SB

319

Richard L. Hutchison, M.D., F.A.C.S.
Plastic & Reconstructive Surgeon

1919 Lathrop Street • Suite 101 • Fairbanks, AK 99701-5956 • (907) 451-8775

March 17, 2004

Senator Ralph Seekins
State Capitol
Juneau AK 99801-1182

Dear Senator Seekins:

I strongly support your efforts to institute medical liability reform in the state of Alaska.

This reform is essential. It will allow the medical community to retain its current physicians and to attract new qualified physicians into the state.

Without a strong, well-trained supply of medical professionals, it will not be possible to provide the citizens of Alaska with high-quality, affordable health care.

Please let me know if you require additional information or if I can help you support this legislation in other ways.

Sincerely,

Richard L. Hutchison, M.D.

THE
FOLLOWING
DOCUMENT(S)
ARE
POOR
ORIGINAL
COPIES

Denali Center
Fairbanks Memorial Hospital
Banner Health System

March 18, 2004

Senator Ralph Seekins
State Capitol, Room 125
Juneau, AK 99801

Dear Senator Seekins:

As Administrator of Fairbanks Memorial Hospital/Denali Center, I am writing to express my appreciation for your introduction of SB 319.

Our ability to succeed in our mission is heavily dependent on our Medical Staff, but in recent years we have experienced increased difficulty recruiting the physicians that our patients need. The litigious climate in which physicians in Alaska are forced to practice is one of the key difficulties.

A medical liability crisis could drive good doctors out of medicine and leave patients in many communities without access to both basic and specialty medical services. This has happened in other states without reform. Nationally, 76% of physicians believe that medical liability litigation has negatively impacted their ability to provide quality care and 78% of Americans fear that skyrocketing medical liability costs could limit their access to care (Wirthlin Worldwide Study, Apr. 2002). The situation is especially concerning to those of us engaged in serving rural areas where access is sometimes difficult; physicians are already in short supply and have always been difficult to recruit.

Our work is being severely compromised by a legal and insurance system that no longer meets the needs of our community. Your authorship of this bill will help us provide the most efficient and effective health care we can.

Thank you for your interest and support.

Sincerely,

Mike Powers
CEO/Administrator

cc: Interior Delegation

AaNA Alaska Nurses Association

t/ 907-274-0827
f/ 907-272-0292

2207 East Tudor Rd, Suite 34
Anchorage, AK 99507-1069
www.aknurse.org
aknurse@aknurse.org

March 31, 2004

Honorable Ralph Seekins
Chair, Senate Judiciary
Alaska State Legislature
State Capitol (MS 3100)
Juneau, AK 99801-1182

Re: Senate Bill 319, "An Act relating to claims for personal injury or wrongful death against health care providers"

Dear Senator Seekins;

The Alaska Nurses Association (AaNA) would like to express our appreciation that you have taken on such an important topic and provide additional information on how this issue impacts healthcare providers in our state.

AaNA supports a liability limitation in Alaska for two main reasons. First, we wish to ensure that there will be affordable malpractice insurance available to healthcare providers in the state. Since Alaska is a small pool of providers, we must look at ways to contain costs of malpractice insurance in order to continue to attract insurance carriers who will then provide competitive options to our healthcare providers.

Our second main concern is healthcare availability. Without available and affordable malpractice insurance we may be unable to attract and/or retain healthcare providers in our state. Decreasing our providers obviously decreases to options for patients, increasing medical costs as our citizens must look outside the state to meet their healthcare needs.

Please refer to the attached article from the Journal of the American Academy of Nurse Practitioners. This article details the issues related to tort reform and its relationship to malpractice insurance costs for nurse practitioners.

Please contact me if we can provide additional information or support.

Sincerely,

Camille Soleil

Camille Soleil, JD
Executive Director

February 2004
Volume 16, Issue 2

Journal of the American Academy of Nurse Practitioners

NURSE PRACTITIONER ISSUE

Tort Reform: An Issue for Nurse Practitioners

Diane L. Klutz, RN, MS, CNS, FNP

Purpose
To inform nurse practitioners (NPs) about the issues related to tort reform and its relationship to malpractice insurance costs.

Data Sources
Current journals, newspapers, professional newsletters, and Internet sites.

Conclusions
NPs are paying more for their malpractice premiums, and many are losing their places of employment as clinics close due to the increased cost of premiums. One method proposed for curbing the flow of monies spent on premiums and litigation is tort law reform. California serves as an example; its Medical Injury Compensation Reform Act (MICRA) tort reform law was passed 25 years ago, and it has maintained stable malpractice premiums. Other states have proposed similar laws, but some have not had similar success. To curb litigation costs, not only should tort laws be reformed, but NPs and physicians should keep abreast of current practice standards in order to provide quality medical care.

Implications for Practice
Like physicians, NPs are affected directly by tort laws. These laws hold NPs accountable at the same level as physicians. In addition, many states limit NPs' practice to delegation of authority by a physician. Liability is therefore transferred from the NP to the physician and vice versa in cases of injury or wrongful act. In addition, many NPs are finding it increasingly difficult to locate insurers who will write policies for medical liability.

Key Words
Tort, tort reform, malpractice, quality medical care, nurse practitioner, advanced practice nurse.

INTRODUCTION

Patients across the United States suffer from limited or decreasing access to medical care as a result of the closings of many hospitals, nursing home facilities, and physician practices (American Nurses Association [ANA], 2003). Increased malpractice insurance premiums caused by poor litigation laws are cited as the foremost reason for the current medical crisis. In response to the premiums, physicians and surgeons are protesting by staging walkouts or simply closing their practices (Rodriguez, 2003; Sloane, 2002; Word, 2003). In similar response, specialty units (such as trauma centers, obstetrics practices, and nursing homes) have closed (Corlin, 2002; Gearon, 2002).

Although the body of literature on tort reform and its effect on nurse practitioners (NPs) is limited, current evidence on increasing malpractice insurance premiums points to the impact that tort liability claims are having on NPs' out-of-pocket costs of providing care. Advanced practice nurses (APNs), especially certified nurse anesthetists and certified nurse midwives, are experiencing increasing liability insurance premiums and/or loss of insurance carriers (ANA, 2003; Lester, 2003). In addition, delegating physicians have eliminated many NP positions in the attempt to reduce liability insurance costs (ANA).

The purpose of this article is to inform NPs about the issues of tort reform and the effects of increased liability insurance premiums on practice. The recommendation of incorporating evidence-based medicine and updated technology in clinical practice is also presented as an adjunct to tort reform legislation. Definitions of the terms *malpractice*, *tort*, and *tort reform* are offered, along with pros and cons of federal and state legislation aimed at curbing the rising costs of premiums.

MEANING OF TORT, MALPRACTICE, AND TORT REFORM

Because *tort* has many meanings and can be a confusing term, clarification of its use within the context of malpractice insurance reform is important. In law, "tort is an injury or wrongful act for which a civil action is brought by the state" (*Webster's Third New International Dictionary*, 1993, p. 2413). A tort is different from a crime in that a crime is an offense against the state, for which the state inflicts punishment. A tort is an offense against an individual.

Malpractice is an offense covered under tort law. It is "a dereliction from professional duty, whether intentional, criminal, or merely negligence by one rendering professional services that results in injury, loss, or damage to the recipient of those services" (Webster's Third New International Dictionary, 1993, p. 1368). Malpractice is based on tort law and relies on judgments that the professional has failed to perform according to the minimum reasonable standards of that profession. Commonly involved in cases of malpractice are physicians; but health providers, such as NPs and other health professionals, are increasingly being brought into malpractice suits.

Conflict of Interest Disclosure
The author has received no funding or financial inducement to write this article.

Author
Diane Klutz is the Family Nurse Practitioner Program Coordinator for Midwestern State University in Wichita Falls, Texas, and a Nursing Doctoral Student at Texas Woman's University in Denton, Texas.

One answer to the broad issues of litigation concerning personal injury as a result of negligence is tort reform. Tort reform is the broad restructuring of laws that deal with the wrongful acts of breach of duty. The purpose of the reforms is to limit or address an aspect of the laws that is perhaps harmful to a population or group. For example, it is reported that the U.S. tort system costs American companies $180 billion a year (Birnbaum, 2002, p. 35). Unlimited damage awards have directly affected major companies such as Wal-Mart, DaimlerChrysler, and Home Depot. Each of these companies is heavily involved in encouraging tort reform and has donated vast sums of money in recent years to assist in the tort reform endeavor (Birnbaum).

BACKGROUND OF THE CURRENT CRISIS

Increased Liability Insurance Premiums

In many states, access to health care is seriously threatened, as medical practices, hospital services, and long-term care facilities are closing. One cause for this condition is the increasing cost of premiums for medical liability insurance (ANA, 2003). Total malpractice premiums have nearly doubled, going from $2.9 billion in 1993 to $4.9 billion in 2002 (Schmitt, 2003). According to the statistics published by *Medical Liability Monitor*, physicians in specialty areas (e.g., internal medicine, general surgery, and obstetrics/gynecology) pay more for insurance in states such as Pennsylvania, Indiana, Texas, Utah, and Arkansas than in other states (Gearon, 2002).

Neurosurgeons are experiencing increases in their professional liability costs in nearly all 50 states. Approximately 50% of neurosurgeons surveyed have had at least a 20% increase from 2000 to 2002, with some paying nearly $300,000 per year (Kohn, Hasty, & Henderson, 2002). A survey of neurosurgeons listed Arizona, Delaware, Florida, Georgia, Illinois, Kentucky, Michigan, Mississippi, Missouri, Nevada, New York, Ohio, Oregon, Pennsylvania, Tennessee, Texas, and Washington as "hot spots" for significantly increased premiums (Kohn et al.).

The southern border of Texas (i.e., the Valley) provides one example of an area that has been especially affected by the loss of neurosurgeons and primary care providers due to increased malpractice premiums. Currently, in one of the larger counties, there are only three neurosurgeons. This small number is not enough to cover the vast population and area size. To compound the issue, the ratio of residents to primary care physicians is 2,023:1 in 29 counties along the border. This compares with a ratio of 1,562:1 statewide (Rodriguez, 2003).

Effects of Rising Liability Premiums

Rising malpractice premium costs have negatively affected the health care system in many states by forcing numerous facilities to close selected specialty areas (ANA, 2003; Gearon, 2002; Kohn et al., 2002; Sloane, 2002; Stoil, 2002). One hospital in Philadelphia eliminated its obstetric services in June of 2002 due to doubled malpractice insurance premiums of $6 million (Gearon, 2002). Similar closings of obstetric units and group practices have occurred in Florida, Arizona, Oregon, and Washington due to exorbitant insurance premiums (Corlin, 2002; Stoil). In some cases premiums have jumped 300% (Gearon).

Trauma centers and long-term care facilities such as nursing homes are not exempt from the crisis in malpractice liability insurance premiums. The nationwide costs of insurance for long-term care facilities have more than doubled within the past 5 years (Stoil, 2002). According to Stoil, 40% annual increases in liability premiums are the rule in some areas, such as Pennsylvania. A number of trauma centers in areas of Mississippi, Nevada, Pennsylvania, and West Virginia have either closed or are threatening to close (Corlin, 2002).

PROPOSED ORIGIN OF THE CURRENT INSURANCE CRISIS

Jury Awards

Both proponents and opponents of tort reform agree that the escalating premiums for liability insurance reflect higher business costs incurred by the insurance companies (Stoil, 2002). Physicians and spokespersons for the insurance industry place the blame on juries who award multimillion-dollar payments to compensate patients and their family members for pain, suffering, and other nonconomic effects of alleged malpractice (Gearon, 2002; Stoil). The median jury award jumped 43% between 1999 and 2000, hitting $1 million. A study conducted by PricewaterhouseCoopers found that "litigation is responsible for 7%, or $5 billion, of new health care costs—equivalent to the price of health insurance for 2 million Americans" ("Malpractice at Heart of New Proposal," 2002, p. 72). Massive jury awards affect even cases settled out of court, according to this theory, because insurers are willing to pay more in settlements rather than risk letting a jury "punish" their clients with huge cash penalties (Stoil).

