**$474,082**
1997				
	1342		$57,500	$12,274
	1433		$40,000	$20,264
	901		$37,500	$5,154
	968		$15,000	$19,593
	485		$3,000	$462
	1476		$2,430	$0
	1358		$1,500	$0
Claims w Payment		7	$156,930	$57,748
Claims w/o Payment		16	$0	$178,811
1997 Total		**23**	**$156,930**	**$236,558**
1998				
	489		$200,000	$12,338
	1438		$111,000	$0
	519		$100,000	$21,667
	1462		$100,000	$9,194
	1184		$60,000	$22
	507		$45,000	$6,302
	1432		$30,000	$568
	1473		$30,000	$881
	896		$1,768	$0
	562		$1,750	$191
	493		$750	$0
Claims w Payment		11	$680,268	$51,163
Claims w/o Payment		40	$0	$272,968
1998 Total		**51**	**$680,268**	**$324,130**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS HEALTH CARE INSTITUTIONS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1999				
	1906		$610,000	$50,164
	1806		$610,000	$28,381
	2231		$600,000	$106,968
	1622		$315,000	$51,905
	1638		$250,000	$69,831
	1669		$200,000	$15,081
	1269		$140,000	$2,110
	1480		$90,000	$0
	1372		$87,500	$8,588
	1817		$65,000	$0
	1014		$35,000	$0
	1338		$20,000	$5,806
	2089		$15,000	$53,459
	1775		$10,000	$19,831
	324		$7,500	$33
	501		$4,500	$300
	1181		$3,500	$0
	518		$3,313	$0
	500		$1,000	$300
Claims w Payment		19	$3,067,313	$412,757
Claims w/o Payment		46	$0	$344,778
1999 Total		**65**	**$3,067,313**	**$757,535**
2000				
	2130		$237,500	$0
	1629		$200,000	$29,859
	1766		$173,000	$0
	1661		$80,000	$0
	1834		$40,000	$1,682
	2022		$37,500	$16,185
	2016		$20,000	$0
	1560		$10,000	$20,401
	1440		$7,500	$0
	1724		$2,000	$0
	608		$398	$0
Claims w Payment		11	$807,898	$68,126
Claims w/o Payment		37	$0	$115,138
2000 Total		**48**	**$807,898**	**$183,264**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS HEALTH CARE INSTITUTIONS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
2001				
	2097		$186,000	$192,877
	2197		$100,000	$16,482
	1849		$70,000	$146
	3344		$50,000	$147,257
	1706		$35,746	$2,187
	1914		$30,000	$2,190
	2024		$29,375	$25,712
	1878		$17,516	$0
	1968		$16,000	$18,079
	1694		$15,000	$0
	1757		$9,924	$0
	1697		$1,843	$0
Claims w Payment		12	$561,404	$404,930
Claims w/o Payment		30	$0	$432,258
2001 Total		**42**	**$561,404**	**$837,188**
2002				
	1979		$325,000	$6,370
	2241		$182,500	$49,243
	1746		$160,000	$12,204
	1926		$160,000	$4,013
	2187		$150,000	$0
	1833		$130,000	$16,089
	1879		$96,000	$0
	2088		$76,729	$82,202
	2161		$52,000	$16,158
	1754		$50,000	$21,455
	2006		$30,000	$0
	1831		$11,900	$56
	1909		$10,000	$19,621
	2123		$10,000	$23,138
	1786		$10,000	$14,129
	1888		$10,000	$20,851
Claims w Payment		16	$1,464,129	$285,530
Claims w/o Payment		35	$0	$350,508
2002 Total		**51**	**$1,464,129**	**$636,038**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS HEALTH CARE INSTITUTIONS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
2003				
	2143		$1,600,000	$61,683
	1985		$750,000	$5,323
	1996		$356,250	$56,601
	2028		$225,000	$14,518
	2083		$212,500	$42,207
	2316		$120,000	$34,343
	2122		$95,000	$2,112
	1877		$30,000	$11,416
	2201		$30,000	$0
	2112		$20,000	$1,050
	2124		$9,000	$5,786
	1952		$2,000	$0
	1975		$29	$0
Claims w Payment		13	$3,449,779	$235,039
Claims w/o Payment		17	$0	$124,623
2003 Total		**30**	**$3,449,779**	**$359,662**
2004				
	3239		$2,000,000	$0
	2177		$600,000	$69,252
	3241		$500,000	$0
	3274		$225,000	$99,818
	3332		$150,000	$64,940
	2180		$120,000	$0
	2168		$75,000	$2,500
	2172		$30,000	$0
	3287		$22,500	$7,441
	2179		$10,000	$0
	2250		$7,432	$13,574
	2169		$6,843	$0
Claims w Payment		12	$3,746,776	$257,524
Claims w/o Payment		18	$0	$250,793
2004 Total		**30**	**$3,746,776**	**$508,317**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

