ALASKA LEGISLATURE
HOUSE and SENATE FINANCE COMMITTEE FILES, 1993-1994

1025

99

is beyond the scope of this letter, but some of the results of this approach can be delineated.

The most obvious is that physicians no longer practice within the probabilities of statistical information nor prioritize with regard to probable results. For example, nearly every patient seen in our emergency rooms complaining of headache ends up with a CAT scan of their head to rule out a brain tumor or a vascular abnormality. Why? The probability that an isolated headache is caused by either of these serious diseases is less than 2 in 10,000, the cost of a CAT scan is about $1000. In other words, we are willing to spend $5,000,000 to $10,000,000 to diagnose one case which may or may not be curable. Why? There are two overwhelming reasons. Number one, the patient and family expect it, because cost is no object when we are discussing their personal health, And two, if we fail to diagnose this rare entity we will be successfully sued. Do not misinterpret this to mean that I blame the legal system for the majority of the problem. The litigious nature of our society is a manifestation of another philosophical error that is only capitalized by the attorneys. However, a direct consequence of this error, is the denial of the significance of cost.

Acceptance of the policy of least potential good has also resulted in the common manifestation of health care workers to accept so called "junk science". There are always experts available to testify that electromagnetic waves from power lines, asbestos in walls and drugs such as Bonine could conceivably be health hazards. Even the most remote possibility, despite valid scientific evidence to the contrary, that a threat may exist is justification for radical economic misadventures, such as removal of asbestos from all public buildings. This problem is evident in even the most elemental of patient-doctor discussions concerning a potential health problem. It results in the dilution of decisions based upon science rather than witchcraft.

Another major source of excessive costs arising from the acceptance of the philosophy of least possible good is in the area of regulation. This applies to the FDA who regulates drugs, to JCAH which regulates and certifies hospitals and Medicare/Medicaid regulations which affects both hospitals and physicians. Very few accounts of the costs of meeting JCAH requirements have been published. One such study by a California hospital of 350 beds done several years ago, found they spent 1.5 million dollars a year to meet these stipulations. The sad, but true, reality is that JCAH certification is superfluous in today's modern medicine. The legal environment is such that acceptable standards would be maintained even if physicians and nurses did not independently demand them in their hospitals. Last year two major New York City hospitals declined JCAH review because of the unjustified expense of adherence to illogical

regulation. We should recall the reduction of airline fares that resulted from deregulation of that industry.

Although I could expound for several pages on other direct ills resulting from this philosophical approach, I believe you can envision many for yourself, given this premise.

How does one go about changing the philosophy of a society? The answer is that one cannot. It will require multiple generations of altered values and attitudes, taught by a generation that does not yet exist.

If it is impossible to change the root cause of the problem, what may we do to temporize until such changes can occur?

If we work backwards, by attempting to control the result, ie, excessive costs, there can be but one result, rationing of care. All managed systems, without exception, have this as a common denominator. Is this intrinsically bad? The answer is that it depends upon whether the rationing is arbitrary and indiscriminately applied, or based on sound scientific probabilities of outcome. In the previous example of the patient with the headache, if we elect not to perform a CAT scan we are, in effect, rationing health care. However, it is being rationed on the basis of the statistical improbability of a rare entity. On the other hand, if we are unable to order the CAT scan because funding allotments have been exceeded at that particular point in time, it becomes indiscriminate and arbitrary and thus a denial o health care. I cannot stress enough the difference between these two form of rationing. One is the result of scientific data, proven and accepted, which can result in the greatest probable benefit to the most, while the other is the result of mindless bureaucratic decree. The current situation in Canada is an example of the latter.

I do not innately object to the concept of universal health care coverage for all.

I do not inherently object to the concept of a single payor system. However neither of these systems can be implemented within the framework of medicine as currently practiced in the United States.

We must recognize that the media hype concerning the 36 million uninsured in the United States is a gross misrepresentation and exaggeration of fact. Some 30% of these people are under the age of 25, and therefore have minimal need of insurance. Many have voluntarily decided to forgo the expense of insurance. In 1992 I performed $60,000 worth of uncompensated surgery on the "uninsured" who, according to the media, have no access to health care. If "someone" is now going to reimburse

me and every other surgeon in the country for this surgery, I feel it fair to ask, "How much is this going to cost and where is the money coming from?"

I assure you, it is going to cost several fold your most extreme projections. Whoever that "someone" is, will very soon insist on dictating how the money is spent and we will find ourselves in scenario number two above, arbitrary rationing of care.

If we are to provide universal coverage, let us provide it in relation to its need. The young, subject to accidents, need coverage for catastrophic events. The old, subject to pre-existing illnesses, need assurance of continued coverage. If it is to be universal, it should be truly universal, ie the Veterans Administration and Public Health Service must be dismantled and it should apply to all federal and state employees. This must include senators and representatives.

If we are to provide a single payor system we must insist upon avoidance of the concept of "free care" by including a significant deductible to the patient to encourage the idea of personal responsibility, now glaringly absent, secondary to the third party payor system. There is little doubt that a single payor system would realize considerable savings from paperwork reduction.

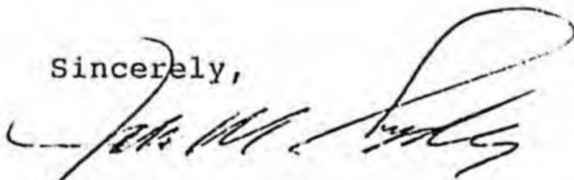
Regardless of the practical mechanics adopted, it is necessary to incorporate an alternative philosophical attitude.

I would favor the up front acknowledgment of rationing under a system as adopted by Oregon. If we are obliged to ration care, let us be honest about it. Let our physicians agree upon the most "bang for the buck" and define a rational, scientific, fair system of rationing that would benefit the majority.

This must be combined with reductions of regulation by divorcing hospital reimbursement from JCAH certification and malpractice reform of a meaningful nature. There are a multitude of other minor points that would be of benefit, but these represent my basic suggestions for change.

Thank you for your time, and I hope this may have offered some alternative views for your consideration.

Sincerely,



John M. Snyder M.D.

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February 11, 1994

Daniella Loper
Staff Counsel
Judiciary Committee
House of Representatives
State Capitol
Juneau, AK 99811

RE: HR 292

Dear Ms. Loper:

We are pleased to respond to your request for information regarding California medical malpractice reform legislation. California, like many other states, enacted tort reform legislation in the mid-70s in response to the medical malpractice insurance availability and affordability crisis. The California legislation known as the Medical Injury Compensation Reform Act of 1975 (MICRA) enacted the following tort reforms:

- Capped non-economic damages at $250,000.
- Required periodic payments on judgments over $50,000 at the request of either party.
- Established three-year statute of repose and minors statute requiring claims by children under six within three years or prior to eighth birthday.
- Permitted evidence of collateral source recovery and barred subrogation.
- Authorized health care providers to enter into contracts with patients for binding arbitration of medical malpractice actions.
- Established limits on attorney contingent fees.
- Required 90 days notice prior to commencement of a medical malpractice action.
- Immunity for medical peer review proceedings.

In addition, California law provided the following:

- Certificate of Merit to be filed with medical malpractice action.
- Joint and several liability abolished.
- Pure comparative fault system to establish liability among joint tort-feasors.
- Pleading hurdle for punitive damages.
- Confidentiality of medical peer review proceedings.

These provisions have been included in model medical tort reform legislation which are enclosed as Exhibit 1. Although these model provisions may form the basis for a comprehensive medical tort reform bill, modification of the definitions would probably be required to fit your statutory arrangement and expand coverage beyond medical providers.

A number of studies have been done regarding the relative cost of medical malpractice insurance and the impact of tort reform. Although we have been advised by actuaries that it is impossible to quantify precisely the impact of any particular tort reform, it is widely acknowledged that California's MICRA law has made medical malpractice insurance widely available and affordable in California as compared to other states that have not enacted tort reform. Enclosed as Exhibit 2 are a series of charts comparing medical malpractice experience in California, Ohio, New York and Alaska.