Increased Litigation

Another factor influencing costs incurred by liability insurance companies is the increased number of lawsuits. Americans in every state have become more litigious over the past several decades (Schulz & Van Wagner, 1999; Stoil, 2002). They expect perfect products and outcomes; if things are less than perfect, they expect compensation (Schulz & Van Wagner).

Insurance Mismanagement

Not everyone, however, is convinced that the present tort system in the United States is the cause of rising malpractice insurance premiums (Gearon, 2002). According to Joanne Doroshow, president and executive director of the Center for Justice and Democracy (a public interest organization), the crisis is driven by the insurance underwriting cycle (Gearon). State trial lawyer associations concur and report that the costs incurred by insurance companies mostly reflect losses suffered in their investment portfolios (Stoil, 2002). Insurance companies were previously able to keep their malpractice premiums artificially low by investing in the booming stock markets; but, because those markets have bottomed, insurance companies have been forced to raise premiums in order to cover the "real" cost of paying for malpractice awards (Kohn et al., 2002; Stoil).

Another factor that suggests a direct reflection of poor insurance management relates to the unstable market following the September 2001 terrorist attacks. Since the attacks, the investment income that underwriters for insurance companies relied on to offset premium hikes declined dramatically. Subsequently, insurance companies pay substantially higher claims under lower priced policies written years ago (Gearon, 2002).

An additional problem occurred during the 1990s when some insurance companies, such as the Saint Paul Companies and PHICO Insurance Company, engaged in premium price wars, using the bull stock market to cover the spread of losses. The invested reserves grew so large that some of the funds were released to the bottom line as profit (Sloane, 2002). During this time, PHICO and other mutual fund companies that providers had started overexpanded When the stock market fell, most of these medical malpractice insurers were either forced out of the market or toward charging huge premium increases.

Loss of Insurance Carriers

Due to rising jury awards and insurance mismanagement, many insurance companies are closing or ceasing to underwrite medical liability insurance. The Saint Paul Underwriting Company stopped writing malpractice insurance policies in 2002, and the TIG Insurance Company, another medical liability carrier, stopped as of June 2003 (Gearon, 2002; Kohn et al., 2002; Lester, 2003). The SCPIE Company, which is a malpractice insurer for over 10,000 physicians, announced that it would stop writing coverage for providers in Texas, Florida, and several East Coast states that did not have liability caps (Ceniceros, 2003). In addition, Farmers Insurance Group revealed that it would stop carrying medical malpractice insurance as of 2004 due to financial loss (Reich, 2003).

Other Causes of the Malpractice Crisis

National organizations, such as the ANA, admit that medical errors and inadequate staffing in many health care facilities, along with the stock market failure and insurance greed, are also factors in the current crisis in medical malpractice premiums (ANA, 2003). However, there is no insurance crisis in states where significant tort reform has placed caps on liability awards, even though these states are influenced by the same national economic conditions. In these states, hospital services are available, physicians are stable in their practices, and insurance premiums are steady (Pollock, 2002).

A FEDERAL PROPOSAL FOR THE INSURANCE CRISIS

HEALTH Act of 2002

Accepting the premise that the current medical malpractice premium situation is due to tort laws, the American Medical Association and the American Hospital Association have founded the Health Care Liability Alliance. This alliance is seeking federal legislation that will change tort laws by limiting liability (Corlin, 2002; Gearon, 2002). A major outcome of this endeavor is the HEALTH (Help Efficient Accessible, Low-Cost, Timely Health Care) Act of 2002. It is an act similar to the Medical Injury Compensation Reform Act (MICRA), which was enacted by California in 1976 and is still in effect. The HEALTH Act would shorten the statute of limitations (i.e., the time within which a suit may be brought) for damages; limit punitive damages to $250,000; limit noneconomic pain-and-suffering damages to $250,000; institute a fair share to allocate damages based on fault; and give courts the power to review lawyers' contingency fees (Corlin; Kelly, 2003; Liptak, 2002). Other provisions would offer periodic payments on damages instead of one lump sum and would give permission for courts to consider existing health care coverage for the medical problem when making awards (Stoil, 2002).

Nursing Support for Tort Reform

Nursing associations are joining in the effort to encourage reform of tort laws. The ANA endorses tort reform on a limited scope. On April 23, 2003, the ANA Board of Directors adopted an expanded policy on medical malpractice liability and tort reform, which addresses the issues of the current crisis in malpractice insurance. The board supports a "balanced, multipronged legislative approach to address the current medical malpractice liability problem" but opposes dollar caps on health care liability litigation until further investigation (ANA, 2003, p. 4). APN organizations that openly support tort reform legislation include the American Association of Nurse Anesthetists (Lester, 2003) and the American College of Nurse Midwives ("National and State Medical Liability Reform," 2003).

Myths About Federal Tort Reform and Insurance Premiums

The HEALTH Act, like MICRA, is not meant to limit the ability to seek litigation against a medical provider or facility. In fact, California has nearly 1.5 times the national average of medical malpractice lawsuits; but the cost of malpractice insurance premiums remains less than half the cost of insurance premiums in other states (Stoil, 2002). Another example is Oregon. From 1987 (when liability caps were enacted) until 1998, insurance premiums in Oregon were low, and there were plenty of insurers. Unfortunately, since the 1999 Oregon ruling that lifted those caps, total insurer indemnity payments jumped from $15 million annually to $60 million (Ceniceros, 2003).

In those states that limited noneconomic damages within a range of $250,000 to $350,000, insurance premiums increased only 12% to 15% during 2001. In contrast, other states experienced increases in premiums averaging 44%. As of 2002, 17 states limit punitive damages for medical malpractice cases, and a few others cap them for all cases (Ceniceros, 2002).

STATES' RESPONSE TO THE MALPRACTICE INSURANCE CRISIS

A federal tort reform law would pre-exempt state law, but several states are not waiting for Congress and are moving forward by seeking their own legislation. In response to the insurance crises, 34 states debated a variety of solutions during the first half of 2003, and 10 states ratified significant tort reform measures. Idaho enacted caps on both noneconomic and punitive damages; Arkansas enacted caps on punitive damages alone; caps on noneconomic damages were passed in Ohio, Oklahoma, Texas, and West Virginia; and in Arkansas, Georgia, Texas, and West Virginia, there was court venue reform legislation (Kelly, 2003).

Issues With Federal Tort Reform

The problems facing federal tort reform have provided motivation for states' individual involvement in tort reform. One such problem is partisan positioning in the House and Senate, which is effectively blocking efforts to pass legislation on tort reform (ANA, 2003; Birnbaum, 2002). Even though the House passed legislation on tort reform, the Senate version failed in July of 2003 (Gerber, 2003; Kelly, 2003). In answer to the failed Senate legislation, Senator Bill Frist (a Republican from Tennessee) stated that he would reintroduce "the Patients First Act of 2003 during the 2003 fall legislative session" (Kelly).

Another rationale for encouraging state legislators to enact their own tort reform laws is directly connected to the issue of states' rights. The U.S. Supreme Court has ruled that tort reform is generally a matter left up to the states and state law, along with questions of civil lawsuits and insurance regulation (Schulz & Van Wagner, 1999; Stoil, 2002). Additionally, partisan support for legislation would have its greatest impact in the state courts with their philosophical commitment to federalism, which would leave most local matters to the states (Liptak, 2002).

Judicial Intervention

It must be mentioned that the judicial branch of government can overturn laws set by the legislative branch, including those pertaining to tort reform. Since 1983, courts have overturned at least 91 tort reform decisions in 26 states (Kelly, 2003). For example, state supreme courts in Illinois and Ohio ruled that the ratified tort reform legislation was unconstitutional (Schulz & Van Wagner, 1999). What is discouraging about these state rulings is that the decisions about the constitutionality of the laws are not appealable to the U.S. Supreme Court. According to Schulz & Van Wagner, if the state's supreme court declares a law dead, it is dead.

MEDICAL ERRORS AS BASIS FOR LITIGATION

Malpractice litigation is not always unfounded, as medical errors do occur. A recent broadly publicized example is that of Jesica Santillan, who died as a result of physician error after receiving a heart-lung transplant in February 2003 (Adler et al., 2003). Surgery-related claims represent just one area of high risk and liability. There are many other incidents of negligence by all health providers, be they nurses or physicians. A 1992 study of 15,000 patients admitted to hospitals in Utah and Colorado found that 3% of surgery patients encountered an adverse event (Dwyer, 2003). Drug errors are another high-liability area. In a study conducted in 1991, drug errors accounted for nearly 20% of all adverse events. By mid-2000, medication errors represented a leading cause of death among hospitalized patients in the United States (HRC, 2000). According to the American Society of Health-System Pharmacists, prescribing errors (such as incorrect drug selection, dose, or dosage form and illegible prescriptions or medication orders) are just one type of error that can adversely affect patient outcomes (HRC).

Capping malpractice damages by reform does not waive the review or discipline of providers who are negligent. Physicians, nurses, and all health providers need to be responsible for the medical care they render. Additionally, state medical and nursing boards need to take action against those providers who may be disproportionately responsible for rate hikes due to more than one claim of malpractice (Lester, 2003). For example, California set up a successful panel of physicians to review and eliminate incompetent doctors. Over the past 25 years, this review process, in addition to tort reform, has held down liability costs to a fraction of the increases seen elsewhere, and California has no flight of physicians (Pollock, 2002).

MALPRACTICE COSTS AND NURSE PRACTITIONERS

Impact on Nurse Practitioners

Health care providers and hospitals across the country are facing economic difficulties and can no longer afford to support the costs associated with unlimited malpractice awards (Pollock, 2002; Simpson & Craig, 2002). As hospitals, nursing home facilities, and physician practices close, patients will be left without needed medical care. In addition, many NPs and APNs will be without a place to practice or adequate malpractice insurance (ANA, 2003; Lester, 2003). This situation will produce a domino effect, as fewer providers and hospitals caring for more patients leads to a greater chance for mistakes, which leads to a greater number of malpractice suits, drives up liability insurance premium costs, and finally forces more physicians, NPs, and hospitals out of practice.

In response to increased malpractice litigation, health care providers are practicing defensive medicine. It appears, however, that defensive medicine has not resulted in better care, just more care at greater cost to society. Unlimited malpractice damage awards can even thwart prospects of early settlement of malpractice cases, because plaintiffs may hold out longer in hopes of larger awards (Simpson & Craig, 2002).

Quality Medical Care

Rather than focusing on defensive medicine as a preventive approach to malpractice litigation, NPs need to focus on providing quality care according to practice guidelines. Keeping abreast of current clinical practice (evidence-based medicine), delivering patient-centered care, focusing on quality improvements, and utilizing current information technology are fundamental in providing the highest quality and safest medical care (Institute of Medicine, 2003). These guidelines include avoiding diagnostic and technical errors by communicating effectively with other clinicians and patients, evaluating patients promptly, returning their phone calls in a timely fashion, and providing adequate discussion as to risks and alternatives to procedures. More importantly, patients need to be involved in and assisted with increasing their own decision-making processes (Dwyer, 2003).