CLAIMS VS HEALTH CARE INSTITUTIONS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
2005				
	2128		$172,500	$25,050
	3255		$60,000	$102,718
	2269		$59,045	$555
	2127		$45,000	$14,396
	2157		$45,000	$0
	2208		$35,000	$0
	2220		$30,084	$1,706
	3260		$30,000	$76,792
	2175		$30,000	$2,838
	2205		$20,000	$6,524
	2259		$20,000	$78
	2180		$10,000	$0
	2251		$6,000	$0
	2173		$5,000	$0
	2199		$5,000	$157
Claims w Payment		15	$572,629	$230,813
Claims w/o Payment		30	$0	$63,510
2005 Total		**45**	**$572,629**	**$294,323**
2006				
	3338		$2,375,000	$350,949
	2293		$270,000	$2,844
	2245		$200,000	$62,260
	3240		$200,000	$27,869
	3262		$165,000	$28,768
	3263		$99,379	$453
	2264		$27,000	$5,798
	2302		$651	$0
Claims w Payment		8	$3,337,030	$478,942
Claims w/o Payment		32	$0	$317,101
2006 Total		**40**	**$3,337,030**	**$796,043**
2007				
	3288		$540,000	$10,212
	3327		$317,500	$4,935
	3307		$20,000	$8,822
	3298		$8,019	$0
Claims w Payment		4	$885,519	$23,969
Claims w/o Payment		30	$0	$30,786
2007 Total		**34**	**$885,519**	**$54,755**
2008				
	3339		$10,000	$0
Claims w Payment		1	$10,000	$0
Claims w/o Payment		17	$0	$0
2008 Total		**18**	**$10,000**	**$0**

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

CLAIMS VS OTHER HEALTH CARE PROVIDERS

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS OTHER HEALTH CARE PROVIDERS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1983				
Claims w Payment		0	$0	$0
Claims w/o Payment		1	$0	$0
1983 Total		1	$0	$0
1984				
12/12/1984	718		$6,000	$7,494
3/19/1984	396		$4,000	$2,308
3/19/1984	394		$2,000	$1,154
Claims w Payment		3	$12,000	$10,956
Claims w/o Payment		0	$0	$0
1984 Total		3	$12,000	$10,956
1985				
12/19/1985	351		$40,000	$38,890
2/5/1985	393		$25,000	$33,550
Claims w Payment		2	$65,000	$72,440
Claims w/o Payment		2	$0	$17,947
1985 Total		4	$65,000	$90,387
1986				
1/20/1986	410		$60,000	$13,640
12/3/1986	614		$30,000	$24,907
12/1/1986	776		$864	$0
Claims w Payment		3	$90,864	$38,547
Claims w/o Payment		4	$0	$0
1986 Total		7	$90,864	$38,547
1987				
10/19/1987	712		$2,500	$1,697
10/23/1987	635		$1,500	$0
10/23/1987	637		$1,500	$0
1/22/1987	814		$268	$0
Claims w Payment		4	$5,768	$1,697
Claims w/o Payment		6	$0	$0
1987 Total		10	$5,768	$1,697
1988				
6/3/1988	328		$50,001	$35,269
Claims w Payment		1	$50,001	$35,269
Claims w/o Payment		10	$0	$2,099
1988 Total		11	$50,001	$37,368

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS OTHER HEALTH CARE PROVIDERS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1989				
3/8/1989	122		$96,889	$7,749
3/15/1989	349		$2,750	$1,481
10/19/1989	695		$2,290	$5
7/10/1989	704		$214	$0
Claims w Payment		4	$102,143	$9,235
Claims w/o Payment		8	$0	$43,697
1989 Total		12	$102,143	$52,932
1990				
8/31/1990	340		$135,000	$2,357
7/30/1990	643		$20,000	$51,727
5/21/1990	626		$13,333	$0
Claims w Payment		4	$168,333	$54,084
Claims w/o Payment		8	$0	$1,491
1990 Total		12	$168,333	$55,575
1991				
3/25/1991	407		$35,000	$0
10/4/1991	719		$7,500	$2,184
7/18/1991	812		$5,000	$0
7/31/1991	759		$1,000	$0
Claims w Payment		4	$48,500	$2,184
Claims w/o Payment		5	$0	$0
1991 Total		9	$48,500	$2,184
1992				
11/2/1992	793		$35,000	$3,113
Claims w Payment		1	$35,000	$3,113
Claims w/o Payment		14	$0	$82,771
1992 Total		15	$35,000	$85,884
1993				
2/2/1993	670		$15,000	$0
2/3/1993	671		$15,000	$9,576
Claims w Payment		2	$30,000	$9,576
Claims w/o Payment		9	$0	$18,006
1993 Total		11	$30,000	$27,582
1994				
8/25/1994	665		$277	$0
Claims w Payment		1	$277	$0
Claims w/o Payment		13	$0	$662
1994 Total		14	$277	$662

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS OTHER HEALTH CARE PROVIDERS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
1995				
4/26/1995	494		$100,000	$40,954
2/1/1995	644		$21,303	$41,807
10/5/1995	837		$4,743	$0
Claims w Payment		3	$126,046	$82,761
Claims w/o Payment		6	$0	$103,185
1995 Total		9	$126,046	$185,946
1996				
8/6/1996	483		$635,975	$436
12/6/1996	482		$400,000	$15,867
1/31/1996	878		$30,000	$5,508
5/31/1996	419		$2,500	$381
1/23/1996	423		$1,000	$0
6/18/1996	705		$139	$0
Claims w Payment		6	$1,069,614	$22,192
Claims w/o Payment		6	$0	$60
1996 Total		12	$1,069,614	$22,252
1997				
6/14/1997	826		$141	$79
Claims w Payment		1	$141	$79
Claims w/o Payment		1	$0	$0
1997 Total		2	$141	$79
1998				
12/17/1998	829		$10,800	$0
4/27/1998	789		$6,000	$0
3/4/1998	639		$5,000	$2,779
3/24/1998	641		$1,768	$0
9/23/1998	495		$1,500	$0
8/5/1998	693		$437	$0
Claims w Payment		6	$25,504	$2,779
Claims w/o Payment		11	$0	$10,507
1998 Total		17	$25,504	$13,286
1999				
8/11/1999	527		$10,000	$0
6/21/1999	875		$9,000	$0
8/4/1999	779		$2,500	$2,364
4/20/1999	619		$1,000	$0
Claims w Payment		4	$22,500	$2,364
Claims w/o Payment		11	$0	$10,776
1999 Total		15	$22,500	$13,140