Chart 2-1 is a graph showing that California medical malpractice losses have trended downward since the enactment of MICRA in 1975. Chart 2-2 shows the California medical malpractice insurance data used to develop Chart 2-1. This chart demonstrates that over the 17-year period that MICRA has been in effect, medical malpractice costs have only increased 83% in California while US costs excluding California have increased by over 413%. Had California medical malpractice premiums increased at the same rate as the rest of the United States, California physicians and hospitals would have paid an additional $663 million during calendar year 1992 alone. Total savings to date exceed several billion dollars. Chart 2-3 demonstrates that California medical malpractice insurers have been able to keep losses under control and return surplus to policyholders as dividends while achieving an average ratio of expenditures to premium income of 101.2%. The industry benchmark is a ratio of 100% over the course of the normal claims payout period which depends on the statute of limitations and other factors affecting the resolution of claims.

The experience of other states also graphically demonstrates that tort reform helps control medical malpractice insurance costs. Several states such as Ohio enacted medical malpractice tort reforms similar to California and also saw a gradual reduction in malpractice costs compared to the rest of the United States. However, in 1982, Ohio's medical malpractice tort reforms were substantially weakened and its costs have risen dramatically as shown on the enclosed Chart 2-4.

Some states such as New York have not enacted medical tort reforms and their physicians and hospitals have suffered severe increases in the cost of medical malpractice insurance resulting from swings in the severity and frequency of losses as shown on Chart 2-5.

Chart 2-6 indicates that Alaska experience appears to be similar to New York with wild swings in losses driving medical malpractice premiums up from $781,000 in 1976 to $13,439,000 in 1992. This is a 1,620% total increase in the cost of medical malpractice costs in Alaska over 17 years or an average of 26% per year, more than twice the national annual average increase of 11.3% as shown on Chart 2-7 and more than five times the average annual increase in California for the same period.

It should be noted that these state-by-state changes in medical malpractice costs translate into different premium costs for individual physicians and hospitals depending on where they practice. Chart 2-8 presents a comparison of premium costs for seven medical specialties in California to other states which clearly demonstrates that MICRA has kept California premiums significantly lower. California physicians not only pay less than their colleagues in other states, but they have seen a drop in their premiums when adjusted for the cost of living. Chart 2-9 shows that the average California physician pays 60% less today than before MICRA. These savings are passed along to patients and keep health care costs lower as demonstrated by Chart 2-10 which compares health care costs in California and New York.

Members of the House Judiciary Committee may want to carefully read the article titled, "California's Medical Malpractice Crisis" which was first published in 1975 by the National Conference of State Legislatures and Georgetown University's Health Policy Center as part of a report entitled <u>A Legislator's Guide to the Medical Malpractice Issue</u> which is attached as Exhibit 3. Barry Keene, legislative author of MICRA, tells the story from the California Legislature's perspective and recounts the difficulties of enacting tort reform in the face of intense pressure from the contingency fee trial attorneys.

California's medical tort reforms have worked in spite of strong pressure from the trial bar to overturn them in the Courts or Legislature. Enclosed as Exhibit 4 is an article appearing in the <u>California Physician</u>, June 1991, titled, "A MICRA Retrospective," that gives a retrospective of MICRA over the past decade and a half. As the article demonstrates, real savings did not occur for many years until the California Supreme Court upheld MICRA in 1985. Because trial courts refused to apply MICRA before the Supreme Court ruled on the constitutionality of MICRA, insurers were unable to report savings from tort reform and malpractice insurance increased in cost during the early 1980s. The MICRA debate was finally put to rest in 1987 when the California Legislature refused to repeal or weaken MICRA. Since that time, California trial courts have recognized MICRA and policyholders have received substantial "MICRA" dividends amounting to several hundred million dollars. These MICRA dividends were paid by California's physician-owned insurers from loss reserve savings in the late 1980s. During

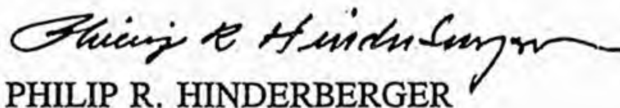
the 1990s, California policyholders have had almost no rate increases and continue to receive substantial MICRA dividends.

Medical tort reform has been recognized as a key component of health care reform in all but one of the major health care bills introduced in Congress. Experts familiar with health care costs believe that physicians have been compelled to undertake expensive diagnostic and treatment procedures in order to avoid the risk of unwarranted medical malpractice actions. Commentators call these practices "defensive medicine" and calculate the cost in billions of dollars annually. Exhibit 5 is a report by the respected health care consulting firm of Lewin-VHI that estimates medical tort reform may result in savings as high as $4.3 billion per year. All of the managed care proposals before Congress including the Clinton Administration bill, contain medical tort reform provisions. The Coalition for Effective National Medical Liability Reform advocates California's MICRA reform as the blueprint for effective tort reform. Its pamphlet entitled, Without True Medical Liability Reform, Health System Reform Is Just a Mirage, is attached as Exhibit 6.

Also enclosed are copies of the MICRA Information Manual dated January 1, 1993 prepared by the Californians Allied for Patient Protection, a coalition of health care and other organizations dedicated to the preservation of MICRA. These materials provide a convincing argument for medical tort reform and the benefits that will be provided to Alaska citizens by a stable marketplace for medical malpractice insurance.

In conclusion, if the Alaska Legislature enacts a comprehensive package of tort reforms along the lines of California's MICRA, the rate of increase in the cost of medical malpractice insurance should over time be brought in line with other states that have enacted similar tort reform. Tort reform should also help eliminate the wild swings in the severity and frequency of losses which will foster a stable marketplace for medical malpractice insurance in Alaska.

Very truly yours,



PHILIP R. HINDERBERGER

PRH/rl

Enclosures

bc: James A. Affleck, M.D., NORCAL Mutual Insurance Company
Brad Cohn, M.D., Medical Insurance Exchange of California
Martin Hatlie, Health Care Liability Alliance
Roger Holmes, Biss & Holmes
Harlan Knudson, Alaska Hospital Association
Jay Michael, Californians Allied for Patient Protection
J. William Newton, NORCAL Mutual Insurance Company
Ray Schalow, Alaska State Medical Association
Art Stanford, NORCAL Mutual Insurance Company
Al Tamagni, Alaskans for Liability Reform
David E. Willett, Hassard, Bonnington, Rogers & Huber
James O. Wood, Tillinghast

FEATURE

Product Liability Tort Reform Needed Now

Calvin A. Campbell Jr., President and CEO, Goodman Equipment Corporation, in testimony on the Fairness in Product Liability Act of 1993 (H.R. 1910) before an Energy and Commerce subcommittee.

I can think of no issue of greater importance and concern to American manufacturers than product liability tort law reform. The current product liability system, patchwork in nature and lacking uniformity, deters innovation, results in lost opportunities for job growth, and impairs significantly the ability of American manufacturers to compete against stiff competition from enterprises based in foreign countries. For smaller companies, these effects are magnified.

Runaway tort law results in untoward consequences in another group as well—the consumer. All of us pay more for goods because of a hidden "tort tax" that imbalanced liability law has placed on American consumer products. For example, the American Ladder Institute reports that product liability costs account for 20 percent or more of the price of the ordinary household stepladder. You and I pay a similar "tort tax" almost every time we purchase an item.

Another effect of imbalanced tort law relates to the principle of joint liability, sometimes called joint and several liability, which allows a minimally at-fault "deep pocket" defendant, for instance a manufacturer, to be held liable for the entire cost of an injury. Because of joint liability, manufacturers of useful and needed medical devices and other products face difficulty obtaining the raw materials necessary to manufacture their products. The several liability for noneconomic damages provision in H.R. 1910 will help to alleviate this problem.