NPs and the Tort Reform Process

NPs need to understand the issues of tort reform and take an active role either for or against. Utilizing NP lobbying groups has proved effective with previous NP issues, such as increased privileges in many states, and can be utilized in formulating a tort reform platform (Herrick, 2003). NPs need to be certain that they are included in the language of tort legislation, thereby avoiding exclusion. NPs also need to work with other health provider groups to encourage legislators to enact reform that will withstand appeals, lower malpractice insurance premiums, and benefit patients by improving access to care.

CONCLUSION

Medical malpractice insurance premiums are out of control, and one strongly proposed reason is a very litigious society and massive jury awards. These premium costs are causing physicians in many states to close their practices and hospitals to shut down certain specialty areas; these closings, in turn, affect NPs' practice. The hope is that with liability caps, insurance premiums will decrease or at least stabilize. This type of reform is designed to limit—not eliminate—noneconomic damages. Tort reform has successfully stabilized liability insurance premiums for over 25 years in California, which serves as an example that such reforms can work for other states.

However, tort reform is not a quick fix, and it is too optimistic to hope caps will lead to an immediate rate reduction. Although many physicians, nurses, and hospital associations believe the answer lies in reforming tort laws, other approaches to reducing malpractice insurance costs deserve consideration. Adhering more closely to current practice standards, providing quality care, and establishing informal peer review through professional associations are just a few. The incorporation of established guidelines into the everyday practice of all health care providers, in conjunction with tort law reform, will stabilize premium rates and, in time, could certainly decrease them.

REFERENCES

Adler, J., Campo-Flores, A., Lacy, B. A., Smalley, S., Ccelfo, J., Raymond, J., et al. (2003, March). A tragic error. *Newsweek, 141*(9), 20. Retrieved September 15, 2003, from EBSCO HOST Databases.

American Nurses Association. (2003, April). Medical malpractice liability/tort reform briefing paper and ANA position statement. Retrieved May 7, 2003, from http://vocusgr.vocus.com/grcovert1/webpub/ana/ProfileIssue.asp?issueID=2951JOINT&XSL=ProfileIssue&hidLegislatorDs=

Birnbaum, J. (2002). Lawyers get the last laugh. *Fortune, 146*(6), 35. Retrieved January 25, 2003, from EBSCO HOST Databases.

Ceniceros, R. (2003, January 27). Malpractice reform heats up: Doctors' insurance costs, losses attracting state and federal attention. *Business Insurance.* Retrieved January 30, 2002, from LexisNexis Database.

Corlin, R. (2002). Liable to be at risk. *Modern Healthcare, 32*(23), 26. Retrieved January 25, 2003, from EBSCO HOST Databases.

Dwyer, K. (2003, April). *Surgery-related claims and the systems involved.* Retrieved September 18, 2003, from http://rmfinteractive.com/Article.FreePreview.asp

Gearon, C. (2002). Up and away. H and HN: Hospitals and Health Networks, 76(8), 16. Retrieved February 2, 2003, from EBSCO HOST Databases.

Gerber, M. S. (2003, August 13). Despite presidential priority, tort reform stalls in Congress. The Hill. Retrieved September 19, 2003, from http://www.hillnews.com/business/081303.aspx

Herrick, T. (2003). *Clinician News, 7*(1), 1, 21–23.

HRC: Risk Analysis. (2000, September). *Medication errors.* Retrieved September 10, 2003, from http://healthcare.ecri.org/PatientSafety/Pharml.pdf Institute of Medicine. (2003, April). Health professions education: A bridge to quality. Retrieved September 10, 2003, from http://www.iom.edu.iom

Kelly, D. (2003, July). As U.S. *Senate stalls, states move on medical malpractice lawsuit reform.* BestWeek. Retrieved September 23, 2003, from LexisNexis Database.

Kohn, C., Hasty, S., Henderson, C. W. (2002a, August 12). Soaring malpractice insurance squeezes out doctors, clinic. *Managed Care Weekly Digest,* 17–20. Retrieved January 30, 2003, from EBSCO HOST Databases.

Kohn, C., Hasty, S., Henderson, C. W. (2002b, September 9). AANS: Professional liability insurance crisis is harming health care. *Managed Care Weekly Digest,* 4–5. Retrieved January 30, 2003, from EBSCO HOST Databases.

Lester, R. C. (2003, February). Assessing the need to enact medical liability reform. Presentation to the House Energy and Commerce Committee: Subcommittee on Health, Washington, DC.

Liptak, A. (2002, November 17). Shot in the arm for tort overhaul. *New York Times,* Section 3, p. 1. Retrieved January 25, 2003, from LexisNexis Database.

Malpractice at heart of new proposal. (2002, June). *Healthcare Risk Management, 24,* 72. Retrieved February 2, 2003, from INFOTRAC Database.

National and state medical liability reform: Board of directors endorses tort reforms. (2003, January/February). Quickening. *Retrieved September 24,* 2003, from http:www.acnm.org

Pollock, F. (2002, September 6). California model tort reform proposal is court-tested and fair for doctors, patients: [Editorial]. *Charleston Gazette,* p. P5A. Retrieved January 30, 2003, from LexisNexis Database.

Reich, K. (2003, September 27). Insurer to drop medical policies. *Los Angeles Times.* Retrieved September 30, 2003, from http: www.latimes.com

Rodriguez, B. (2003, March 3). Budget shortfall may worsen strain on border health system. *Dallas Morning News,* pp. A1, A6.

Schmitt, C. H. (2003). A medical mistake. *U.S. News and World Report, 134*(23), 24–27. Retrieved September 15, 2003, from EBSCO HOST Databases.

Schulz, I., & Van Wagner, J. (1999). Tort reform on shaky ground in state supreme courts. *Urology Times, 27*(10) 18–19. Retrieved February 2, 2003, from EBSCO HOST Databases.

Simpson, K., & Craig, P. (2002). Should there be "caps" on pain and suffering awards for medical malpractice cases?: Writing for the pro position. MCN: *The American Journal of Maternal/Child Nursing, 27*(3), 142.

Sloane, T. (2002). Back on the tort reform merry-go-round. *Modern Healthcare, 32*(28), 22. Retrieved January 25, 2003, from EBSCO HOST Databases.

Stoil, M. (2002). States take the lead on tort reform. *Nursing Homes Long-Term Care Management, 51*(9), 8–9. Retrieved January 25, 2003, from EBSCO HOST Databases.

Webster's third new international dictionary. (1993). Springfield, MA: Merriam-Webster.

Word, R. (2003, May 7). *Doctors' walkout affecting hospitals.* Denton Record Chronicle, pp. 7A.

Texas Medicine Magazine – March 2004

Future Fears: Medical Students Antsy About Liability Climate That Awaits Them

By Ken Ortolon
Senior Editor

America's medical students are increasingly anxious about the threat of lawsuits that will hang over them when they graduate and begin practicing medicine. That anxiety could spell bad news for the availability of skilled physicians in specialties hardest hit by the nation's medical liability crisis.

At least two recent surveys show that medical students across the country believe medical liability is a crisis, and it's affecting their decisions on taking up a high-risk specialty and applying for residency training in states considered liability hot zones.

"The conclusion is frightening but obvious," said David A. Rosman, a fourth-year student at the University of Massachusetts Medical School and medical student trustee on the American Medical Association Board of Trustees. "We're going to see tremendous shortages of physicians in high-risk specialties, and the result will be a massive and frightening decrease in access to care."

Even in Texas, where a constitutional amendment and legislation recently passed, capping noneconomic damages in medical liability cases, students seem only cautiously optimistic about the liability climate.

"Texas has made big steps recently, and the situation is not quite as severe as in some highlighted counties and states, but there is a lot that remains to be seen," said Lindsay K. Botsford, an officer in the Texas Medical Association student chapter at Baylor College of Medicine in Houston.

Student Attitudes

In December, AMA released the results of its first survey on the impact the nation's medical liability environment is having on medical students' decision making. The results, which included responses from nearly 4,000 students in 45 states and the District of Columbia, showed that 86 percent of students believe medical liability is a crisis or a major problem. Half also said medical liability was a factor in their specialty choice, and 39 percent said it was a factor in their choice of the state in which they want to complete residency training.

The results were similar to another survey conducted by the Association of American Medical Colleges. Its 2003 Medical School Graduation Questionnaire, which annually questions recent

graduates on a variety of topics, found that 94.5 percent of 2003 graduates believe physicians' legal liabilities and the high cost of professional liability insurance are major problems. That was up from 82.5 percent in 2001 and 84.3 percent in 2002.

While there are no formal data on Texas medical students' attitudes about medical liability, students at Texas medical schools say there is considerable concern among their classmates.

"In an informal poll conducted of our first-year class, medical liability was the No. 2 issue concerning students, behind health care for the uninsured and before tobacco use," said Ms. Botsford. "Personally, it is a concern that is shaping my decisions to explore certain specialties and areas of the country to locate."

Heather Shipman, a third-year student at The University of Texas Medical Branch at Galveston and chair of TMA's Medical Student Section, says students there also are keeping a keen eye on the liability climate.

"I have been impressed with the number of students who follow the medical liability crisis," Ms. Shipman said. "Their concern is usually in regard to what specialty they will choose, especially obstetrics and gynecology. While many students have limited knowledge of the liability crisis, they know enough to know which specialties are most affected."

Mr. Rosman says the results of the student survey were not really surprising. "Being educated in today's environment, I think it would be difficult not to think it's a major problem," he said. "I've seen concern over liability increase in the time I've been here. In that time, I've watched it change from a topic never discussed, and which seemed not really to be of importance to medical students, to one on which medical students -- and certainly residents -- are focusing much more than you'd hope they would have to in an educational environment."

Risk Avoidance

Some medical students say the liability crisis has had no impact on their choice of specialty. "Although surgery is a high-risk specialty, it still remains the only specialty in which I have interest," said Thomas B. Roshek III, who is scheduled to graduate from UT Medical School at Houston in 2005.

However, others fear the liability situation will significantly impact the number of students pursuing careers in obstetrics-gynecology, neurosurgery, emergency medicine, and a handful of other high-risk specialties.

"I interview quite a few students for TMA loans every year," said TMA President Charles W. Bailey Jr., MD. "Very rarely do I find one who is going into OB-Gyn or neurosurgery."

Dr. Bailey says he believes the students' decisions are affected not only by fear of being sued but also by the high premium costs they will have to pay as young physicians in high-risk specialties.

"It's just a question of having large student loans and not being able to afford the first year's premium for a lot of these high-risk specialties. They're likely to say, 'If I go into pediatrics, my premiums will be lower and I can probably pay off my loan three, four, or five years quicker than I would if I tried to be an obstetrician.'"

Mr. Rosman says that with the average medical student now graduating with a debt in excess of $100,000 it makes sense to choose a specialty for which liability premiums are lower. "The result of that is that any sort of decision where you're going to end up in a field where you've got a liability expense of tens of thousands, and in some cases hundreds of thousands, of dollars can very clearly and, sadly, justifiably affect specialty choice."

Houston emergency physician Diana Fite, MD, chair of TMA's Council on Medical Education, says she also believes liability concerns are having an impact on the overall number of students interested in medicine.

"We definitely think it has a lot to do with the still overall declining number of applicants to medical school," Dr. Fite said. "We've talked about this at length, and we think this is a definite part of the problem."

Easing the Crisis

Texas is one of 19 states that AMA considers to be "states in crisis" in terms of their medical liability climate and high liability insurance premiums. Texas physicians, however, hope that will change due to passage of Proposition 12, the constitutional amendment that authorized caps on noneconomic damages in liability cases. While those caps prompted the Texas Medical Liability Trust to lower its premiums across the board by 12 percent and may be luring new liability carriers into the Texas market, students here seem to be taking a wait-and-see attitude about whether the caps will be enough to keep them from going elsewhere for their residency training.