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS
CLAIMS VS OTHER HEALTH CARE PROVIDERS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
2000				
Claims w Payment		0	$0	$0
Claims w/o Payment		8	$0	$32,432
2000 Total		8	$0	$32,432
2001				
3/19/2001	2014		$19,105	$0
6/8/2001	1829		$174,000	$0
Claims w Payment		2	$193,105	$0
Claims w/o Payment		0	$0	$0
2001 Total		2	$193,105	$0
2002				
2/21/2002	2073		$125,000	$97,090
3/21/2002	1896		$60,000	$2,830
5/13/2002	1789		$1,445	$0
Claims w Payment		3	$186,445	$99,920
Claims w/o Payment		2	$0	$2,980
2002 Total		5	$186,445	$102,900
2003				
Claims w Payment		0	$0	$0
Claims w/o Payment		1	$0	$0
2003 Total		1	$0	$0
2004				
1/2/2004	3290		$225,000	$99,818
Claims w Payment		1	$225,000	$99,818
Claims w/o Payment		0	$0	$0
2004 Total		1	$225,000	$99,818
2005				
3/18/2005	2162		$8,169	$0
Claims w Payment		1	$8,169	$0
Claims w/o Payment		1	$0	$24,725
2005 Total		2	$8,169	$24,725
2006				
Claims w Payment		0	$0	$0
Claims w/o Payment		0	$0	$0
2006 Total		0	$0	$0

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

CLAIMS VS OTHER HEALTH CARE PROVIDERS

Report Year	Claim ID #	# of Claims	Settlement Amount	Adjusting Expense
2007				
Claims w Payment		0	$0	$0
Claims w/o Payment		2	$0	$0
2007 Total		2	$0	$0
2008				
Claims w Payment		0	$0	$0
Claims w/o Payment		2	$0	$0
2008 Total		2	$0	$0

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

SUMMARY REPORT BY YEAR

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

ALL HEALTH CARE PROVIDERS

Report Year		# of Claims	Total Settlement Amount	Total Adjusting Expense
1983	Claims w Payment	1	$10,000	$46,624
	Claims w/o Payment	3	$0	$108,419
	Total	4	$10,000	$155,043
1984	Claims w Payment	10	$567,457	$100,685
	Claims w/o Payment	3	$0	$55,070
	Total	13	$567,457	$155,755
1985	Claims w Payment	25	$1,416,980	$522,041
	Claims w/o Payment	23	$0	$224,285
	Total	48	$1,416,980	$746,326
1986	Claims w Payment	27	$2,311,866	$456,553
	Claims w/o Payment	55	$0	$641,550
	Total	82	$2,311,866	$1,098,103
1987	Claims w Payment	36	$3,204,370	$741,734
	Claims w/o Payment	111	$0	$1,349,985
	Total	147	$3,204,370	$2,091,719
1988	Claims w Payment	29	$3,761,183	$463,392
	Claims w/o Payment	57	$0	$435,403
	Total	86	$3,761,183	$898,794
1989	Claims w Payment	28	$3,515,915	$395,075
	Claims w/o Payment	78	$0	$275,192
	Total	106	$3,515,915	$670,267
1990	Claims w Payment	37	$4,342,478	$1,996,186
	Claims w/o Payment	76	$0	$651,685
	Total	113	$4,342,478	$2,647,871
1991	Claims w Payment	38	$4,323,604	$340,843
	Claims w/o Payment	62	$0	$267,978
	Total	100	$4,323,604	$608,822
1992	Claims w Payment	30	$4,109,157	$306,395
	Claims w/o Payment	86	$0	$1,131,642
	Total	116	$4,109,157	$1,438,036
1993	Claims w Payment	43	$6,689,843	$689,360
	Claims w/o Payment	78	$0	$488,620
	Total	121	$6,689,843	$1,177,980
1994	Claims w Payment	27	$2,986,514	$381,891
	Claims w/o Payment	77	$0	$380,281
	Total	104	$2,986,514	$762,172