The ability of manufacturers to compete in the international marketplace also is challenged by the problem of "long-tail" liability. Capital goods manufacturers in the United States are exposed to liability for products that were manufactured a very, very long time ago. An example of this problem comes from Harris Corporation, which in 1985 was forced to defend a product liability case brought by a Pennsylvania worker whose hand was severely injured in a printing press that was manufactured in the 1890s. Although the product had been modified significantly over the century, a jury rendered a verdict against Harris in the amount of $687,000.

The machine tool industry also is hurt by the current law. Cases involving very old machine tools result in substantial legal costs and put American machine tool builders at a disadvantage with foreign competitors. Generally, foreign companies do not have machines in this country that are over 25 years old. Therefore, they have significantly less liability exposure and pay lower liability insurance premiums than their American counterparts.

The European Community has resolved this problem for manufacturers by establishing a 10-year statute of repose, which places an outer time limitation on litigation for *all* products. The moderate statute of repose contained in H.R. 1910 would establish a 25-year limit and would apply only to injuries resulting from capital goods for which workers' compensation benefits are available. This assures that no claimant will go uncompensated for a workplace injury caused by a capital good.

The workers' compensation offset section in H.R. 1910 clarifies the relationship between the workers' compensation system and the product liability system by providing rules that keep these systems separate, minimize legal costs and promote safety.

Currently, in most states, an employer can take an action that causes a workplace injury by, for example, removing a guard from a machine tool, resulting in an injury to an employee. If the employee files a lawsuit against the machine tool builder to obtain a recovery in addition to workers' compensation, the employer can join in that action, using a "subrogation lien." If the worker's suit is successful, the employer can recover all of the money it paid in workers' compensation, even though the employer was a principal cause of the accident!

Under the approach in H.R. 1910, a machine tool builder would have an opportunity to abrogate the employer's subrogation lien if it can be proven by clear and convincing evidence that the accident occurred because of the employer's fault.

In sum, H.R. 1910 would restore fairness and provide uniformity in liability law. It also would promote job growth and continued economic recovery, and position American enterprise to compete effectively in the global marketplace.

Washington Concentrate, American [illegible] Feb 11, 1994

Received

REP [illegible] PORTER

Robert B. Stephenson
P.O. Box 81314
College, Alaska 99708

February 17, 1994

To Whom It May Concern:

It is my understanding that HB 292 would severely limit Alaskans' right to recovery from accidents and negligence.

In 1988, I and two others suffered massive 3rd degree burns from a 500 gallon propane spill and explosion near Fairbanks. Untrained workers were directed to move a large propane tank (1,200 gal. cap., 3' x 18') containing about 500 gallons of liquid propane. That's illegal. They broke a bottom valve, and all 500 gallons leaked out and exploded within minutes. In addition, the resulting fire burned down a huge warehouse, a loss of several million dollars.

I spent a month in the hospital, including two weeks in the intensive care burn unit, and did not recover from my burns and skin grafts for about three years. In fact, my skin will never be the same as it was. My hospital and doctor bills for the first month alone were well over $100,000. None of us will ever be the same after these burns and emotional injuries.

This accident was a result of improper handling of a propane tank. The owner of the tank did not want to remove the propane from the tank BEFORE moving it, as is required.

My burns and skin grafts have healed now, but I will never be the same, as I am sure you can understand.

It was more than a year after the explosion that symptoms of Post Traumatic Stress Disorder (PTSD) began to surface. Nightmares, sleeplessness, fear of the workplace, just to name a few, were common.

I still have flashbacks and nightmares of amputation and death squads.

43% of my body had little or no skin. I could only begin to describe the pain of being lowered into a whirlpool for debriding (dead skin scrubbed off). No amount of morphine can prevent the screaming and the horrible pain.

No amount of money can compensate for that pain, which took place once a day for thirty days. Would you go through that for $10,000 a day? How about $20,000? What's YOUR price? If this happened to your son or daughter or family member, would you want to cap their recovery for pain and suffering?

Stephenson
Page 2

It would be my recommendation for industry to be regulated by stricter standards and be made to follow existing standards. In my opinion, this would limit the negligence and the injuries to Alaska's work force.

Let's stop the negligence, not prevent the fair recoveries for injured Alaskans.

I believe that HB 292 is completely unfair to innocent victims in Alaska. It would have serious consequences to the citizens of Alaska, your constituents. I strongly urge you to vote against such tort reform bills.

Your response would be greatly appreciated.

Sincerely,

Robert B. Stephenson

JOHN W. HENDRICKSON
ATTORNEY AT LAW

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Received

February 11, 1994

Representative Brian Porter
State Capitol (MS-3100)
Juneau, AK 99801-1182

RE: H.B. 292

Dear Brian:

Please oppose H.B. 292 (L & C). It proposes no attorney fees for someone who gets run over by a truck on a crosswalk. This is absolutely crazy. That person has an absolute right to attorney fees as part of his costs.

Why should a banker get attorney fees when he sues you on a note and an injured person cannot. The only people who will benefit from this are large insurance carriers. It is a fact that insurance carriers will not settle large claims even when liability is plain unless the injured parties' damages go far beyond the policy limits. I have been in personal injury cases for 28 years and the foregoing is fact.

Also putting a $10,000.00 limit on the loss of a single person's life, if he or she has no dependents is draconian. Think about some drunk driver killing a single son, daughter or grandchild.

Please put this bill in file 13, We have been tort reformed twice already. What we need is an insurance reform bill.

Very truly yours,

John W. Hendrickson

kmp

Alaska Court System
State of Alaska
OFFICE OF ADMINISTRATIVE DIRECTOR

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Anchorage, AK 99501
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CHARLES S. CHRISTENSEN III
Staff Counsel

January 24, 1994

The Honorable Bill Hudson
Chairman, House Labor and
Commerce Committee
State Capitol, Room 108
Juneau, Alaska 99811

Dear Representative Hudson:

Thank you for giving me the opportunity to testify on House Bill 292, relating to civil actions, on November 22, 1993.

As I stated at the meeting, the supreme court generally does not take a position on legislation. Passage of legislation is a matter of public policy which our constitution leaves to the purview of the legislature. The exception to this general rule is when legislation directly affects the internal administration of the courts. The majority of HB 292 does not fall into this category, and the court takes no position on those sections of the bill. However, HB 292 does propose to change one important court rule, Civil Rule 82. As you know, that rule provides that the prevailing party in a civil suit is entitled to recover a portion of its attorney fees. HB 292 would repeal Rule 82 in tort cases. I have been instructed by the supreme court to state its opposition to this change. This position is not taken lightly; this is the first time in many years that the court has formally opposed a change to one of its rules.

I have reviewed the materials submitted by the group "Alaskans for Liability Reform." The stated justification for the repeal of Rule 82 is to "reduce litigation costs and court time, and streamline the civil process for expediency and fairness." The supreme court disagrees that this would be the result of the repeal of Rule 82.

Rule 82 and its predecessors have been around in Alaska since 1884, so we have had a good opportunity to see how it works. The rule has been continuously revised over the years, and the supreme court completed a substantial multi-year revision process in July, 1993. The latest revisions were intended to make the operation of the rule even more fair, and we believe that this goal has been achieved.

In a very basic sense, Rule 82 is a rule which recognizes the reality of attorney's fees. Such fees are an inherent part of any civil justice system. Rule 82 has a dual effect: it provides partial compensation to the party who wins a lawsuit, and it streamlines the civil justice process. These effects are manifested as follows:

First, Rule 82 discourages unfounded lawsuits by plaintiffs. Relatively few plaintiffs are willing to press a frivolous case against a defendant if they know that it is very likely that they will end up paying a substantial amount in attorney's fees to the defendant. Rule 82 weeds out many of those plaintiffs who know that their claim has no real merit.