"I think everyone is hopeful that it will effect change in both insurance premiums and litigation, but I think some will remain skeptical about the magnitude of the change until they see actual results," Ms. Botsford said. "The changes probably increase my likelihood to stay in Texas because the policy environment seemed friendly to physicians' concerns, but I don't think they have yet to change my eagerness to go into a high-risk specialty."

Sarah Hicks, a student at Texas College of Osteopathic Medicine in Fort Worth and a TMA delegate, also says she is encouraged by the reforms enacted in 2003. "The passage of House Bill 4 and the caps have made Texas, in my eyes, a safer place for obstetrics. I intend to practice rural medicine, family practice, but I would like to be able to deliver babies for my patients. Before the recent reform in Texas, I was not considering returning to Texas. I'm glad it's an option now because this is where I grew up."

Looking to Washington

So far, there appears to be no shortage of residents lining up for training in Texas despite the liability climate. The overall residency program match rate for Texas in 2003 was 92 percent, higher than the national average and the highest rate in five years. Even high-risk specialty programs had high match rates, says Marcia Collins, director of TMA's Medical Education Department. The state's obstetrics-gynecology residency programs matched at rates higher than those for family practice, she says.

But there is still concern that if the liability crisis is not fixed, crisis states such as Texas will see real physician shortages in high-risk specialties because of early retirement by veteran physicians and relocation of other doctors to more liability-friendly states.

"The ultimate reason why we need to fix the liability system has very little to do with physicians and much more to do with protecting access to care," Mr. Rosman said.

But fixing the liability problem at the national level does not appear to be in the cards any time soon without a drastic change in the political makeup of the U.S. Senate, says William Gamel, MD, of Austin, chair of the Texas Delegation to the AMA and incoming chair of the AMA Council on Legislation. The U.S. House passed medical liability reform legislation last year and President George W. Bush has made it a priority again this year. Senate Democrats, however, are blocking consideration of the bill, and Republicans lack the necessary votes to prevent a Democratic filibuster.

"This has turned into a partisan fight, and we need votes from both sides of the aisle," Dr. Gamel said. "If physicians want liability reform to pass in the next session of Congress, they need to get busy in U.S. Senate races across the country to change the representation in the U.S. Senate."

Ken Ortolon can be reached at (800) 880-1300, ext. 1392, or (512) 370-1392; or by e-mail at ken.ortolon@texmed.org.

ALASKA STATE SENATE

Session:
State Capitol
Juneau, Alaska 99801-1182
(907) 465-2327
(907) 465-5241 Fax

Interim:
119 N. Cushman, Suite 201
Fairbanks, Alaska 99701
(907) 456-8161
Senator_Ralph_Seekins@legis.state.ak.us

Senator Ralph Seekins
District D

Senate Bill 319 Sponsor Statement

"An Act relating to claims for personal injury or wrongful death against health care providers."

Senate Bill 319 amends AS 09.55.548 and 556. The proposed legislation intends to alleviate a growing crisis in Alaska's health care industry with respect to the availability of liability insurance. It places a hard cap on damage awards; clarifies informed consent language; and limits liability with respect to health care advice communicated through electronic means.

The fact is Alaska's medical system is breaking down. Alaska ranks near the bottom in the number of physicians per capita. What's more, over half of Alaska's physicians exceed the age of 50. Many will be retiring in the next 10 years. Attracting and keeping adequate numbers of high quality physicians in Alaska is of utmost importance.

The availability of liability insurance plays a critical role in solving this crisis. Half of the insurers have ceased doing business in Alaska in the last 12 months. Other professional liability insurance carriers have not shown an interest in doing business in the state due to the volatile medical liability environment.

This is a complex issue. However, one solution that has proven particularly effective in other states is capping non-economic damages. SB 319 intends to help establish a predictable risk-assessment environment by placing a $250,000 cap on this type of award. It *does not* change awards for quantifiable economic damages such as lost wages and past and future medical expenses.

The bill also makes revisions which limit liability in cases where a patient elects not to follow advice that was communicated by a health care provider through electronic means. Lastly, qualifying language is added relating to informed consent along with a sprinkling of punctuation marks.

The bottom line? Instituting a $250,000 cap on non-economic damages will help stabilize the professional medical liability insurance market here in Alaska thereby reinforcing efforts to attract the next generation of doctors to replace those who are nearing retirement age.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 23, 2004

SUBJECT: Sectional Analysis for SB 319
(Work Order No. 23-LS1693\A)

TO: Senator Ralph Seekins
Attn: Brian Hove

FROM: Donald M. Bullock Jr.
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. This section includes findings by the legislature and the intent of the Act.

Section 2. The section adds four new subsections to AS 09.55.548. Subsection (c) limits damage claims for noneconomic losses identified in the subsection; subsection (d) limits the amount of damages that may be awarded for noneconomic damages; subsection (e) bars the disclosure of the award limit to the jury and requires the award to be limited before the entry of judgment; subsection (f) states that multiple injuries sustained by one person as a result of a single incident are treated as a single injury.

Section 3. This section amends AS 09.55.556 and relates to informed consent. The amendment adds the words "course of action" to the terms "treatment" and "procedure" as the subjects of information to be provided to a patient in the course of obtaining the patient's consent.

Section 4. This section amends AS 09.55.556 by adding two subsections. Subsection (c) describes the risks a health care provider must disclose to a patient and the standard for identifying and disclosing the risks. Subsection (d) relieves a health care provider from liability for advising a patient to seek further medical care or evaluation when the patient elects not to follow that advice.

Section 5. This addition to the uncodified law makes the Act applicable to suits against health care providers initially filed on or after the effective date of the Act.

Section 6. This section makes the Act effective July 1, 2004.

If I may be of further assistance, please advise.

DMB:lmb
04-049.lmb

Senate Bill 319
Supplemental Sectional Description

Section One. Section one deals with legislative findings and intent. The legal effect of section one is to confirm the Legislature's intent to modify Alaska Supreme Court opinions in Korman vs. Mallin and Marsingill v. O'Malley as described in sections three and four.

Section Two. The non-economic damage cap which applies to all wrongful death and personal injury actions in Alaska (AS 09.17.010) is $400,000 or $8,000 times the life expectancy of the claimant, whichever is greater, for most injuries. For severe physical impairment or severe disfigurement the cap amount is $1,000,000 or $25,000 times life expectancy, whichever is greater. Section two caps non-economic damages against all healthcare providers for wrongful death and personal injury actions at a maximum of $250,000.

Section Three. Section three makes minor stylistic changes to Alaska's informed consent law without changing the effect in any consequential way.

Section Four. The Alaska Supreme Court in Korman vs. Mallin held that when jurors evaluate whether or not a health care provider has adequately informed the patient of the common risks and reasonable alternatives of treatment, they are to evaluate the information based upon what a reasonable patient would expect to hear under the circumstances. This standard fails to provide a healthcare practitioner with any objective basis upon which to determine at the time of treatment what risks and alternatives should be conveyed to the patient. Section four, subparagraph (c) over rules the Supreme Court opinion and makes the standard of disclosure what a skilled health care provider of the same or reasonably similar specialty would disclose under similar circumstances. This paves the way for the health care profession to adopt reasonable guidelines for healthcare providers to ensure patients receive adequate information without exposing the healthcare provider to later second guessing.

The Alaska Supreme Court in Marsingill v. O'Malley stated that Marsingill called Dr. O'Malley at night, the doctor advised her to go to the emergency room for treatment and she declined to do so. The court held that the jury, under these circumstances, would still be able to find the doctor negligent. Section four (d) protects healthcare providers, who are consulted other than in person and who are thereby unable to personally evaluate the patient and assess first hand the nature of the patient's condition, from legal liability if their recommendation is for the patient to seek further treatment and the patient chooses not to follow that advice. This section applies to healthcare providers who are contacted by phone, electronically, or who provide telemedicine services to Alaskan communities not otherwise served by a particular medical specialty.

Section Five. Section five makes the changes in this bill applicable to all medical malpractice claims which are filed on or after the effective date of the act regardless of the fact that the medical treatment occurred prior to the effective date of the act.

Section Six. Section six provides for an effective date of the act.

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 319
(S) Publish Date: 3/12/04

Revision Date/Time (Note if correction):
Dept. Affected: LAW
Title "An Act relating to claim for personal injury wrongful death against health care providers..."
RDU CIVIL
Component Torts & Workers' Compensation
Sponsor Senator Seekins
Requester Senate Labor & Commerce Committee
Component No.

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2005 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill adds a new section to the Code of Civil procedure in order to place limits on the amount of recoverable damages for personal injury or wrongful death based on the provision of services by a health care provider. The bill makes a minor change to the requirement that health care providers obtain the informed consent of a patient prior to embarking on a course of action involving the patient, and that informed consent include information regarding risk of death, serious bodily harm, and common serious complications that may occur. The bill also makes clear that a health care provider is not responsible for certain types of advice given that the patient elects not to follow.

Passage of this legislation will have no foreseeable fiscal impact on the Department of Law.

Prepared by: Kathryn A. Daughhetee, Director
Phone 465-3673
Division Administrative Services
Date/Time 2/26/04 3:04 PM
Approved by: Kathryn Daughhetee for Gregg D. Renkes, Attorney General
Date 2/26/2004
Agency Department of Law

(Revised 12/2003 OMB)

FISCAL NOTE

STATE OF ALASKA
2004 LEGISLATIVE SESSION

Fiscal Note Number: 2
Bill Version: SB 319
(S) Publish Date: 3/12/04

Revision Date/Time (Note if correction):
Dept. Affected: DCED
Title: Claims Against Health Care Providers
RDU: Insurance (116)
Component: Insurance Operations
Sponsor: Senator Seekins
Requester: Senate Labor & Commerce
Component No.: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2004) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2005 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This legislation limits the damages for non-economic losses that may be awarded against health care providers for personal injury or wrongful death.

This legislation has no fiscal impact on the operations of the division.

Prepared by: Linda S. Hall, Director — Phone (907) 269-7900
Division: Insurance — Date/Time 3/1/04 11:30 AM
Approved by: Edgar Blatchford, Commissioner — Date 3/1/2004
Agency: Department of Community & Economic Development

HOUSE BILL 472/SENATE BILL 319

1. What is the problem?

A. Alaska ranks between 46 and 49th in the country in doctors per patient population depending upon the study. With the aging of the Alaska physician population this problem only stands to get worse. According to Leslie Gallant of the Division of Occupational Licensing, 48% of Alaska physicians are aged fifty or older. According to a physician need study by Providence Health Systems Alaska, almost 26% of practicing Anchorage physicians are over 55 and almost 6% are over 65 years of age.[1] The Providence study found in 2002 Anchorage alone had 153 fewer physicians practicing in the public sector for its population base than the national average.[2] The study projects this figure will rise to 180 by 2008. The Providence study revealed that in Anchorage between 1998 and 2002 in Anchorage the actual number of primary care providers dropped from 184 to 151 and the number of hospital based providers dropped from 114 to 92. Unless aging physicians are replaced, the shortage will grow even larger. Many sub specialties are vastly under staffed.[3] Most doctors do not get out of residency until after their thirtieth birthday. By that time, many have school loans in excess of $200,000. Most specialists locate within 100 miles of their residency. Alaska has no medical school In order to attract competent physicians to relocate to Alaska, it is important that the state be able to offer physicians a stable environment in which malpractice insurance is both available and affordable.

B. Until recently Alaska had several medical malpractice carriers. Now it has two - NORCAL and MIEC, both doctor owned, not for profit insurers. According to the report of a joint United States Congressional committee, medical malpractice insurance capacity has shrunk at least 15% in the recent past. The Professional Liability Underwriting Society has stated A.M. Best views the outlook for the medical malpractice sector as negative and the remaining insurers simply don't have the capacity to write all the business that is available to them. In a time of scarce

---

[1]Providence found that 22% of Anchorage primary care physicians, 26% of Anchorage medical specialty physicians, 19% of Anchorage pediatric specialists, 34% of Anchorage surgical specialty physicians and 29% of anchorage mental health physicians were over the age of 55 in 2002.