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

ALL HEALTH CARE PROVIDERS

Report Year		# of Claims	Total Settlement Amount	Total Adjusting Expense
1995	Claims w Payment	34	$5,867,454	$755,397
	Claims w/o Payment	90	$0	$1,123,921
	Total	124	$5,867,454	$1,879,318
1996	Claims w Payment	34	$5,141,148	$884,402
	Claims w/o Payment	68	$0	$606,021
	Total	102	$5,141,148	$1,490,423
1997	Claims w Payment	30	$8,013,571	$606,452
	Claims w/o Payment	40	$0	$448,137
	Total	70	$8,013,571	$1,054,589
1998	Claims w Payment	32	$7,285,096	$487,490
	Claims w/o Payment	102	$0	$409,068
	Total	134	$7,285,096	$896,558
1999	Claims w Payment	51	$8,499,046	$1,211,289
	Claims w/o Payment	113	$0	$741,108
	Total	164	$8,499,046	$1,952,397
2000	Claims w Payment	34	$8,250,331	$869,498
	Claims w/o Payment	88	$0	$424,755
	Total	122	$8,250,331	$1,294,253
2001	Claims w Payment	37	$6,191,259	$986,931
	Claims w/o Payment	71	$0	$1,351,963
	Total	108	$6,191,259	$2,338,894
2002	Claims w Payment	48	$13,704,574	$1,180,401
	Claims w/o Payment	105	$0	$1,446,401
	Total	153	$13,704,574	$2,626,802
2003	Claims w Payment	41	$9,534,001	$774,858
	Claims w/o Payment	57	$0	$545,841
	Total	98	$9,534,001	$1,320,699
2004	Claims w Payment	21	$6,961,776	$595,345
	Claims w/o Payment	42	$0	$695,895
	Total	63	$6,961,776	$1,291,239
2005	Claims w Payment	21	$1,730,798	$395,462
	Claims w/o Payment	47	$0	$333,237
	Total	68	$1,730,798	$728,700
2006	Claims w Payment	16	$5,753,884	$707,157
	Claims w/o Payment	59	$0	$514,858
	Total	75	$5,753,884	$1,222,014

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

ALL HEALTH CARE PROVIDERS

Report Year		# of Claims	Total Settlement Amount	Total Adjusting Expense
2007	Claims w Payment	4	$885,519	$23,969
	Claims w/o Payment	60	$0	$84,879
	Total	64	$885,519	$108,848
2008	Claims w Payment	2	$13,868	$425
	Claims w/o Payment	32	$0	$0
	Total	34	$13,868	$425

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

PHYSICIANS

Report Year		# of Claims	Total Settlement Amount	Total Adjusting Expense
1983	Claims w Payment	0	$0	$0
	Claims w/o Payment	1	$0	$34,500
	Total	1	$0	$34,500
1984	Claims w Payment	4	$212,124	$62,019
	Claims w/o Payment	3	$0	$55,070
	Total	7	$212,124	$117,089
1985	Claims w Payment	6	$163,000	$153,223
	Claims w/o Payment	12	$0	$137,238
	Total	18	$163,000	$290,461
1986	Claims w Payment	15	$1,412,269	$367,468
	Claims w/o Payment	28	$0	$350,708
	Total	43	$1,412,269	$718,176
1987	Claims w Payment	21	$2,256,211	$269,387
	Claims w/o Payment	57	$0	$63,584
	Total	78	$2,256,211	$332,971
1988	Claims w Payment	15	$2,961,976	$290,299
	Claims w/o Payment	25	$0	$127,225
	Total	40	$2,961,976	$417,524
1989	Claims w Payment	13	$1,746,000	$218,006
	Claims w/o Payment	36	$0	$76,779
	Total	49	$1,746,000	$294,784
1990	Claims w Payment	22	$3,795,039	$1,902,042
	Claims w/o Payment	45	$0	$264,832
	Total	67	$3,795,039	$2,166,874
1991	Claims w Payment	23	$3,597,463	$91,877
	Claims w/o Payment	37	$0	$201,887
	Total	60	$3,597,463	$293,764
1992	Claims w Payment	18	$2,816,157	$217,637
	Claims w/o Payment	36	$0	$820,479
	Total	54	$2,816,157	$1,038,116
1993	Claims w Payment	26	$4,324,271	$288,722
	Claims w/o Payment	45	$0	$305,147
	Total	71	$4,324,271	$593,869
1994	Claims w Payment	17	$2,678,400	$293,188
	Claims w/o Payment	35	$0	$209,653
	Total	52	$2,678,400	$502,841

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

PHYSICIANS

Report Year		# of Claims	Total Settlement Amount	Total Adjusting Expense
1995	Claims w Payment	24	$4,780,768	$562,214
	Claims w/o Payment	37	$0	$318,455
	Total	61	$4,780,768	$880,669
1996	Claims w Payment	19	$3,076,579	$569,210
	Claims w/o Payment	31	$0	$424,880
	Total	50	$3,076,579	$994,089
1997	Claims w Payment	22	$7,856,500	$548,625
	Claims w/o Payment	23	$0	$269,326
	Total	45	$7,856,500	$817,951
1998	Claims w Payment	15	$6,579,324	$433,549
	Claims w/o Payment	51	$0	$125,593
	Total	66	$6,579,324	$559,142
1999	Claims w Payment	28	$5,409,233	$796,167
	Claims w/o Payment	56	$0	$385,555
	Total	84	$5,409,233	$1,181,722
2000	Claims w Payment	23	$7,442,434	$801,372
	Claims w/o Payment	43	$0	$277,185
	Total	66	$7,442,434	$1,078,558
2001	Claims w Payment	23	$5,436,750	$582,001
	Claims w/o Payment	41	$0	$919,705
	Total	64	$5,436,750	$1,501,706
2002	Claims w Payment	29	$12,054,000	$794,951
	Claims w/o Payment	68	$0	$1,092,913
	Total	97	$12,054,000	$1,887,864
2003	Claims w Payment	28	$6,084,222	$539,819
	Claims w/o Payment	39	$0	$421,218
	Total	67	$6,084,222	$961,037
2004	Claims w Payment	8	$2,990,000	$238,003
	Claims w/o Payment	24	$0	$445,101
	Total	32	$2,990,000	$683,104
2005	Claims w Payment	5	$1,150,000	$164,649
	Claims w/o Payment	16	$0	$245,002
	Total	21	$1,150,000	$409,651
2006	Claims w Payment	8	$2,416,854	$228,215
	Claims w/o Payment	27	$0	$197,757
	Total	35	$2,416,854	$425,971