Second, Rule 82 gives a plaintiff a personal stake in a lawsuit. This personal stake would otherwise be lacking in a case where the plaintiff was represented by an attorney with a contingent fee arrangement. The significance of giving the plaintiff a personal financial stake is that a plaintiff is more likely to disclose the weak points of his case to his attorney up front, and to express a more realistic attitude in evaluating it. This enables the attorney to evaluate the client's case more fairly at the beginning of the process, by shifting the emphasis away from sympathy, revenge, or so-called "principle." Cases which are evaluated fairly and early by the plaintiff and his attorney are more likely to settle early.

Third, Rule 82 makes it more likely that insurance companies will settle claims before the hiring of lawyers or the filing of lawsuits. If a claim is clearly valid, the company has an economic incentive not to allow the plaintiff to file a suit. Thus, Rule 82 gives insurance companies an extra incentive to evaluate claims early and fairly. Without Rule 82, the insurance company of a potential defendant cannot, without incurring expenses to itself, sit around and wait to see if the plaintiff if serious enough to hire an attorney and file a lawsuit.

Fourth, Rule 82 allows plaintiffs with small cases to bring them. Understand that attorneys generally will not handle cases under $20,000 or $30,000 on a contingent fee basis. The amount of work relative to the potential payback makes it too great a risk. Small plaintiffs have to pay attorneys on an hourly bases, just as defendants do. The reality is that a plaintiff will not file a claim for a small amount, if he knows that he will end up giving most of it to a lawyer. Rule 82 ensures that if the plaintiff wins, the defendant will pay at least a portion of the plaintiff's fees. Without Rule 82, defendants would have an incentive to ignore meritorious small claims, because they know that it would not be economical for the plaintiff to hire an attorney.

Fifth, Rule 82 discourages marginal appeals by the losing party. Borderline appellate grounds can be bargained against the Rule 82 fee award in most instances. By this mechanism, the rule again prompts a realistic evaluation of the merits of the case before an appeal is filed.

Finally, in a very basic sense, Rule 82 is fair. In each lawsuit there is a winner and a loser. One party has a claim or a defense that is valid, and the other does not. Rule 82 ensures that the party who prevails is at least partially compensated for the cost of prosecuting or defending the suit. Without Rule 82, the winning party is solely responsible for its own attorney's fees, solely responsible for bearing the costs of a lawsuit in which it should never have been involved. The court does not believe that this is a fair result.

Thank you for your consideration. Please advise if you have any questions or comments.

Very truly yours,

C. S. Christensen III
Staff Counsel

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HB-292

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February 15, 1994

Post-it™ brand fax transmittal memo 7671	# of pages ▸ 1
To Danielle	From Luck
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Dept.	Phone # 465-2538
Fax # 465-3834	Fax # 465-2974

Kari Luck, Director
Division of Occupational Licensing
3601 C Street
Anchorage, AK 99503

Dear Mr. Luck,

I am writing this in response to proposed legislation entitled, Medical Practice Parameters. I have some significant concerns about this legislation. Notwithstanding the potential cost, I am more than concerned about what impact regulatory practice standards might have on the constantly changing practice of medicine. I am very concerned that regulating the practice of medicine will create more of a nightmare than the problem it is trying to solve. I am not in favor of this legislation.

Who shall pay for this committee representing medical specialties?. And of course, what shall be the reimbursement? Since the parameters must be revised every 2 years, this will incur an ongoing significant expense indefinitely.

Some innovative individuals who are on the cutting edge, are accused of quackery, and then their practices are embraced within a few years. Others might be practicing current, accepted standards which may find themselves outmoded even though the practice is still being done. Are we to have cookbook medicine? One of the fears of the profession is that the Clinton administration wishes to set up how medicine should be practiced with a set form of treatment for each diagnosis. That is impossible. Each patient is a human being with different parameters and must be treated individually.

I feel there are other far more appropriate ways to deal with the practice of medicine. As a private physician, I would be happy to discuss this with any member of the legislature concerned about this issue.

The language in this legislation is quite broad and requests an all encompassing document. I cannot see any conceivable or reasonable mechanism by which that can happen by the Alaska State Medical Board or even Alaska physicians. This would ask us to undertake the writing of a major medical textbook for virtually every specialty requested.

Sincerely,

Robert Jay Rowen, M.D.
Alaska State Medical Board Member

DRAFT Comments to: Larry Weiss (907) 333-5862 - 5862 Kennyhill Dr. Anchorage AK 99504 (Professor of Sociology, UAA)

A Few Comments About Tort Reform and Medical Negligence

By Lawrence D. Weiss December 1993

MEDICAL MALPRACTICE

Medical malpractice involves the negligent treatment of patients by a variety of health care providers including physicians. Negligent physicians may be drunk, drug impaired, incompetent, or otherwise unable to exercise adequate judgement or skill in the treatment of patients. The consequences of physician negligence range from no effect to full permanent disability or death. From a public health perspective the key issues involve the negligence of the physician and the consequences for the patient. In other words, what social structures or processes detect and deter medically negligent physicians from harming their patients, and what structures act as obstacles to the detection and deterrence of negligent physicians? What patients are at risk as victims of malpractice, and what are the consequences for those patients?

The media image of medical malpractice has been predominantly formed and conditioned not by the public health perception of malpractice, but rather by the institutions involved with the financial consequences of medical malpractice. These social institutions include primarily the private insurance industry and physicians through their professional organizations. As a result medical malpractice is commonly discussed in the context of the high cost of malpractice insurance premiums and the issue of tort reform rather than the effective control of negligent physicians and the toll they take in medical injury and human suffering.

Public health institutions in both the private and public sectors are starved for resources and have minimum access to the powerful media machines that churn out public opinion. On the other hand the $1.8 trillion insurance industry (Weiss 1992, 17) and the American Medical Association engage legions of public relations flacks, hundreds of lobbyists and scores of millions of dollars each year to influence the media and public opinion. This uneven access to the media during the last couple of decades has resulted in a highly skewed public perception of the various issues related to medical negligence and malpractice. As a result the public discussion has been heavily weighted by vested interests wielding ideological arguments. The bright light of non-ideological research and analysis has been noticeably absent from most public discussion.

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Magnitude of The Medical Negligence Problem

Until the last few years the only major piece of research addressing the relationship between medical negligence, patient injuries, and malpractice claims was a study conducted in the mid-1970s published by the California Medical Association (Mills 1977). In that study a convenience sample of nearly 21,000 medical records was analyzed for evidence of medical negligence. This study revealed a negligence rate of 0.8 percent, or about eight injuries due to medical negligence for every 1,000 hospitalizations. It was estimated that only about ten percent of those injured as a result of medical negligence ever filed a claim for damages (Danzon 1985, 19).

A more recent and methodologically stronger study confirms the magnitude of the medical negligence problem and suggests that a much smaller fraction of those injured seek compensation than was indicated in the California study. The Harvard Medical Practice Study (Hiatt 1989) selected a random sample of approximately 31,000 records from 51 hospitals in the state of New York in the year 1984. Teams of physicians evaluated these records to uncover injuries caused by medical negligence, i.e. "the failure to meet standards reasonably expected of the average physician, other provider, or institution..." (Hiatt et al. 1989, 481).

The Harvard study revealed a medical negligence rate of 10 in every 1,000 hospitalizations, somewhat higher than the California study (Brennan et al. 1991). The injuries included in the study were at least serious enough to result in a longer hospital stay, disability upon discharge, or death. Further, projecting their findings to the entire state of New York in the year of the study, the researchers estimated over 27,000 serious injuries due to medical negligence among 2.6 million patients discharged from acute care hospitals. These projected injuries included nearly 7,000 deaths and almost 900 cases of permanent and total disability. Table 4.1 summarizes the relationship between adverse events (injuries or illnesses caused by medical intervention) not resulting from negligence, adverse events resulting from negligence, and the resulting litigation.