[2]In 2002 in Anchorage the number of primary care providers was below the national average by a total of 27.5 providers; hospital based providers by 12.5; medical specialists by 15.5; surgical specialists by 48.85; and mental health providers by 50.85.

[3]The Providence study identifies the following Anchorage subspecialties all with a 20% or greater deficit when compared to the US national average benchmark: general internal medicine, pathology, radiology, allergy/immunology (pediatric and adult), dermatology, hematology/oncology (pediatric and adult), neurology, preventive medicine, rheumatology; pediatric cardiology, general surgery, ENT, urology and psychiatry (adult and pediatric).

insurance availability due to under capacity in the market, insurers are going to concentrate their resources in the most stable of climates.[4]

C. Alaska's medical malpractice premiums are too high. California in 1976 adopted a $250,000 cap on non economic damages. California physicians now pay an average of $14,564 per year for malpractice insurance. Alaska physicians pay an average of $30,627 or 110% more than California physicians on average. This is the 8th highest average cost in the country .[5] Since 1976, the rates for California physicians have increased 182% vs the rates for Alaska physicians which have increased $1,593%! Only seven states have seen a higher rate of increase.[6] In the last year, MIEC raised the rates for neurologists 20% and the rates on the excess portions of higher limit policies for all its physicians as much as 22%.

D. Alaska is one of 26 states the AMA considers are showing signs of a serious medical liability problem. California is listed as one of only six states showing few or no signs of problems.[7]

E. MIEC claims experience reveals the its average cost of claims in which there was a pay out in Alaska, including indemnity and legal defense, more than doubled from the period 1991-96 ($138,676) to 1997-2002 ($289,153). Northwest Physicians Mutual Insurance Company withdrew from the Alaska market this year claiming its recent claims experience in Alaska was sufficiently negative to support a rate increase of well over 100%. When the Division of Insurance failed to approve a requested rate increase, Northwest withdrew from the Alaska market. In 2001, according to the National Practitioner Data Bank, the average medical liability payment in Alaska was $308,476, the 14th highest in the country.

2. **Why didn't prior tort reform prevent this problem?**

A. A hard cap on non economic damages is the single most effective way to combat insurance. Alaska did not adopt a hard cap for non economic damages for severe cases until 1997 and then it became $1,000,000 or $25,000 times life expectancy. For an obstetrician who delivers a female child the cap could reach almost $2,000,000.

---

[4]Source, Liability for Medical Malpractice: Issues and Evidence. A Joint economic Committee Study, Joint Economic Committee United States Congress, 5/2003. The study found that those insurers which have exited the market completely have not done so simply due to short-term cycles, but rather because the long-term outlook is so bleak as to make continued business operation untenable.

[5]Source, A.M. Best & Co. 2001.

[6]Source, NAIC Profitability by Line by State 1976-2001 (Medical Malpractice.)

[7]Source, American Medical Association, July, 2003.

3. **Isn't this just an insurance problem which can be solved by more closely regulating insurers?**

A. The General Accounting Office found that insurers are not charging and profiting from excessively high premium rates.[8] The two major malpractice insurance carriers operating in Alaska are non profit doctor owned companies whose sole existence is to provide stable, low cost insurance protection for the medical community. There is no evidence to suggest either company is poorly managed, or that its overhead is unrealistically high. NORCAL and MIEC (the two remaining medical malpractice carriers in Alaska) have returned millions of dollars to their policy holders.

B. NORCAL has consistently performed better than the insurance reform mandates in California. Since Proposition 103 was passed in California, NORCAL's base rate increases have been far less than those of the control levels set for all types of California liability insurance. Not a single medical liability rate filing has been denied in California since Prop 103 was enacted.

C. Providence Alaska is the single largest healthcare facility in the state. It is non profit and it is self insured. All the gains from this reform will be immediately returned to Alaska patients. Likewise, many other hospitals in the state, such as Bartlett Memorial Hospital in Juneau, are locally owned by their communities which will stand to gain from this reform.

4. **What assurances are there that a hard cap of $250,000 on non economic damages will solve any of Alaska's problems?**

A. The $250,000 hard cap has worked in California. California and Alaska both enacted medical malpractice reform legislation in 1976. The major difference was that California adopted a hard cap of $250,000 for non economic damages. Rather than try to artificially pick any dates within the quarter century since this occurred, a look at what has happened in both California and Alaska spanning the entire time period seems appropriate. Since 1976, NORCAL estimates MICRA has returned savings to policy holders from all medical liability insurers in California in excess of five hundred million dollars. California anesthesiologists now pay ½ of what they paid in malpractice premiums for similar coverage in 1976. California physicians pay an average of $14,564 per year for malpractice insurance. Alaska physicians pay an average of $30,627 or 110% more than California physicians on average.[9] Since 1976, the rates for California physicians have increased 182% vs the rates for Alaska physicians which have

---

[8]U.S. General Accounting Office, Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates, GAO-03-702, p.32 (6/03)

[9]Source, A.M. Best & Co. 2001.

increased $1,593%![10] In 2001 the average medical liability payment in Alaska was $308,476 vs California of $178,499 - meaning Alaska payments were 72% higher.[11] In 1975 California had approximately 10% of all the physicians in the United States but its physicians paid almost 25% of all the medical liability premiums paid in the United States. Today California's share is only about 10% of all medical liability premiums paid in the United States.

B. The following entities have published studies which have established that a hard cap on non economic damages is the most significant factor in controlling medical malpractice rates. The Congressional Budget Office, the U.S. Department of Health and Human Services[12], The Joint Economic Committee of the United States Congress[13], Standard & Poors, The American Academy of Actuaries, the National Conference of State Legislators (NCSL), Tillinghast and Milliman, USA[14].

C. *The U.S. Department of Health and Human Services found that states with caps on non economic damages experienced about 12% more physicians per capita than states without such a cap. Moreover, the report found that states with relatively high caps were less likely to*

---

[10]Source, NAIC Profitability by Line by State 1976-2001 (Medical Malpractice.) No one expects caps on non economic damages to reduce insurance rates. Inflation will continue to take rates higher. For instance, as the cost of medical care and wages rises, so too do the economic damages of claimants. Insurance company overhead rises as office space and equipment become more expensive for insurers, salaries increase and fringe benefits, such as medical care, also rise. Over time, as has happened between California and Alaska, the rate of increase differs substantially between those states with a $250,000 cap on non economic damages and those without.

[11]Source, National Practitioner Data Bank, 2001.

[12]"Over the last two years, states with limits of $250-350,000 on non-economic damages have seen average combined highest premium increases of 18% but states without reasonable limits on non-economic damages (in states representing almost half of the entire United States population) have seen average increases of 45%." Source, U.S. Department of Health and Human Services: Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care, 3/3/03.

[13]Source, Liability for Medical Malpractice: Issues and Evidence. A Joint economic Committee Study of the United States Congress, 5/2003.

[14]Milliman, USA study based upon a survey of the National Practitioner Data Bank reports between 1990-2001 states: "The data indicate that caps on non-economic damages reduce the cost of insuring medical malpractice for physicians in the states in our study that have instituted this element of tort reform..."

experience an increase in physician supply than states with lower caps.[15] And a recent study found that the number of doctors at the state level is sensitive to the malpractice insurance costs: higher premiums reduce the number or practicing physicians.[16]

D. Today there are seven strong companies actively competing to sell medical malpractice insurance in California vs. two in Alaska.

5. **But, didn't the GAO, in a study released in 2003, find no support for capping damages?**

A. Two reports concerning medical malpractice were issued by the GAO in 2003.[17] The first report confirms that since 1999 medical liability premiums skyrocketed in some states and specialties and increasing settlements and jury awards are the primary drivers for these increases. The second report confirms that the country's medical liability crisis is causing access to health care problems in high risk medical specialties and in select locations throughout America. *The GAO confirmed that premiums were higher (GAO 03-702, p. 14) and grew more quickly (GAO 03-836, p. 30) in states without non-economic damage caps than in states with non-economic damage caps.* The GAO found increased losses on claims are the primary contributor to higher medical liability premium rates (GAO 03-702, p. 15), physician responses to medical liability pressures in the five crisis states have reduced access to services affecting emergency surgery and newborn deliveries (GAO 03-836, p. 5), and similar examples of access reductions attributed to medical liability pressures were not identified in non-crisis states. (GAO 03-836, p.5)

6. **Won't a $250,000 cap on non economic damages just encourage more malpractice?**

A. No one knows for certain how many medical errors occur every year in hospitals. The two major studies on this issue seem to indicate that negligence in hospitals is one percent or less. And there has been a marked decrease over the last decade in some of the leading causes of death in the U.S. In addition, infant mortality rate has improved by 25% and the average life expectancy at birth has increased by a year and a half. These indicators suggest that health care in the U.S. is generally improving and dispels the notion that widespread negligence in medicine has hurt the overall quality of health care.[18] The federal government, state governments and the

---

[15]The Impact of State Laws Limiting Malpractice Awards on the Geographic Distribution of Physicians, U.S. Department of Health & Human Service, 7/3/03.

[16]Mark P. Gius, "An examination of the determinants of Physician Supply at the State Level," Journal of Business and Economic Studies 6, no. 1 (Spring 2000): 73-79.

[17]U.S. General Accounting Office, Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates, GAO-03-702 (6/03); and Medical Malpractice: Implications of Rising Premiums on Access to Health Care, GAO -03-836 (8/03).

[18]Source, Liability for Medical Malpractice: Issues and Evidence. A Joint economic Committee Study of the United States Congress, 5/2003.

hospital credentialing agencies are working closely with hospitals across the country to insure the safety of all patients.

B. The cap on non economic damages does not limit damages for recklessness. Reckless doctors are subject to punitive damage awards, license revocation proceedings and hospital credentials proceedings.

C. Doctors and hospitals are subject to far more scrutiny than most professions. Doctors must report any malpractice payment to the State Medical Board, the National Practitioner Data Bank and their hospitals. Hospitals are regularly inspected by the federal government, the state government and the Joint Commission on Hospitals.

D. If a physician carries $500,000 in insurance coverage but the damages are in excess of $1,000,000, typically if there is negligence on the part of the physician the case is settled for policy limits. To suggest that the doctor, who must report this settlement to the National Practitioner Data Bank, the Alaska State Medical Board and the hospitals where (s)he is credentialed, has no incentive to refrain from causing another injury seems a stretch - especially since either the licensing board or the hospital could decide to take action against the doctor's privileges and or license. All hospitals in the state now appear to be requiring insurance. Any incident which results in a large payment could result in a substantial financial surcharge by the doctor's malpractice insurer or outright cancellation with no ability to procure replacement insurance. This would mean the physician could not practice in any hospital in the state. Again, to suggest there is no incentive to refrain from committing a negligent act seems unlikely. Finally, the settlements and verdicts reported to the State Medical Board become a public record. This also, serves as an incentive for a physician to practice "good medicine."

E. Each physician swears an oath to do his/her best to take care of patients. Physicians are required to continually educate themselves. To suggest that any physician would willingly ignore these requirements and not continually strive to do better, seems at odds with the way the vast majority of hard working physicians in this state conduct themselves.