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

PHYSICIANS

Report Year		# of Claims	Total Settlement Amount	Total Adjusting Expense
2007	Claims w Payment	0	$0	$0
	Claims w/o Payment	28	$0	$54,093
	Total	28	$0	$54,093
2008	Claims w Payment	1	$3,868	$425
	Claims w/o Payment	13	$0	$0
	Total	14	$3,868	$425

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

HEALTH CARE INSTITUTIONS

Report Year		# of Claims	Total Settlement Amount	Total Adjusting Expense
1983	Claims w Payment	1	$10,000	$46,624
	Claims w/o Payment	1	$0	$73,919
	Total	2	$10,000	$120,543
1984	Claims w Payment	3	$343,333	$27,710
	Claims w/o Payment	0	$0	$0
	Total	3	$343,333	$27,710
1985	Claims w Payment	17	$1,188,980	$296,378
	Claims w/o Payment	9	$0	$69,100
	Total	26	$1,188,980	$365,478
1986	Claims w Payment	9	$808,733	$50,538
	Claims w/o Payment	23	$0	$290,842
	Total	32	$808,733	$341,380
1987	Claims w Payment	11	$942,391	$470,650
	Claims w/o Payment	48	$0	$1,286,401
	Total	59	$942,391	$1,757,051
1988	Claims w Payment	13	$749,206	$137,823
	Claims w/o Payment	22	$0	$306,079
	Total	35	$749,206	$443,902
1989	Claims w Payment	11	$1,667,772	$167,834
	Claims w/o Payment	34	$0	$154,716
	Total	45	$1,667,772	$322,550
1990	Claims w Payment	11	$379,106	$40,060
	Claims w/o Payment	23	$0	$385,362
	Total	34	$379,106	$425,422
1991	Claims w Payment	11	$677,641	$246,783
	Claims w/o Payment	20	$0	$66,092
	Total	31	$677,641	$312,874
1992	Claims w Payment	11	$1,258,000	$85,644
	Claims w/o Payment	36	$0	$228,392
	Total	47	$1,258,000	$314,036
1993	Claims w Payment	15	$2,335,572	$391,062
	Claims w/o Payment	24	$0	$165,466
	Total	39	$2,335,572	$556,528
1994	Claims w Payment	9	$307,837	$88,703
	Claims w/o Payment	29	$0	$169,967
	Total	38	$307,837	$258,669

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

HEALTH CARE INSTITUTIONS

Report Year		# of Claims	Total Settlement Amount	Total Adjusting Expense
1995	Claims w Payment	7	$960,640	$110,422
	Claims w/o Payment	47	$0	$702,281
	Total	54	$960,640	$812,702
1996	Claims w Payment	9	$994,956	$293,001
	Claims w/o Payment	31	$0	$181,081
	Total	40	$994,956	$474,082
1997	Claims w Payment	7	$156,930	$57,748
	Claims w/o Payment	16	$0	$178,811
	Total	23	$156,930	$236,558
1998	Claims w Payment	11	$680,268	$51,163
	Claims w/o Payment	40	$0	$272,968
	Total	51	$680,268	$324,130
1999	Claims w Payment	19	$3,067,313	$412,757
	Claims w/o Payment	46	$0	$344,778
	Total	65	$3,067,313	$757,535
2000	Claims w Payment	11	$807,898	$68,126
	Claims w/o Payment	37	$0	$115,138
	Total	48	$807,898	$183,264
2001	Claims w Payment	12	$561,404	$404,930
	Claims w/o Payment	30	$0	$432,258
	Total	42	$561,404	$837,188
2002	Claims w Payment	16	$1,464,129	$285,530
	Claims w/o Payment	35	$0	$350,508
	Total	51	$1,464,129	$636,038
2003	Claims w Payment	13	$3,449,779	$235,039
	Claims w/o Payment	17	$0	$124,623
	Total	30	$3,449,779	$359,662
2004	Claims w Payment	12	$3,746,776	$257,524
	Claims w/o Payment	18	$0	$250,793
	Total	30	$3,746,776	$508,317
2005	Claims w Payment	15	$572,629	$230,813
	Claims w/o Payment	30	$0	$63,510
	Total	45	$572,629	$294,323
2006	Claims w Payment	8	$3,337,030	$478,942
	Claims w/o Payment	32	$0	$317,101
	Total	40	$3,337,030	$796,043

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

HEALTH CARE INSTITUTIONS

Report Year		# of Claims	Total Settlement Amount	Total Adjusting Expense
2007	Claims w Payment	4	$885,519	$23,969
	Claims w/o Payment	30	$0	$30,786
	Total	34	$885,519	$54,755
2008	Claims w Payment	1	$10,000	$0
	Claims w/o Payment	17	$0	$0
	Total	18	$10,000	$0