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Table 4.1 Negligent Injury and Resulting Litigation
Of Every 10,000 Hospital Patients

9,630 will experience no adverse events and

370 will suffer adverse events, but

270 of those will be without negligence. Of the

100 negligent adverse events, in

98 no claims for compensation will be made. Of the

2 claims made, only

1 will receive any compensation.

Source: Saks 1993, 9. (Based on findings of the Harvard Medical Practice Study)

People 65 years of age and older were particularly likely to be victims of medical negligence regardless of the severity of their initial illness (Brennan et al. 1991, 373) indicating a greater propensity among the elderly to be treated by substandard medical practitioners. In addition, "[t]here was more negligence among the Medicaid patients than the privately insured, and much, much more among the uninsured." (Hiatt 1992, 258) In other words, there is an inverse relationship between wealth and negligent medical treatment.

While the California study (Danzon 1985) found that an estimated 90 percent of those injured by medical negligence never filed a claim, the Harvard Medical Practice Study found that more than 98 percent of all the injuries caused by medical negligence were not followed by a malpractice claim (Localio et al., 1991). In summary the investigators observed that:

> the civil-justice system only infrequently compensates injured patients and rarely identifies and holds health care providers accountable for substandard medical care....The abandonment of malpractice litigation is unlikely unless credible systems and procedures, supported by the public, are instituted to guarantee professional accountability to patients (Localio et al. 1991, 250).

Detection and Deterrence

There is an extensive array of institutional structures across the nation with the nominal purpose of deterring, limiting, or terminating the practices of negligent physicians. Nevertheless, nationwide projections based on the Harvard Medical Practice Study (Brennan et al. 1991) as well as other studies (Wolfe 1992) indicate that physicians cause 100,000 to 300,000 serious injuries and deaths every year resulting from medical negligence. Clearly these facts put in serious question the actual effectiveness of institutional safeguards.

Hospital Peer-review Committees Hospital peer-review committees have the benefit of knowing the professional strengths and weaknesses of physicians with whom they share hospital privileges. The intimacy of the hospital setting, however, makes effective self-regulation among friends and colleagues unlikely. The threat of suits against individuals sitting on the peer-review committees adds to the obstacles inhibiting effective detection and deterrence of negligent physicians by these committees (Schwartz and Mendelson 1989, 1342). In 1991, for example, American hospitals sanctioned only 750 physicians with restrictions lasting longer than one month (Wolfe 1992, 1). This

is the equivalent of 1.25 such sanctions for each 1,000 physicians. Contrast this rate to physician-owned malpractice insurance companies which terminated insurance for 6.6 physicians per 1,000 due to medical negligence (Schwartz and Mendelson 1989:1345). In the latter case physicians are personally liable for a colleague's malpractice, in the former case they are not.

State Licensing Boards At the state level licensing boards have the authority to investigate and discipline physicians for medical negligence as well as other problems relating to their practice of medicine. A maximum of 5 per 1,000 physicians nationally have been disciplined by state boards in a any recent year, and the figure is a fraction of that for serious disciplinary actions such as license revocation or suspension. Moreover, only about 12 percent of all disciplinary actions actually relate to medical negligence. The rest have to do with criminal behavior, overprescribing drugs, ethics issues, etc. The most aggressive states discipline about 10 per 1,000 physicians annually, while the most reticent discipline about one per 1,000. In 1991 state medical boards disciplined only 3,034 physicians, whereas in that same year an estimated 150,000 to 300,000 serious injuries or deaths occurred due to physician negligence in hospitals. These figures do not include estimates of medical negligence that occur in physician office settings outside the hospital (Wolfe 1993c).

Apart from the periodic situation of friends and colleagues reluctant to enforce sanctions against each other, most of these boards face a number of additional obstacles. A most difficult one is the standard of proof state boards are required to use to identify and manage negligent physicians. "'Clear and convincing evidence'" must be produced rather than the less stringent "'preponderance of evidence'" that is typically used in other settings such as state courts (Schwartz and Mendelson 1989, 1345). Another serious obstacle is the widespread shortage of investigators and resources necessary for boards to effectively conduct investigations. As a result boards often have backlogged cases numbering in the hundreds. A third obstacle is that state boards generally do not have extensive peer-review capabilities, inhibiting the quantity and quality of information received during an investigation. Finally, the case of an accused physician who fully contests State licensing board charges typically drags on six to eight years. The physician may remain in practice that entire time. One public interest lawyer wryly noted that '"This system is so slow, so meager, and so trivial that death is weeding out incompetent physicians much faster than is the board."' (Chesteen and Lally 1991)

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Medicare Peer Review Organizations Medicare Peer Review Organizations (PROs) were created in each state by the federal government in 1982 to monitor the quality and cost of hospital care reimbursed by Medicare. Theoretically these organizations wield a big stick. They can discipline problem physicians and hospitals by denying them participation in Medicare, refer serious quality of care problems to the state medical licensing board, or "educate" the offender. A review of their work in the mid-1980s indicates that the rate of PRO recommendations for exclusions from Medicare and Medicaid declined dramatically. The trend corresponds with an emerging policy revision in the Health Care Financing Administration (HCFA) which oversees the PROs. HCFA has decided to adopt the strategy of "educating" errant physicians rather than disciplining them.

A study of eight randomly selected PROs by the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) during a six month period in 1990 found 131 physicians responsible for serious medical negligence or other breaches of quality of care. Despite the fact that these problems had led to hospital readmission, disability, or death; and despite the fact that 30 percent of these physicians had multiple infractions, only two were ever referred to the OIG for termination with Medicare, and three were referred to the state licensing board. The rest of the physicians were notified that a problem had been discovered and were monitored more closely by the PROs to a greater or lesser extent. Most of the physicians also received a phone call or brief letter from the PRO, and that served as the additional "education" they were supposed to receive.

> In fact, the study reveals that PROs squander opportunities for genuine improvement of substandard physicians' skills. And by categorically rejecting more punitive measures in favor of ineffective education, they fail to deter repetition of serious problems by the same--or other--incompetent doctors. (Wolf 1991)

Physician-owned Insurance Companies Approximately 40% of all physicians in patient care are insured against medical negligence claims through physician-owned insurance companies (Schwartz and Mendelson 1989). Unlike the alternative of commercial insurance, and unlike either state licensing boards or hospital peer-review committees, members of physician-owned insurance companies are personally liable for claims made against any of their co-owners. As a result of this financial accountability, applicants to physician-owned insurance companies are often carefully screened for competence by a committee of members prior to admission. Once admitted, members who have had

claims for malpractice filed against them may be rigorously evaluated by peers, outside consultants, and underwriters.

Sanctions against negligent physicians may include additional surcharges on their insurance premiums, deductibles in the event of successful claims, restrictions on practice, additional training, or the termination of insurance. In about a third of the cases, however, the latter sanction takes the form of a resignation from part ownership in the insurance company (and therefor termination of coverage) under pressure from the insurance company. Schwartz and Mendelson (1989, 1345) estimate that in 1985 state boards suspended or revoked the licenses of about 0.08% of all practicing physicians, less than one per 1,000, because of incompetence or negligence. During the same year physician-owned insurance companies terminated coverage for 6.6 per 1,000 member physicians due to medical negligence. In other words the maximum sanction was applied by the physician-owned insurance companies over eight times more frequently than the maximum sanction applied by state boards.

Certainly it can be argued that suspension of license is considerably more serious than loss of insurance so that the penalties are not comparable. However, lesser sanctions for negligence were levied by the physician-owned insurance companies at a rate about thirteen times more frequently than lesser sanctions applied by the boards. There is a strong suggestion in these research findings that structurally the physician-owned insurance companies, characterized by personal financial liability, are far more effective at weeding out negligent physicians than are the state licensing boards.