G. The Congressional study on malpractice opined that in almost 80% of malpractice claims the doctor is found to be not negligent. The report states: "The discordance between claims and negligence makes it very difficult, if not impossible, for health care providers to recognize and thereby avoid negligent behavior... This evidence supports the contention that the tort system not only fails to compensate negligent injuries, but also fails to penalize negligent behavior." The study quoted a 1996 study of family doctors in Florida which found that better doctors (those with a higher degree of knowledge) are more likely to be sued than other doctors.[19]

---

[19]Source, Liability for Medical Malpractice: Issues and Evidence. A Joint economic Committee Study, 5/2003. This report found that empirical evidence indicates that damage awards are more a function of injury severity than quality of care.

J. Michael Carroll, M.D., P.C.
Internal Medicine, Hematology, Oncology
Fairbanks Cancer Treatment Center
1640 Cowles, Suite 1
Fairbanks, Alaska 99701-5992

Telephone: (907) 452-4768 Fax: (907) 452-1009

February 16, 2004

Honorable Ralph Seekins
Senator – US State Legislature
119 N Cushman Rd Ste 201
Fairbanks, AK 99701

RE: Tort Reform Measures

Dear Senator Seekins:

Thank you very much for your willingness to support the tort reform measures that you have recently become involved with. As I am sure you are aware, in November of this year, in Fairbanks, malpractice insurance became an acute problem. Almost half of the physicians had their malpractice insurance canceled through CNA and were left with very short notice, trying to find coverage. Any efforts that will improve malpractice insurance availability is appreciated.

Again, thank you for what you are doing for Fairbanks and the State of Alaska, through all of your hard work.

Sincerely,

J. Michael Carroll, MD

JMC:tpw1
2023498

cc: Legislative Affairs Office (sent via Fax transmittal)

Alaska Physicians & Surgeons, Inc
4120 Laurel Street, Ste. 206
Anchorage, Alaska 99508
Phone: 907-561-7705 Fax: 907-561-7704
E-mail: akphys@Alaska.net Website: www.apsdoctors.org

January 28, 2004

Senator Ralph Seekins
Room 125
State Capitol
Juneau, AK 99801-1182

Dear Senator Seekins:

Malpractice insurance for Alaskan physicians is becoming less available and more expensive. In 2003, two of the four remaining med-mal insurance companies in Alaska stopped writing policies. Physicians and hospitals in California own the two remaining companies. We worry they may leave the state also.

If malpractice insurance becomes even less available or more expensive than it is now physicians will necessarily restrict their practices or leave them altogether. Patients in other parts of the country have already experienced first hand what a serious health risk and inconvenience this can be.

Malpractice insurance companies voluntarily do business in Alaska. They are only able to remain viable in a legal climate that allows them to charge what it costs to provide coverage, and are legally bound to be actuarially responsible. They must charge rates, which cover anticipated future costs. If malpractice/personal awards remain unpredictable and injury awards continue to escalate, insurers will retreat to states with a more favorable and predictable climate.

We in Alaska are on the brink. Without affordable medical malpractice insurance, most high-risk medicine in Alaska will cease, and availability of primary care will become even more restricted than it already is. Patients (your family and mine) will be forced to travel outside for obstetrical deliveries, neonatal intensive care, neurological surgery, orthopedic surgery, cardiac procedures and the like.

The causes of this liability crisis are many. The only practical solution now is legislative.

Sincerely,

Michael Norman, MD
Chairman of the Board
Alaska Physicians & Surgeons, Inc.

Legal Department

NORCAL Mutual Insurance Company

560 Davis Street, 2nd Floor • San Francisco, California 94111
(415) 397-9700 • (800) 652-1051 • Facsimile (415) 835-9819 • www.norcalmutual.com

March 2, 2004

Senator Ralph Seekins
Alaska State Senate
Alaska State Capitol
Juneau, AK 99801

Re: SB319 Letter of Support

Dear Senator Seekins:

NORCAL Mutual Insurance Company, a physician owned and managed insurer providing medical liability insurance to approximately one-half of the practicing physicians in Alaska, supports SB319 because this legislation will make health care more readily available to the citizens of Alaska.

NORCAL, as the successor to MICA, has provided medical liability insurance to hundreds of Alaska physicians since 1991. During that time, there have been several efforts to reform the tort law in Alaska to bring Alaska law into parity with other states. Unfortunately, these efforts have not had the desired effect. SB319 is necessary to accomplish where other efforts have failed.

Today, Alaska finds itself as one of the costliest states for physicians. A major cost for Alaska physicians is medical liability insurance. Alaska physicians pay on average $30,627 per year, which is the eighth highest average cost in the county. By comparison, California physicians pay $14,564 per year on average. This means Alaska physicians pay 110% more on average each year than California physicians.

Alaska's expensive medical liability premiums are the result of high jury awards and settlements. The average medical liability payment in Alaska during 2001 was $308,476. This means Alaska payments are the fourteenth highest in the country. California payments by comparison averaged $178,499. This means Alaska payments were 72% higher than California.

Over the years, Alaska has experienced some of the most dramatic increases in the cost of medical liability in the country. According to the National Association of Insurance Commissioners (NAIC), Alaska premiums have increased by 1593.47% between 1976 and 2001.

Only seven states have seen a higher rate of increase. By comparison, California medical liability premiums have only increased by 182.16% during the comparable period.

Numerous studies have been done to determine why some states have experienced higher premiums, larger awards, and more dramatic year-to-year increases in cost than other states. These studies have uniformly found that medical liability reform is the single most important factor controlling medical liability premiums and losses. California's Medical Injury Compensation Reform Act (MICRA) has been identified as the most successful effort to control medical liability costs. MICRA's $250,000 cap on non-economic damages is the keystone of this legislation. We believe the $250,000 cap on non-economic damages contained in SB319 will go a long way toward bringing the cost of Alaska's medical liability insurance into line with national averages.

For these reasons, Alaska physicians and their patients will benefit through enactment of SB319

Very truly yours,

Philip R. Hinderberger
Senior Vice President and General Counsel
NORCAL Mutual Insurance Company

PRH/cm

cc: Steven S. Fountain, M.D.
Ronald Keller, M.D.
Jim Jordan, ASMA
Mike Hangen, APNS

PAUL M. WORRELL, M.D.
INTERNAL MEDICINE
UNIVERSITY PROFESSIONAL CENTER
3650 LAKE OTIS PARKWAY
ANCHORAGE, ALASKA 99508
561-4402

February 23, 2004

Senator Ralph Seekins
Juneau, AK 99801

Dear Senator Seekins:

I am in support of SB319. This legislation would put a $250,000 cap on non-economic damages. It would help Alaska recruit and keep well-trained physicians. We continue to need physicians in our communities, especially the smaller communities. The cap would help control the cost of physician's overhead, which effects what they have to charge patients. This would especially help critical areas, such as Obstetricians and Neurosurgeons. Passing this legislation would also help us keep our current insurance companies and, with a little luck, we could recruit new insurers to Alaska's medical market place.

Please pass this bill so we can stay ahead of other states where insurance premiums have reached crisis proportions and physicians are leaving those states.

Thank you for your support.

Paul M. Worrell, MD
PMW:pk

Alaska State Medical Association

Statement to the State of Alaska Senate Labor and Commerce Committee
By: James J. Jordan, Executive Director, Alaska State Medical Association
Regarding: SB 319 Medical Liability Reform
March 2, 2004

Chairman Bunde, Labor and Commerce Members, I am Jim Jordan, Executive Director for the Alaska State Medical Association, and I will be testifying in that capacity today.

However, by way of disclosure, I also serve on the Board of Directors for the Medical Underwriters of California, which is the operating company for the Medical Insurance Exchange of California (MIEC). MIEC is one of the two remaining providers of medical liability insurance coverage for doctors in Alaska. You will receive testimony from an executive representing MIEC.

Dr. Alex Malter, current president of the Alaska State Medical Association will also provide testimony regarding SB 319. He will speak to the critical shortage of physicians in Alaska today and how SB 319 will help us recruit those doctors that we need.

Most important is the cap of $250,000 on the pain and suffering or non-economic damages, which is the most subjective type of damages to determine. I will specifically address the provisions of SB 319 that pertain to "informed consent" issues created by two Alaska Supreme Court cases – Korman v. Mallin, a 1993 case, and Marsingill v. O'Malley, a fall 2002 case.

First, I should address the term "informed consent". In essence, informed consent is the process required in Alaska law (AS 09.55.556) whereby a healthcare provider is required to provide sufficient information to the patient about a proposed procedure or course of treatment. The information provided is obviously intended to give the patient the information necessary so that she or he can decide whether or not to embark on the course of treatment recommended.

Section 3 of SB 319 makes minor stylistic changes to Alaska's informed consent law. The Alaska Supreme Court in Korman v. Mallin held that when jurors evaluate whether or not a health care provider has adequately informed the patient of the common risks and reasonable alternatives of treatment, they are to evaluate the information based on what a "reasonable patient" would expect to hear under the circumstances. However, the "reasonable patient" standard set by the court fails to provide a healthcare provider with any objective basis upon which to determine at the time of treatment what risks and alternatives should be conveyed to the patient.

Section 4 of SB 319 establishes the standard of disclosure to be what a skilled healthcare provider of the same or reasonably similar specialty would disclose under similar circumstances. This paves the way for the healthcare professional to adopt reasonable guidelines so that patients are insured to receive adequate information without subjecting the healthcare provider to later second-guessing.
Marsingill v. O'Malley deals with another problematic situation. Ms. Marsingill called Dr. O'Malley at night. The doctor advised her over the phone to go to the emergency room for treatment and she declined to do so and several hours later suffered a cerebral injury. The Court held that the jury, under the circumstances, would still be able to find Dr. O'Malley negligent of not providing "informed consent".

Section 4 of SB 319, in the new subsection AS 09.55.556 (d), protects healthcare providers from legal liability who are consulted other than in person and who are, therefore, unable to personally evaluate the patient and assess first hand the nature of the patient's condition, if their recommendation is for the patient to seek further treatment and the patient chooses not to follow that advice. This provision applies to healthcare providers who are contacted by phone, email, or who provide telemedicine services, for example, to our remote communities not otherwise served.

Since the Marsingill decision, some physicians will not take phone calls at all after hours, and instead, all patients are directed right to the emergency room or to call 911. This is not optimal healthcare with patients being directed to the most expensive care setting – the hospital emergency room.

ASMA supports SB 319 and urges you to support it as well.

I will be happy to answer any questions.

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

Testimony Provided by

Alex Malter, MD, MPH

President

Alaska State Medical Association

Before the State of Alaska Senate Labor and Commerce Committee

March 2, 2004

Testimony of the Alaska State Medical Association
Presented March 2, 2004

Chairman Bundy and Committee Members, my name is Alex Malter. I am an internist in private practice in Juneau and have the privilege of representing the Alaska State Medical Association as this year's president. ASMA represents physicians statewide and is primarily interested in ensuring Alaska's citizens have access to high quality health care.

I am speaking today to express ASMA's support of Senate Bill 319, and to urge you to support the bill as well. The medical liability reforms it establishes are important to Alaskans for a number of reasons. I expect others to testify how SB 319 will help stabilize the professional liability market, and, by so doing, temper future increases in state health care expenditures. Others may describe the near disaster that recently occurred when two of the state's four main professional liability carriers abruptly stopped offering coverage. I wish to use my remarks, however, to explain how strong medical liability reforms will help Alaska recruit and retain enough well trained physicians to provide for the future health care needs of its citizens.

Access to medical services is limited in much of the state. Alaska has one of the smallest-- if not the smallest-- number of physicians per capita in the country. A recent American Medical News story pertaining to the special Medicare payment reforms for Alaska noted our precarious situation: "Alaska has long ranked among the worst states in terms of physician supply. In 2002, the state had fewer than 1,350 doctors in private practice and another few hundred in the military or other government posts.... Only six states had a lower doctor to patient ratio".