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

OTHER HEALTH CARE PROVIDERS

Report Year		# of Claims	Total Settlement Amount	Total Adjusting Expense
1983	Claims w Payment	0	$0	$0
	Claims w/o Payment	1	$0	$0
	Total	1	$0	$0
1984	Claims w Payment	3	$12,000	$10,956
	Claims w/o Payment	0	$0	$0
	Total	3	$12,000	$10,956
1985	Claims w Payment	2	$65,000	$72,440
	Claims w/o Payment	2	$0	$17,947
	Total	4	$65,000	$90,387
1986	Claims w Payment	3	$90,864	$38,547
	Claims w/o Payment	4	$0	$0
	Total	7	$90,864	$38,547
1987	Claims w Payment	4	$5,768	$1,697
	Claims w/o Payment	6	$0	$0
	Total	10	$5,768	$1,697
1988	Claims w Payment	1	$50,001	$35,269
	Claims w/o Payment	10	$0	$2,099
	Total	11	$50,001	$37,368
1989	Claims w Payment	4	$102,143	$9,235
	Claims w/o Payment	8	$0	$43,697
	Total	12	$102,143	$52,932
1990	Claims w Payment	4	$168,333	$54,084
	Claims w/o Payment	8	$0	$1,491
	Total	12	$168,333	$55,575
1991	Claims w Payment	4	$48,500	$2,184
	Claims w/o Payment	5	$0	$0
	Total	9	$48,500	$2,184
1992	Claims w Payment	1	$35,000	$3,113
	Claims w/o Payment	14	$0	$82,771
	Total	15	$35,000	$85,884
1993	Claims w Payment	2	$30,000	$9,576
	Claims w/o Payment	9	$0	$18,006
	Total	11	$30,000	$27,582
1994	Claims w Payment	1	$277	$0
	Claims w/o Payment	13	$0	$662
	Total	14	$277	$662

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

OTHER HEALTH CARE PROVIDERS

Report Year		# of Claims	Total Settlement Amount	Total Adjusting Expense
1995	Claims w Payment	3	$126,046	$82,761
	Claims w/o Payment	6	$0	$103,185
	Total	9	$126,046	$185,946
1996	Claims w Payment	6	$1,069,614	$22,192
	Claims w/o Payment	6	$0	$60
	Total	12	$1,069,614	$22,252
1997	Claims w Payment	1	$141	$79
	Claims w/o Payment	1	$0	$0
	Total	2	$141	$79
1998	Claims w Payment	6	$25,504	$2,779
	Claims w/o Payment	11	$0	$10,507
	Total	17	$25,504	$13,286
1999	Claims w Payment	4	$22,500	$2,364
	Claims w/o Payment	11	$0	$10,776
	Total	15	$22,500	$13,140
2000	Claims w Payment	0	$0	$0
	Claims w/o Payment	8	$0	$32,432
	Total	8	$0	$32,432
2001	Claims w Payment	2	$193,105	$0
	Claims w/o Payment	0	$0	$0
	Total	2	$193,105	$0
2002	Claims w Payment	3	$186,445	$99,920
	Claims w/o Payment	2	$0	$2,980
	Total	5	$186,445	$102,900
2003	Claims w Payment	0	$0	$0
	Claims w/o Payment	1	$0	$0
	Total	1	$0	$0
2004	Claims w Payment	1	$225,000	$99,818
	Claims w/o Payment	0	$0	$0
	Total	1	$225,000	$99,818
2005	Claims w Payment	1	$8,169	$0
	Claims w/o Payment	1	$0	$24,725
	Total	2	$8,169	$24,725
2006	Claims w Payment	0	$0	$0
	Claims w/o Payment	0	$0	$0
	Total	0	$0	$0

NORTH DAKOTA MEDICAL MALPRACTICE CLAIMS

OTHER HEALTH CARE PROVIDERS

Report Year		# of Claims	Total Settlement Amount	Total Adjusting Expense
2007	Claims w Payment	0	$0	$0
	Claims w/o Payment	2	$0	$0
	Total	2	$0	$0
2008	Claims w Payment	0	$0	$0
	Claims w/o Payment	2	$0	$0
	Total	2	$0	$0

MEDICAL MALPRACTICE CLAIM REPORT

NORTH DAKOTA INSURANCE DEPARTMENT

SFN 17118 (Rev. 1-2006)

INSTRUCTIONS

a. Complete Sections A, B, and C for all adjudicated, paid or closed claims within thirty (30) days of such event.
b. Complete Section A, only, for each claim not previously reported pursuant to instruction a reported to your company during the six-month periods ending June 30th and December 31st of each year. The June 30th reports are due on or before September 30th, and the December 31st reports are due on or before March 31st of the following year.
c. Include all professional liability claims involving the providing of health care services including, but not limited to, physicians, hospitals, nurses, chiropractors, etc.
d. When completing the section about individuals named in the complaint, include the name of the physician, nurse, chiropractors, etc. and their addresses, if they are named as the defendant or named in the complaint.
e. A copy of North Dakota Century Code Section 26.1-01-05, which explains the purpose of this form, is provided on the reverse side of this form.
f. Mail report to the North Dakota Insurance Department, State Capitol, 600 E. Boulevard Avenue, Bismarck, North Dakota 58505- 0158.
g. If more space is needed, please attach additional sheets.

NOTE: IF THE PROVIDER OR THE INSURER OF A PROVIDER DOES NOT HAVE ANY CLAIMS, SETTLEMENTS OR CLAIMS OR FINAL JUDGMENT TO REPORT, IT IS NOT NECESSARY TO FILE A FORM WITH THE COMMISSIONER.