The occasional revocation of a physician's license by the state board due to negligence, the board's ultimate sanction, may effectively prevent a physician from endangering the people of a particular state. However, that same negligent physician is free to start a practice in another state whose licensing board may be entirely unaware of the physician's history of incompetence. Physician-owned insurance companies administer their ultimate sanction, termination of insurance, far more frequently than boards revoke or suspend licenses, however the social result is the protection of member-physicians' finances rather than protection of the public's health. The sanctioned physician is relatively free to continue his or her flawed practice of medicine with commercial insurance or without insurance coverage at all. In addition he or she may be accepted to practice in the military, or in a state or municipal hospital.

National Practitioner Data Bank In the fall of 1990 the Department of Health and Human Services initiated the National

Practitioner Data Bank. The nominal purpose of this data bank is to collect and disseminate information about medical malpractice payments and a range of adverse professional actions involving physicians and other health care practitioners:

> This system...was created to help meet a national need to restrict the ability of incompetent practitioners to move from state to state without disclosure or discovery of the practitioner's previous damaging or incompetent performance. The data bank contains information on adverse actions taken against a practitioner's license, clinical privileges, and professional society memberships, as well as information on malpractice payments resulting from judgements or settlements (U.S. General Accounting 1992b, 2).

Unfortunately, the political compromises made during the formation of the data bank legislation have seriously flawed the use of this information to protect the public's health. Congress refuses to allow disclosure to consumers of any information that might reveal the identity of an individual practitioner. The only organizations allowed to obtain this information are hospitals and other health care entities, professional societies, state licensing boards, and individual practitioners. Of these, only hospitals are actually required to query the data bank when hiring, granting clinical privileges, or evaluating physicians. Despite the stated major purpose of the data bank, state licensing boards are not required to evaluate data bank information prior to granting new licenses. A recent study by the U.S. General Accounting Office (1993) found that the data bank's effectiveness is further hampered by long delays in providing requested information, lax security regarding sensitive information, inadequate federal monitoring of the data bank contractor, and poor planning for the data bank's future.

Verifying Physicians' Credentials There is no single, public source for information about physicians who have been disciplined because they were drug impaired, incompetent, negligent, unethical, or engaged in criminal behavior. Most state medical societies will release a list of names of physicians that they have disciplined, but that list will not contain the names of physicians who have been disciplined by a myriad of federal agencies, other state medical boards, hospital peer review boards, or a number of other institutions. The closest thing to such a list that may be as accessible as the local library is a book updated every couple of years under the title *Questionable Doctors* (Van Tunen 1991), produced by Public Citizen Health Research Group, a consumer advocacy Ralph Nadar spinoff group. This publication lists in one source physicians

who have been disciplined by several federal agencies and most state medical societies.

While it is almost impossible to find out if a particular physician has been disciplined by all of the institutions that potentially might do so, it is even more difficult for a person seeking health care to verify that a physician has the training and experience that he or she claims. In a study conducted by Reade and Ratzan (1989) their conclusion was that "obtaining access to complete, up-to-date, and verified information about physicians is all but impossible."

> Physicians listed in the yellow pages of the phone book typically are free to list just about whatever they want. The phone companies typically run no independent checks on state licensure or specialty credentials listed.
>
> Many state or county medical societies do not independently verify biographical information given to them by physicians such as medical school, residencies, or board certification. Whether they verify such information or not, often medical societies will not release crucial information to the inquiring public such as whether or not the physician is board certified.
>
> The 23 specialty and subspeciality boards of the American Board of Medical Specialities (ABMS) are wildly inconsistent to public inquiries about board certification and other information concerning the qualifications of member-physicians. Some released all pertinent information over the phone, but most did not. Some would release such information only to hospitals, or only to mailed inquiries. Some would only release information with a signed release from the physician, and some boards referred inquiring members of the public to the library, often to a copy of Marquis' *Directory of Medical Specialists* (American Board of Medical Specialities 1991-92)
>
> The *Directory of Medical Specialists* in theory only lists physicians who are board certified. A serious problem with this compendium is that, for a number of reasons, a physician who is board certified in a specialty area may not be listed in here. Finally, only board certification is independently certified. Other biographical information, for example regarding residency and fellowship training, simply reflects what the physician indicated, and is not independently verified.

The American Medical Association directory does contain verified information about state licensure, medical school, and specialty-board certification, but the directory is not easy to find, is heavily coded making it quite user unfriendly, and can be quite misleading to the lay person. In addition the directory provides no information on advanced training or certification in subspecialties.

State licensing boards verify training and certification information to a greater or lesser degree initially, but may not verify additional information given during licensure renewal, for example about advanced training. State boards vary in terms of how much information they will release to the public, and under what circumstances.

Sleep-Deprived Medical Residents. Residents are typically recently graduated medical students who are doing one to four years of additional clinical training, usually on the house staff of a hospital. Residents are terribly exploited, working 100 to 120 hours per week or more, and often working up to 36 hours straight with no sleep or only a quick nap (U.S. General Accounting Office 1992a). A substantial body of research dating back to the early 1970s supports the common sense assumption that fatigued residents are likely more prone to medical negligence than well rested physicians.

The Accreditation Council for Graduate Medical Education (ACGME) accredits the nearly 7,000 residency programs across the United States. For several years during the late 1980s ACGME, the AMA, and the Association of American Medical Colleges (AAMC) worked together to develop accreditation standards that would limit the excessive hours typically worked by medical residents. These efforts were opposed by the American Boards of Medical Specialities (ABMS), in particular the six surgical specialty areas of the 24 medical specialities in the ACGME. Only one of these six surgical specialities restricted the maximum number of hours a resident could work per week, only one of them limited the number of days per week a resident had on-call duty, and only one of them required a minimum of one day per week off (U.S. General Accounting Office 1992a, 45). The surgical specialities wanted virtually no restrictions on their exploitation of medical residents.

Nevertheless, as a compromise ACGME finally adopted the following language the end of 1991:

> 'It is desirable that residents' work schedules be designed so that on the average, excluding exceptional patient care needs, residents have at least one day out of

seven free of routine responsibilities and be on-call in the hospital no more often than every third night.' (U.S. General Accounting Office 1992a, 3)

This sounds like a mushy equivocating statement because it is. Under these guidelines residents can still work 96 hours or more per week. The guidelines are the result of opposition to a more meaningful policy by the surgical specialties of the ACGME, the American Board of Surgeons, and the American College of Surgeons. Surgeons objected to any ACGME regulations on the basis that "such limits interfere with the development of the resident's sense of commitment to the patient and impede the continuity of care necessary for patient safety." (U.S. General Accounting Office 1992a, 3). Apparently severe fatigue and stress, and the resultant increased risk of medical negligence was not thought to interfere with "patient safety" to a significant degree.

New York State is the only state that attempts to regulate the number of hours residents work. The impetus for this regulation arose from a 1986 New York county grand Jury investigation of the suspicious death of a teenager admitted to New York Hospital who was treated by two overworked and undersupervised residents. New York limits residents to 80 hours per week, averaged over a four week period. The state also requires one full day off each week, a minimum of eight hours off between scheduled on-duty assignments, and a specific level of supervision. The additional personnel required to replace the medical residents now limited to "only" 80 hours per week cost the hospitals of the State of New York an estimated $227 million the first year. This cost projection along with others indicates how widespread the exploitation of cheap, abundant medical resident labor is to the current practice of hospital-based health care nation-wide (U.S. General Accounting Office 1992a, 32-36.