The article went on to identify Idaho as having the worst physician shortage, estimating it had one non-government physician for every 544 patients. However numbers from ASMA's own database-- which we believe to be more accurate than those from the article-- showed only 1,115 physicians in private practice in 2002, or approximately one physician per 578 patients. Thus, it's highly likely that Alaska actually had the lowest physician to patient ratio in country for that year. Updated estimates show this is still true in 2003. By comparison, to reach the national average of one doctor per 360 patients, the state would need about 500 more actively practicing physicians.

Exacerbating the problem, Alaska's doctors are aging quickly. Our database shows that over half of the state's practicing physicians are older than 51. A 2002 local study of physicians by Providence Health System noted a looming recruitment crisis. That analysis confirmed Anchorage physicians were getting older, and highlighted immediate shortages of psychiatrists, surgeons, and general internists, among others.

This recruitment challenge is the main reason medical liability reform is so important to Alaska right now. Unfortunately, the state does not have the capacity to "grow" its own physicians. Alaska has no medical school, and of the small number of students graduating annually from the WWAMI program, some do not return to practice. Likewise, the state's lone residency training program is small. Alaska is-- and will continue to be-- a net importer of doctors. As such, we have to compete with other states facing physician shortages, a competition that is influenced significantly by the state's medical practice environment.

A recent study of medical students found the legal environment and the availability of affordable liability insurance plays a major part in a graduate's decision regarding where to set up practice. Alaska needs to optimize its medical-legal environment to help us recruit the doctors we need. That is why the Alaska State Medical Association supports SB 319. With its $250,000 cap on non-

economic damages, the bill provides the "gold standard" in liability reform, and will help create the healthy practice environment so important to recruit physicians.

ASMA understands that this legislation only one element in developing this healthy environment. Still, because the State had the foresight to enact other important medical practice legislation, we believe liability reform is the most critical element remaining. ASMA is proud to have worked with the Legislature on other key statutory changes to reach this point. These reforms include the Alaska Patient Bill of Rights, Prompt Pay and Physician Joint Negotiation legislation. We have also worked with our Congressional Delegation on Medicare payment updates specifically for Alaska. ASMA has even offered the current Administration ideas regarding strategies that could be used to actively "market" Alaska to out-of-state physicians. As a result of these reforms, ASMA believes that-- with the exception of strong medical liability reform-- the state's practice environment is actually quite favorable.

ASMA appreciates the opportunity to share this information with the committee. The Association is committed to continuing our efforts to improve the practice environment so as to help physician recruitment. As noted, our greatest concern is that Alaskan citizens have access to high quality health care. It is for this reason that I urge you to support SB 319. I'd be happy to answer any questions that you may have at this time.

Good afternoon, Mr. Chair. My name is Dr. John Duddy. I am an Orthopedic Surgeon practicing in Anchorage since 1999. I have served on the American Academy of Orthopaedics Surgeon's Board of Councilors since 2003 and recently been elected the President of Alaska Physicians and Surgeons.

I did my Undergraduate and Medical School at The Ohio State University. I also did my Orthopedic training at Ohio State. I was initially planning on staying on staff at Ohio State but that all changed after visiting Alaska. At that time, the practice environment in Alaska was very good. Practicing physicians in the Mid-West were complaining about malpractice insurance rates and availability, while the doctors that I spoke with in Alaska were upbeat and happy---a marked change from my experience in Ohio.

After moving to Alaska the practice environment remained good for a couple of years. The practice environment began to change about 3 years ago. Although the AMA declared that Alaska was an "at risk" state with respect to potential for a medical malpractice crisis, very few practicing physicians, including myself, noticed the gradual change until May, 2003 when Northwest Physicians Mutual Insurance co. notified my practice and all other Alaska Physicians that that they were no longer going to issue policies in Alaska. This was the first wake up call for many physicians in AK.

In the last year, the loss of half of our medical malpractice carriers (we are down to two) has had a direct negative impact on recruiting new physicians. My group and others would like to recruit more orthopaedic and trauma surgeons but have been less successful than due to the less than favorable environment that has developed. The state's only neurosurgeons have been unsuccessful in attracting new neurosurgeons. Internist and Family Practice Specialists are leaving the state and not being replaced in adequate numbers. Not only has it become difficult to attract new or currently practicing physicians to the state but also when a crisis develops, many of the practicing physicians will retire early.

SB319 is about access of high quality medical care---continued care for our loved ones in Alaska. We have a shortage of practicing physicians. The July 3, 2003 study from the Agency for Healthcare Research and Quality looked at the distribution of physicians across states with and without caps on non-economic damages since 1970. After adjusting for multiple factors, AHRQ found that by 2000, states with damage caps averaged 12 percent more physicians per capita than states without caps. This study also found that caps are effective in improving the supply of physicians and patients' access to care. The lower the cap, the greater its effectiveness in ensuring patients' access to care.

A February 2003 poll (Wirthlin Worldwide, What Americans Think About the Health Care Liability Crisis, at http://www.hcla.org) shows that 84% of Americans fear that skyrocketing medical liability costs could limit their access to medical care. A Blue Cross/ Blue Shield survey (BlueCross Blueshield Ass'n, supra note 7, at 4) also showed

that rising medical malpractice premiums are causing access and cost problems in crisis states. The BC/BS study also validates the conclusion that reduced access to care is a result of the current medical liability crisis.

a. 56% of BC/BS plans in crisis states responded that physicians are refusing some high-risk procedures. (In non-crisis states 32% of plans report this finding.)

b. 56% of BC/BS plans in crisis states report that physicians are leaving practice or retiring (In non-crisis states 42% of plans report this finding.)

c. Almost 1/3 of BC/BS plans in crisis states are moving practice out of state. (In non-crisis states 1/5 of plans report this finding.)

Currently only 6 states are considered stable. Alaska is among the 25 states that have the potential to be deemed "in crisis". In the last year, this situation has worsened and the AMA and AAOS feels we may be moved to a "Crisis" state in the next year.

Let us examine some of the states in crisis. In Nevada, the only Trauma Center in Las Vegas closed for 10 days this past summer when orthopedic surgeons couldn't afford professional liability insurance. The CEO of the hospital warned the public to "Drive home carefully."

In Pennsylvania, over the past five years, eight companies have stopped offering medical liability insurance with only two companies remaining. In Philadelphia suburbs,

trauma centers were closed when because there were not enough Trauma Surgeons after medical liability insurance was not available.

In Florida, the average time for women seeking mammography rose from 20 days in 2000 to 150 days in 2002. Many radiologists could not find or afford the necessary liability insurance. In a recent survey of Palm Beach, Miami Dade, and Broward Counties, 7 of the 29 radiologists said they had stopped reading mammograms, and 8 others are considering this possibility.

62% of Texas physicians, prior to their recent malpractice reform, had begun denying or referring high-risk cases, and 52% stopped providing certain services to their patients. Home to about 20 malpractice carriers in 1999, Texas had only 4 in 2002 willing to write new policies (Houston Chronicle Aug. 3, 2002).

Alaskan physicians have lost all but two medical malpractice carriers. As we have seen in other states, as insurance becomes unavailable, physicians will relocate, close their practices, or drop vital services---all of which seriously impede patient access to care. Some officials in AMA feel that Alaska is less than one year away from a crisis. We know from the experience in the lower 48 that high-risk procedures such as obstetrics, neurosurgery, spine surgeries and trauma would certainly be sent south to WA or elsewhere.

We have a chance to avert such a crisis in Alaska. We know it is only a matter of time before the crisis that is affecting those states without medical liability reform in the lower 48 will affect Alaskans. This bill's hard cap is just what the doctor ordered for a dying medical liability system in Alaska. A study from Tillinghast-Towers

Perrin found that savings could be expected with a $250,000 cap on non-economic damages, whereas, a cap of $500,000 is likely to be of very little benefit to physicians (Letter from James D. Hurley and Gail E. Tverberg, to Ray Cantor, Dir. Of Gov't Affairs, Med. Soc'y of N.J., (Jan. 7, 2003) on file with the AMA). AHRQ found that the lower the cap, the greater its effectiveness in ensuring patients' access to care.

Physicians feel SB 319 is good for Alaskans.

Subject: [Fwd: SB319]
Date: Mon, 15 Mar 2004 16:25:24 -0900
From: Joe Michel <Joe_Michel@Legis.state.ak.us>
Organization: Alaska State Legislature
To: Brian E Hove <brian_hove@legis.state.ak.us>

Subject: SB319
Date: Mon, 15 Mar 2004 16:46:11 -0800
From: "Hinderberger, Phil" <Phil_Hinderberger@norcalmutual.com>
To: <joe_michel@legis.state.ak.us>
CC: <Rep_tom_anderson@legis.state.ak.us>, <mcguired@alaska.net>, <roger.bh@gci.net>, <akphys@alaska.net>, <asma@alaska.net>, <valiant@alaska.net>, <jduddy@gci.net>, <jefflogan@gci.net>, "Keller, Ronald" <rwkeller@alaska.net>, "Osborne, Michael" <mosborne@NorcalMutual.com>, "Lyde, Charles" <Charles_Lyde@NorcalMutual.com>, "Kim, Julia" <Julia_Kim@NorcalMutual.com>, "Gabel, Paul" <Paul_Gabel@NorcalMutual.com>, "Fountain, Steve" <Steven_Fountain@Norcalmutual.com>, "Sunseri, Jim" <Jim_Sunseri@norcalmutual.com>, "Pautler, Mike" <mpautler@norcalmutual.com>

Dear Senator Seekin,

The Alaska Action Trust has published a position paper on HB472-SB319 that attempts to compare medical liability insurance rates in California and Alaska in order to draw the conclusion that over the past decade Alaska physicians have fared better than their counterparts in California. The authors of this study offer this flawed analysis in order to advance the proposition that California's MICRA legislation has failed to control medical liability insurance costs and that similar legislation is unnecessary in Alaska.

Nothing could be further from the truth. Since MICRA was enacted in 1975, US medical malpractice rates have increased over 500%. California rates have gone up 175%, while Alaska rates have skyrocketed by almost 1500%.

During the past decade, there have been modest changes in relative costs between California and Alaska physicians. In 1995, Alaska physicians typically paid 1.5 to 3.0 times more in premium than comparable specialist in California. In 2004, the relative range remains the same.

For example, California anesthesiologists paid $10,000 in 1995 and pay $9,069 in 2004 while Alaska anesthesiologist paid $26,500 in 1995 and pay $26,731 today. In 1995, the relative difference between anesthesiology premiums in California and Alaska was 2.5x higher while it is 3.0 times higher today.

The attached charts demonstrate the relative premiums for anesthesiology, family practice, neurology, OB/GYN and orthopedic surgery. Had the relative spread between the cost of medical liability insurance substantially decreased between 1995 and 2004, the Alaska Action Trust would have had a statistical basis for their argument. We can find no evidence to support their argument. In fact, altough rates have changed modestly in California and Alaska, the relative spread between California and Alaska remains, for the most part unchanged, which supports the argument of the proponets of SB319 that prior efforts at medical liability reform have failed and additional measures are needed to bring down the cost of Alaska medical liability insurance in line with national averages.