SECTION A

PLEASE TYPE ALL INFORMATION

Name of Reporting Insurer			Current Date
Claim File I.D.	Date of Injury	City Where Injury Occurred	Date Reported
Individual Named in Complaint (Defendant) - See Instruction d			
Address			
City		State	Zip Code
ure and Substance of Claim			

SECTION B

Date of Payment, Judgment, or Closing of File	Claim Disposition
	☐ Settled by Parties ☐ Disposed by Court ☐ Binding Arbitration ☐ Claim Abandoned/Not Pursued
Settlement ☐ Before Trial of Hearing ☐ During Trial or Hearing ☐ After Trial or Hearing	Court Results ☐ No Proceedings ☐ Verdict/Judgment for Plaintiff ☐ Verdict/Judgment for Defendant ☐ All Other

SECTION C

Please Provide a Brief Explanation for Closing of Claim		
Amount Paid to Plaintiff	Loss Adjustment Expense Paid to Defense Counsel	
Amount of Other Allocated Loss Adjustment Expense		
Contact Person	Title	Telephone Number
Address		
	State	Zip Code
Signature of Person Responsible for this Report		

REPORTING OF MEDICAL MALPRACTICE

The 1983 North Dakota Legislature enacted 26.1-01-05 as follows:

26.1-01-05. REPORTING AND REVIEW OF MEDICAL MALPRACTICE CLAIMS, SETTLEMENTS, AND JUDGMENTS.

1. A health care provider or the insurer of a health care provider, if any, shall report all claims, settlements of claims, or final judgments against the health care provider to the commissioner. The report must be made in the manner prescribed by the commissioner and must provide those facts the commissioner deems necessary to gather adequate information regarding claims, settlements of claims, and final judgments against health care providers. For purposes of this section, a "health care provider" includes any person, corporation, facility, or institution licensed by this state to provide health care of professional services as a physician, hospital, dentist, professional or practical nurse, physician's aide, optometrist, podiatrist, chiropractor, physical therapist, or psychologist, or an officer, employee, or agent acting in the course and scope of employment.

2. The commissioner shall forward copies of all reports required by this section to the appropriate board of professional registration, examination, or licensure. That board shall review all reports which it receives and may take any necessary disciplinary action against a health care provider where the action is appropriate, including censure, imposition of probation, or suspension or revocation of the health care provider's license. The board shall conduct the review as an administrative hearing in the manner provided in chapter 28-32, including the giving of appropriate notice.

Submit to: North Dakota Insurance Department
600 E. Boulevard Avenue - Dept 401
State Capitol
Bismarck, ND 58505-0158

WRONGFUL DEATH CHART

State	Statute of Limitations	Empowered Plaintiff(s) (In order of priority)	Beneficiaries (In order of priority)	Recoverable Damages (Note: other damages may be available through separate survival actions in some states)	Ceilings on Recovery (Includes Wrongful-Death-Specific caps and Non-Wrongful-Death-Specific. Does not include state tort caps; see immunity chart)	Settlement (Wrongful Death Statutes Requiring Court Approval)	Award Exempted (In full or in part) from Liability of Decedent's Debts
			heirs. (2) Children of deceased's spouse (3) Those who are devisees under the will of the deceased. [600.2922]. **Legislative History:** No recent changes.	(Mich. 1960), but hedonic damages for decedent's loss of enjoyment of life not available. *Brereton v. United States*, 973 F.Supp. 752 (E.D. Mich. 1997). Punitives: Not available. *See Kirk v. Ford Motor Company*, 383 N.W.2d 193 (Mich. App. 1986) (court properly did not include punitive damages as element of wrongful death claim in jury instructions). Loss of Consortium: Available. [600.2922(6)]. **Legislative History:** No recent changes.	Injury, Property Damage, Wrongful Death, Tort: If Plaintiff is 51% at fault, no noneconomic damages. Mich. Comp, Laws § 600.2959. Noneconomics/Product Liability: Cap of $280,000, or $500,00 if product defect caused death or permanent loss of bodily function. Mich. Stat.§ 600.2946a. Punitives/Generally: Punitive damages are not allowed except as authorized by statute. *McAuley v. General Motors Corp.*,578 N.W.2d 282 (Mich. 1998), overruled in part on other grounds, *Rafferty v. Markovitz*, 602 N.W.2d 367 (Mich. 1999). **Legislative History:** Mich. Stat.§ 600.1484 en. 1999.	motion and request leave of the court to settle the claim. Settlement requires court approval. [600.2922]. **Legislative History:** No recent changes.	death damages are exempt. *See Carder v. Marhoff*, 143 F.Supp. 920(E.D. Mi. 1956)(interpreting prior statute to prohibit paying debts through proceeds of wrongful death action). **Legislative History:** No recent changes.
MN **Minn. Stat. Ann.**	**Current Status: 3 years** **Description of law:** 3 years from date of death. Provided that	**Description of law:** Court appointed Trustee upon petition of spouse or next of kin. [573.02]. **Legislative**	**Description of law:** After funeral expenses, exclusive benefit of surviving spouse and next of kin. [573.02].	**Description of law:** Generally: Damages proportional to pecuniary loss suffered, funeral expenses, & punitive damages allowed. [573.02]. "The proper measure of damages for wrongful death, then, is the pecuniary loss resulting from the death, not the value of a human life in the abstract." *Ahrenholz v. Hennepin County*,	**Current Status: No cap.**	**Current Status: Court Approval Not Required By Statute** **Description of law:** *See generally* wrongful death	**Description of law:** Although no specific exemption statute, damages not distributed until after funeral expenses paid. [573.02]. **Legislative**

LOCATION MATTERS

Even in a more stable medical liability climate, physicians in large metropolitan areas continue to pay some of the highest insurance premiums. Below is a summary of the highest and lowest reported rates for three specialties as of July 1, 2008. Companies reported their data based on annual rates for specific mature claims-made policies with limits of $1 million/$3 million. The rates do not reflect credits, debits or dividends. The rankings are based on the highest or lowest reported rates in a particular state, by city or county, and are not an average for the state.