Unfortunately there have been no published studies regarding why surgeons and possibly other groups of physicians are so resistant to allowing residents to have reasonable working conditions, thereby reducing medical negligence caused by fatigue, stress, and sleep deprivation. The additional costs may be a factor, but presumably that is the worry of the hospital administrator and not physicians with training responsibilities or hospital privileges. Perhaps the systematic overwork of the residents is seen as a kind of hazing ritual that functions to bond the residents to the profession while simultaneously loosening ties with patients, family, and non-physician friends. Surely an important impetus to the gross exploitation of the residents' time is fear by the physician-educators that their own

time would be severely impacted by additional work if residents were allowed to cut back. In any case these questions need additional research because the medical and social consequences of the systematic overwork of residents are so serious.

Tort Reform

The American Medical Association and its state affiliates, insurance companies, and the media have combined to make the issues of medical malpractice and tort reform almost inseparable in the public consciousness. A tort is a legal action specifying:

> ...allegations of injury or wrong committed either against a person or against a person's property by a party or parties who either failed to do something that they were obliged to do or did something that they were obligated not to do (Ostrom et al., 1993, 19).

Torts include a wide variety of court actions such as product liability, automobile torts, personal injury, libel, etc. A medical malpractice suit is a particular type of tort requiring a patient to show that he or she was injured during medical treatment, that the physician's treatment (or lack of appropriate treatment) caused the injury, and that the physician failed to provide the generally accepted standard of care. In 1991 an estimated 1.2 million tort cases of all kinds were filed in state courts, a figure which has been fairly stable for several years (Ostrom et al., 1993, 19). However, only about 10% of all torts decided at trial are medical malpractice cases (Ostrom et al., 1992, 81).

Organized Physicians' groups and the insurance industry take the lead in arguing that there is need to reform the legal structure as it pertains to torts, and in particular to medical malpractice cases. Some of the commonly cited reasons include:

> There is an explosion of medical malpractice litigation, and much of it is trivial or unwarranted.
>
> Lawyers' contingency fees are the cause of the high cost of medical malpractice insurance.
>
> Enormous, unfair settlements are the cause of the high cost of medical malpractice insurance.
>
> The high and rising cost of health care can in large part be attributed to the high cost of medical malpractice insurance.

> Defensive medicine, the ordering of largely unnecessary tests and procedures by physicians trying to avoid malpractice suits, is driving up the cost of health care.
>
> High medical malpractice insurance premiums are forcing physicians to stop delivering babies, to reduce or eliminate other medical procedures, and to quit the practice of medicine altogether.

These allegations provide important ideological ammunition for their respective adherents. The AMA has an interest in diverting attention from the responsibility of physicians in committing widespread medical malpractice, and the insurance industry has an interest in diverting attention from the fact that its profits are derived from increasingly higher premiums. In other words, the insurance industry has historically had little reason for taking an active role in reducing the incidence of malpractice because it has been able to cash in on it (Peck 1986). Nevertheless, two decades of frequently unproven, ideologically-driven allegations pumped up by massive media campaigns and political lobbying efforts have resulted in wide spread tort reform across the United States.

Some of the tort reforms have been aimed at creating barriers to legal suits (Spernak and Budetti 1991). Many states, for example, have "frivolous suit" penalty statutes requiring the party with an allegedly weak claim or defense to pay court costs and attorney fees for the other party. Some states have shortened various statutes of limitation applying to medical injury claims, and a number of states have "good samaritan" statutes giving immunity to negligent physicians who provide emergency care at the scene.

Many states have initiated tort reforms intending to alter the plaintiff's burden of proof. Some of these have increased the plaintiff's burden of proof beyond the standard "preponderance of the evidence." Others, such as *res ipsa loquitur* greatly ease the burden of proof on the plaintiff by allowing the judge to instruct the jury in certain very self-evident cases that negligence did in fact cause the injury. These cases typically settle out of court.

Finally, a major category of tort reform involves laws designed to reduce damage awards. In its most direct form, states have enacted caps on the economic, non-economic, and punitive damages a plaintiff may receive from a jury. Some states allow defendants to pay out large awards in installments rather than all at once. For the defendant this has the added

benefit that the plaintiff may die, perhaps saving the defendant a considerable sum of money.

The consequences of these reforms have varied considerably. (Spernak and Budetti 1991, 13-15). Several studies indicate that limits on damage awards are associated with slightly or modestly reduced insurance premiums, and reduced amount paid per claim. Many of the reforms seem to have had no measurable effect on insurance rates, claims filed or damages paid. Some of the reforms have had consequences opposite those anticipated. For example, the establishment of mandatory pre-trial screening panels has increased average claim payments by over 50 percent.

Most importantly, however, there is no evidence that any of the tort reforms have actually helped to detect or deter the widespread incidence of malpractice known to exist. Further, there is no evidence that any of the tort reforms have made the attainment of compensation easier for the overwhelming majority of victims of medical negligence who never file a claim, who never make a settlement, and who are never paid a penny by the negligent physician or medical facility. These, however, are not the goals of tort reform.

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Box 4.1

MEDICAL MALPRACTICE INSURANCE IN CANADA: MUCH CHEAPER

Canadian physicians are sued about one fifth as often as U.S. physicians despite the lack of evidence that the incidence of medical negligence is significantly less in Canada than in the United States. Moreover, their malpractice insurance costs about one ninth as much as it does for U.S. physicians. The medical malpractice insurance premium in Canada costs on average a mere 1.5% of a physician's net professional income. There are a number of factors that may account for why this is so:

In most Canadian provinces the limitation period, that is the period during which the plaintiff may file a malpractice claim, is considerably shorter than in the U.S.

In Canada punitive damages are rarely awarded, and damages for pain and suffering are considerably less than in the U.S., due in part to a nation-wide cap.

Since there is universal access to health care in Canada, estimated costs for past and future health care needs are a minimal component in the decision to sue, and a smaller part of any award or settlement compared to the United States.

Social security programs in Canada are generous and relatively comprehensive compared to the U.S., minimizing the incentive to sue primarily for these kinds of benefits.

Contingent fee systems are not typically used by lawyers in Canada. This may reduce speculation, but it may also reduce access to compensation by low income people.

Under the Canadian legal system losers must pay a large portion of the winner's legal costs.

Over 95 percent of all medical malpractice claims are defended by one professional liability association, the Canadian Medical Protective Association, in contrast to hundreds of associations and insurance companies in the U.S. This concentration of resources and experience more effectively protects physicians and inhibits marginal claims.

Despite the above facts, the growth of malpractice actions in Canada is comparable to that in the United States. Between 1971 and 1989 the number of malpractice claims against Canadian Physicians grew nearly 700 percent, however only about one third

of those claims resulted in payments. The average malpractice award was $150,640 in 1989 (expressed in 1991 Canadian dollars), and had grown at the rate of 9.7 percent per year between 1971 and 1989, adjusted for inflation. The Average malpractice insurance premium increased nearly 15 percent per year between 1976 and 1988, adjusted for inflation.

In summary, Canadian physicians pay much lower medical malpractice premiums than their U.S. counterparts in large part because Canadian physicians are sued far less often. This appears to be the case due to obstacles in the legal system to the pursuit of compensation, and due to more encompassing health care and social security programs in Canada. The negative consequences of the Canadian system are that low income people and people with legitimate but difficult to prove cases are discouraged from seeking compensation. Furthermore, the Canadian system does not appear to be any more likely to identify and deter negligent physicians from practicing in the first place. Finally, the rate of growth of malpractice claims and payments is comparable to that in the U.S.. This portends controversy in the future for Canadians.

Source: Coyte, Peter C. et al. Medical Practice--The Canadian Experience. *The New England Journal of Medicine* 324 no. 2:89-93.