Philip R. Hinderberger
Sr. Vice President and General Counsel
NORCAL Mutual Insurance Department
560 Davis Street
San Francisco, CA 90041-1902
(415) 397-9700 ext 2816
(800) 652-1051

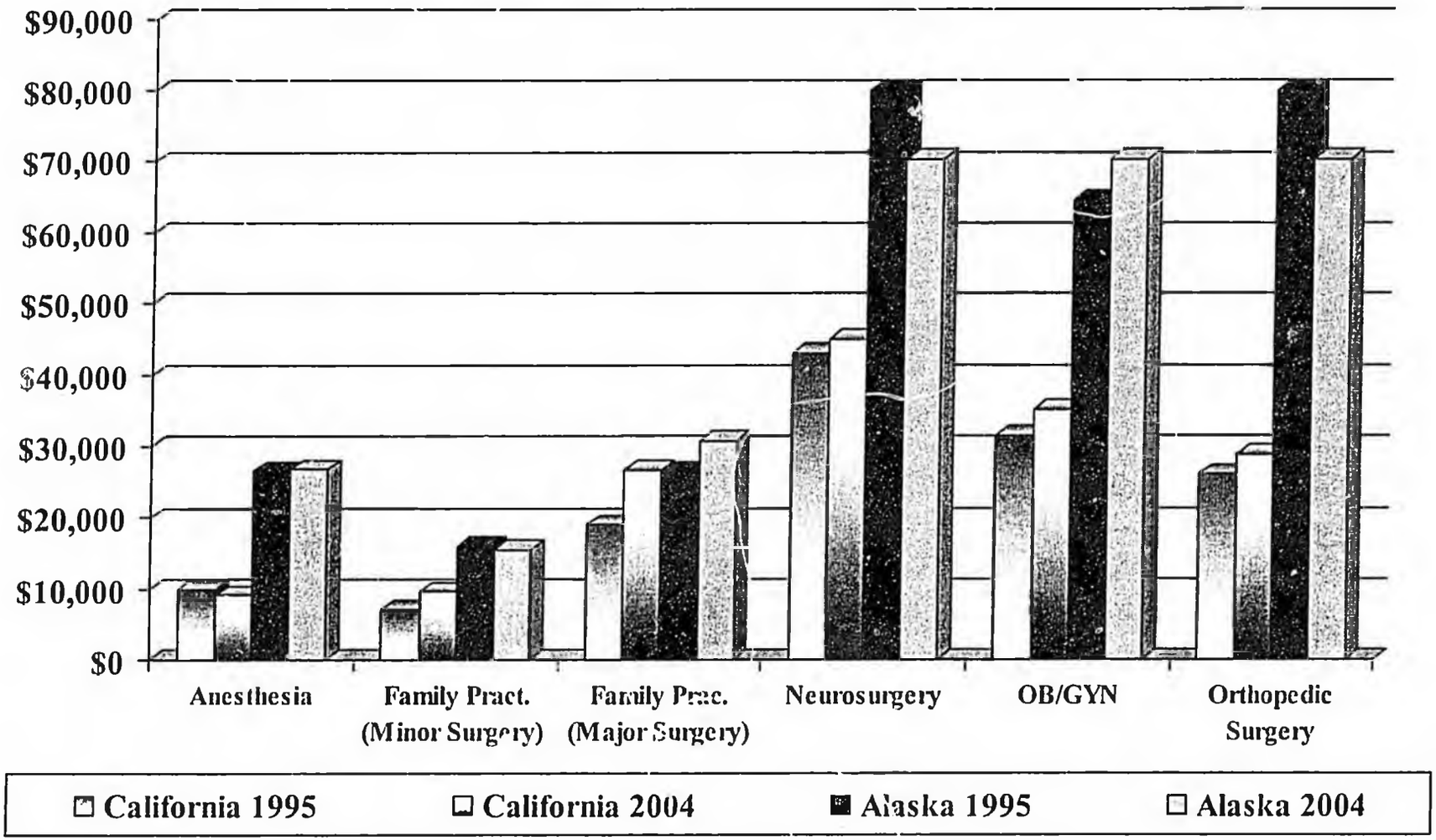
MEDICAL LIABILITY INSURANCE COSTS

California v. Alaska

	1995			2004		
	CALIFORNIA	ALASKA		CALIFORNIA	ALASKA	
Anesthesiology	10,000	26,500	2.5x	9,069	26,731	3x
Family Practice / Minor Surgery	7,000	16,000	2x	9,560	15,556	1.5x
Family Practice / Major Surgery	19,000	26,500	1.5x	26,580	30,651	1.25x
Neurology	43,000	80,000	2x	45,011	70,348	1.5x
OB/GYN	31,500	64,500	2x	35,157	70,348	2x
Orthopedic Surgery	26,000	80,000	3x	28,736	70,348	2.5x

NOTE: NORCAL, Mature Claims Made $1/3 Million Northern California and Alaska filed Preimum Rates.

Medical Liability Insurance Costs
California v Alaska
1995 & 2004



Note: NORCAL, Mature Claims Made $1/3 Million, Northern California & Alaska filed premium rates

Gary L. Livengood
PO Box 10377
Fairbanks, Alaska 99710

March 1, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill number 472- Medical TORT Bill

Dear Representative Anderson:

I am writing to encourage your support of House Bill 472. I feel it is important to put a cap on awards issued in frivolous lawsuits. The costs for physicians and health care facilities keep going up. This increases the cost of health care. Also, Physicians have limited, or quit, their practices because of insurance costs.

Thank you for your time.

Sincerely,

Gary L Livengood

Gary L. Livengood

cc: Interior Delegation
House HESS Committee

Jane Walsh
1097 Vicki Lane
North Pole, AK 99705

March 1, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

Dear Representative Anderson:

Healthcare costs are at an all-time high. Alaska must join the other 25 states in passing this type of non-economic liability reform. Failure to act on this bill will threaten the quality of healthcare in every community in Alaska.

I urge you to vote in favor of the TORT Bill and enact legislation that will limit non-economic damages.

Thank you for your time and consideration,

Jane Walsh

Cc: Interior Delegation
House Judiciary

Shelby Nelson
340 Snowy Owl Lane
Fairbanks, AK 99701

Phone: 907-455-7112
Email: sdnelson@acsalaska.net

March 1, 2004

Representative Tom Anderson
Room 432
State Capital
Juneau, AK 99801-1182

RE: House Bill No. 472—Medical TORT Bill

Dear Representative Anderson:

Alaska must pass effective liability reform. Patient access to care is suffering and will worsen if the State fails to act. Physicians are being forced to limit services, retire early, or move to other states where liability premiums are more stable—all of which seriously threaten access to quality health care services.

This is a statewide problem that deserves and Alaskan solution. Currently, 25 states have enforceable damage caps. Damage caps are and effective way of stabilizing the liability insurance market by prohibiting excessive damage awards. Excessive awards can result in increased liability insurance premiums for all physicians. A full 72% of Americans favor capping non economic damages in medical liability cases, according t a 2003 Gallup poll.

I urge the senate to pass SB319 and the House to pass HB 472. Your actions now will save a potential crisis in the future.

Sincerely,

Shelby Nelson

Cc: Interior Delegation
House Judiciary

Jon Lundquist
752 Donohue Drive
Fairbanks, AK 99712
March 1, 2003

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT

Dear Representative Anderson:

I support the medical Tort Bill (H.B. No. 472). Due to the escalating costs and exorbitant jury awards, the costs of being a physician are increasing to the point where people are no longer willing to take the risk of becoming a doctor. In order to control these costs and avoid shortages, especially in rural areas, I urge you and your fellow Representatives to pass House Bill No. 472.

Sincerely,

Jon Lundquist

cc: Interior Delegation
House HESS Committee

Charles E. Holyfield
P. O. Box 10789
Fairbanks, Alaska 99710

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

Dear Representative Anderson:

I would like to voice support of HB-472, Medical TORT Reform as a way to continue premium healthcare in Alaska. By capping the potentially huge judgments in professional liability cases, the cost of healthcare can be maintained at a less expensive level for the public, physicians would be more readily available, and more high-risk procedures could be available to those requiring them.

HB 472 does not limit any economic damages, such as, past and future medical expenses. loss of earnings, or cost of domestic services, but rather, limits the non-economic damages to one quarter of a million dollars.

Please support this bill and help Alaska's healthcare future.

Sincerely,

Charles E. Holyfield

Cc: Interior Delegation
House Judiciary

Sheryl Barnett
1027 Noel Drive
Fairbanks, AK 99712

March 1, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

Dear Representative Anderson,

I am writing you in support of House Bill 472. I have lived in Interior Alaska for 25 years and have always appreciated having access to skilled health care in my "home town." But recently; I, like others in this community have become aware of physicians being forced to limit their practice or retire early or even worse move to other states where their liability premiums are more affordable and stable. I recognize this as a serious threat to my access to healthcare. Because of this threat I am writing in support of your introduction of House Bill 472 and I urge the House and Senate to support the Medical Tort Bill.

Sincerely,

Sheryl Barnett

Cc: Interior Delegation, House HESS Committee

Rodney Perdue
1422 Kent Court
Fairbanks, Alaska

February 27, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

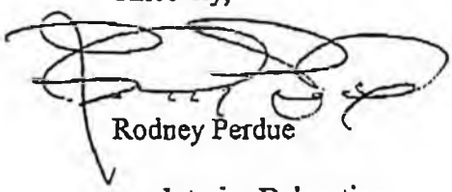
Dear Representative Anderson:

I am writing in response to the current situation with healthcare in Alaska, specifically with respect to Alaska's medical liability system.

I think that this situation is approaching the state of being a crisis because if left as is, it will cause a shortage of quality healthcare providers. This is a statewide problem and needs to have a statewide solution. He rising costs of medical insurance will make it unfeasible for many to continue in the field of practice that they are currently in.

I urge the Senate to pass SB319 and I also urge the House to enact similar legislation.

Sincerely,



Rodney Perdue

cc: Interior Delegation
House Judiciary

Sandra Larson
2537 Talkeetna
Fairbanks, Alaska 99709

February 27, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 - Medical TORT Bill

Dear Representative Anderson:

I am writing to you about the current situation with healthcare in Alaska, and Alaska's medical liability system.

The frivolous lawsuits that are commonplace today are endangering the availability of healthcare in the future. Liability insurers are leaving the market or raising the rates to astronomical levels.

Patients are paying escalating costs that are generated by our nation's dysfunctional medical liability system. The cost of liability insurance for physicians continues to escalate which causes physicians to limit services, retire early or move to other states where liability premiums are more stable. The continued availability of adequate medical care depends directly on the availability of adequate insurance coverage.

I urge the Senate to pass SB319 and I also urge the House to enact similar legislation.

Sincerely,

Sandy Larson

cc: Interior Delegation
House Judiciary

Elizabeth Wcodyard
1070 Ellesmere
Fairbanks, Alaska 99709

February 27, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

Dear Representative Anderson:

I am writing in order to voice my opinion about the current situation with healthcare in Alaska, specifically with respect to Alaska's medical liability system.

Patients are paying escalating costs that are generated by our nation's dysfunctional medical liability system. The cost of liability insurance for physicians continues to escalate which causes physicians to limit services, retire early or move to other states where liability premiums are more stable.

The frivolous lawsuits that are commonplace today are endangering the availability of healthcare in the future.

I urge the Senate to pass SB319 and I also urge the House to enact similar legislation.

Sincerely,

Liz Woodyard

cc: Interior Delegation
House Judiciary

Debra Hall
959 Windflower Lane
Fairbanks, AK 99712

March 1, 2004

Representative Tom Anderson
Room 432
State Capitol
Juneau, AK 99801-1182

RE: House Bill No. 472 – Medical TORT Bill

Dear Representative Anderson,

I am writing you in support of House Bill 472. I have lived in Interior Alaska for 25 years and have always appreciated having access to skilled health care in my "home town." But recently; I, like others in this community have become aware of physicians being forced to limit their practice or retire early or even worse move to other states where their liability premiums are more affordable and stable. I recognize this as a serious threat to my access to healthcare. Because of this threat I am writing in support of your introduction of House Bill 472 and I urge the House and Senate to support the Medical Tort Bill.

Sincerely,

Debra Hall

Cc: Interior Delegation, House HESS Committee