HIGHEST RATES	2007	2008	CHANGE
INTERNISTS			
Florida (Miami-Dade)	$54,751	$54,710	-0.1%
Illinois (Cook, Madison, St. Clair)	$50,464	$41,066	-18.6%
Ohio (Cuyahoga, Lorain)	$44,467	$40,020	-10.0%
Michigan (Wayne)	n/a	$38,414	n/a
Pennsylvania (Philadelphia, Delaware)	$37,476	$37,380	-0.3%
GENERAL SURGEONS			
Florida (Miami-Dade)	$275,478	$214,893	-22.0%
Michigan (Wayne)	$162,623	$143,445	-11.8%
Ohio (Cuyahoga, Lorain)	$157,039	$141,336	-10.0%
Pennsylvania (Philadelphia, Delaware)	$138,209	$137,227	-0.7%
Missouri (Kansas City)	$132,314	$132,314	0.0%
OB-GYNS			
Florida (Miami-Dade)	$247,964	$238,728	-3.7%
New York (Nassau, Suffolk)	$194,935	$194,935	0.0%
Illinois (Cook, Madison, St. Clair)	$178,291	$178,291	0.0%
Pennsylvania (Philadelphia, Delaware)	$172,873	$171,813	-0.6%
Ohio (Cuyahoga, Lorain)	$190,505	$171,456	-10.0%

LOWEST RATES			
INTERNISTS			
Minnesota	$3,375	$3,375	0.0%
South Dakota	$3,697	$3,697	0.0%
Wisconsin	$4,633	$3,946	-14.8%
Oregon	$5,930	$5,479	-7.6%
Idaho	$5,844	$5,552	-5.0%
GENERAL SURGEONS			
Minnesota	$11,306	$11,306	0.0%
South Dakota	$12,569	$12,569	0.0%
Wisconsin	$16,216	$13,813	-14.8%
Iowa	$19,589	$17,860	-8.8%
North Dakota	$20,044	$18,063	-9.9%
OB-GYNS			
Minnesota	n/a	$17,166	n/a
Wisconsin	$21,312	$18,154	-14.8%
South Dakota	$23,086	$20,042	-13.2%
Texas	$26,516	$26,516	0.0%
Iowa	$29,927	$27,285	-8.8%

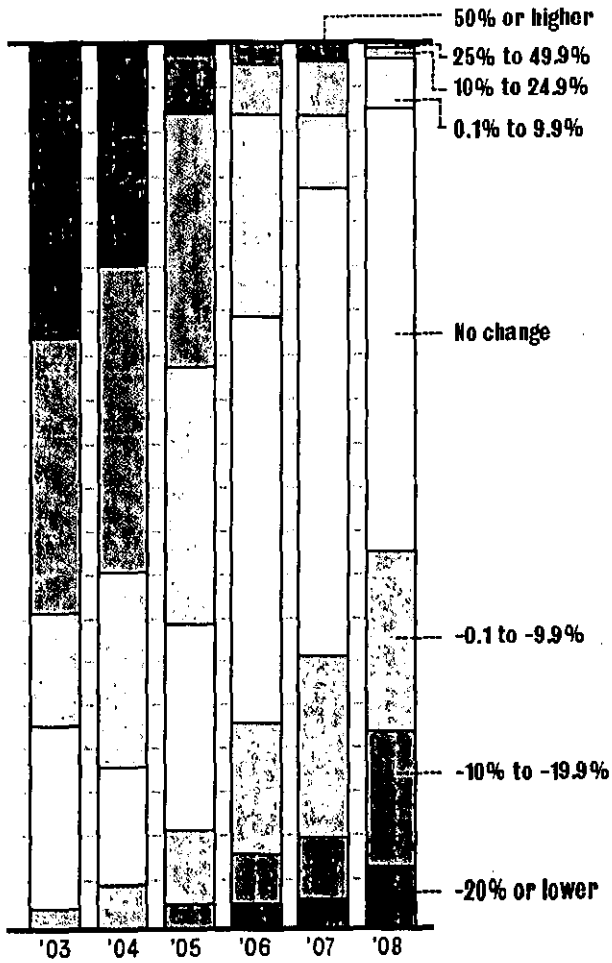
SOURCE: *MEDICAL LIABILITY MONITOR* 2008 RATE SURVEY

PUBLISHED IN THE JANUARY 6, 2009 ISSUE OF AMERICAN MEDICAL NEWS. WWW.AMEDNEWS.COM

ON THE MEND?

Medical liability insurance still is not cheap, but 43% of rates reported in 2008 fell — compared with 31% in 2007 — while half held steady.

BREAKDOWN OF LIABILITY RATE CHANGES



FAVORABLE TREND

After significant hikes in 2003-05, the past three years showed a significant stabilization and reduction in overall average medical liability rates — signs of a softening market, according to industry experts.