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Closer Look at Pro-Tort Reform Arguments

Explosion of Medical Malpractice Litigation The growth of all forms of tort filings across the nation has been relatively flat since 1986 (Ostrom et al., 1993, 21). A nine-state study just of medical malpractice filings indicates a similar overall trend, with five of the nine states showing an increase in filings since 1986, and four showing a decrease (Ostrom 1993). Even if the data demonstrated an increase in medical malpractice litigation, it would be expected due to the rising proportion of physicians to population (a 27 percent increase between 1975 and 1985), and due to an increasingly more intensive practice of medicine that involves each physician seeing more patients, and each patient receiving more treatment (Saks 1993, 13). Finally, there is the critical issue of the relationships between the incidence of medical negligence, the actual filings for malpractice, and the potential filings for malpractice:

> Our results surely provide no basis for the charge that the tort system produces excessive litigation. Further, the implications are rather sobering....[T]here was a surge of claims in the 1970s and 1980s. Our data suggest that, absent change, we can anticipate a surge in the 1990s. Indeed, if the number of people who bring claims were closer to the number of people who are injured, we might see not 18 claims per 100 doctors per year as in 1985, but two claims per doctor per year (Hiatt 1992, 259).

Excessive Lawyers' Fees Typically the attorney in a medical malpractice suit claims 30 to 50 percent of the plaintiff's damage award on a contingency fee basis. In 1991 total medical malpractice costs including all claims paid, administrative costs, and attorneys' fees amounted to $9.1 billion (Harty 1992). This was slightly more than one percent of the nation's medical bill. Even if attorney's fees were eliminated altogether the national medical bill would decline less than one-half of one percent. Moreover, there is no research evidence that there is an inverse relationship between attorney fees and insurance premiums, claim severity (the amount of compensation paid for comparable injuries), or the frequency of filing claims (Spernak and Budetti 1991, 13-5). Clearly, this is a hollow issue.

Enormous Settlements For every 100 cases of medical negligence resulting in serious injury, claims will be made for only two of those cases. Ninety percent of these will be resolved without a trial, with the plaintiffs in half of these receiving no compensation. For those that go to trial, only about a third of them will find the defendant liable (Saks 1993,

9, 14). In such a situation the median jury trial award for medical malpractice cases is $200,000 (Ostrom et al. 1992, 84). Studies of medical malpractice torts and other torts indicate that compensation for economic loss is inversely related to the magnitude of the loss. Smaller losses are adequately compensated, larger losses are increasingly undercompensated. A study of medical malpractice awards in five states covering most of the 1970s and 1980s found no statistically significant trends after adjusting for inflation and other relevant factors (Saks 1993, 12-15). In summary, the facts appear to indicate that medical malpractice awards are rarely made, often inadequate, and have been stable for two decades.

The High Cost of Medical Malpractice Insurance In 1991 commercial insurance companies sold about $4 billion worth of malpractice insurance. This represented a steadily shrinking proportion of all insurance sold by property-casualty insurers, down to 1.8 percent in 1991 from 2.2 percent in 1987 (A.M. Best 1992, 67). One very important reason why commercial insurers have stagnated in the medical malpractice market involves the meteoric rise since the mid-1970s of physician-owned medical malpractice insurance companies. These companies now account for 50-60 percent of the malpractice market (Spernak and Budetti 1991, 11). Typically their premiums are considerably lower than insurance commercial companies, and they have more control over who is insured and how much premiums will cost. Altogether commercial malpractice insurance, physician-owned insurance, and other miscellaneous forms of malpractice insurance costs totalled $9.1 billion in 1991, about one percent of the nation's health bill (Harty 1992). Even if malpractice insurance were entirely eliminated it would barely make a dent in the cost of health care in the United States.

Defensive Medicine The American Medical Association estimates that defensive medicine costs $15 to $20 billion each year (Seekins 1993). Critics, however, believe that the real costs of defensive medicine are a fraction of the AMA's estimate. Moreover, some critics, such as Dr. Sidney Wolfe of the Health Research Group in Washington DC, point out that physicians often profit from conducting extra tests and procedures. Such physicians may use the issue of "defensive medicine" simply as a cover for profit-maximizing at the expense of their patients (Hudson 1990a). Another AMA survey conducted in 1987 found that respondents estimated that the time they spend away from their office due to malpractice litigation combined with the extra costs of defensive medicine totalled $19.3 billion. Even if entirely true, these costs were only 4 percent of the total expenditures for health care services that year (Hudson 1990a).

High Medical Malpractice Insurance Premiums The literature is heavy with studies indicating that family physicians and obstetricians are quitting obstetrics, i.e. the business of delivering babies (Rosenblatt et al. 1990; Rosenblatt et al. 1991; Nesbitt et al. 1992). The most common reasons given are the cost of malpractice premiums and the threat of being sued. During the 1980s thousands of physicians stopped delivering babies. In the last half of the 1980s alone 20 percent of the physicians who had been delivering babies stopped doing so (Nesbitt et al. 1992). This has disproportionally affected women in rural areas who have been hardest hit by the chronic lack of physicians practicing obstetrics, and disproportionally affected low income women who are often refused obstetric services by many of those physicians who continue practicing obstetrics.

There is no question that the cost of malpractice insurance premiums and the threat of suit have some bearing on the physician flight from obstetrics, but the question is "how much?" A study of 26 counties in northern California compared family physicians that continued to practice obstetrics with those that had continued to practice medicine but stopped delivering babies (Nesbitt et al. 1992). The researchers found that those who stopped delivering babies most often cited the cost of malpractice premiums, yet those who continued to deliver babies earned an average of $30,000 per year beyond the cost of their malpractice premiums just from the obstetrics part of their practice. In addition, more than half those physicians who had stopped delivering babies indicated that no "specific circumstances" (such as lower malpractice premiums) could entice them back to obstetrics. Of those who indicated they could be enticed back, the problems of being on call and not making as much money as they thought they should were almost as important as the cost of malpractice premiums. In another study of about 2,000 physicians in four western states the researchers noted that strong tort reform legislation in all four states did not seem to be stemming the tide of physicians abandoning obstetrics. They noted, however, that it might be too early to tell (Rosenblatt et al. 1991).

In summary, medical malpractice is widespread in the American health care establishment, but the issue of negligent physicians has been almost entirely obscured by the carefully cultivated message of tort reform. This message meets the financial needs of the American Medical Association and the insurance industry. Tort reform may enhance the profits of the commercial insurance industry, and may reduce the risk for self-insured groups of physicians, but it will not and cannot reduce the estimated 100,000 annual victims of medically negligent treatment. Physicians have the technical expertise to detect

negligent health care providers, but the social structure of state licensing boards and hospital peer review committees is an obstacle to both detection and deterrence of negligent practitioners. Despite the somewhat better detection record of physician-owned insurance companies, the social consequences of their sanctions protect the company but leave the public's health at risk. Federal efforts to protect the public from medical negligence have been politically compromised and poorly implemented.

The resolution to the problem of pervasive and chronic medical negligence must start with a more public, accountable process of detection and deterence. The Canadian approach of systematic review of records by physicians from another region is an excellent strategy. The placement of more lay-persons on licensing boards and other peer review organizations would help tremendously. Very little work has been done in the area of alternative forms of detection and deterence, but clearly it needs to be seriously discussed.

AKPIRG
ALASKA PUBLIC INTEREST RESEARCH GROUP
Post Office Box 101093 / Anchorage, Alaska 99510 / (907) 278-3661

Representative Ron Larson
House Finance Committee, Co-Chairman
State Capitol
Juneau, AK 99801-1182

March 4, 1994

Corrected Letter Re: The Fiscal Impact of HB 292 (Limiting the Liability of Tortfeasors).

Dear Representative Larson:

As you may already know, the fiscal impact of HB 292 may be enormous if it is enacted. I hope that you will consider even the few examples listed below in what we hope will be significant hearings in the House Finance Committee. It is undeniable that the State is already struggling to pay for basic services. The public cannot afford to pay what may be millions of dollars of direct General Fund expenditures because of the radical, unprecedented changes in the statute of limitations contained in HB 292. The State will have to pay for a number of losses which will no longer be paid for by the parties who are responsible for them.

HB 292 will, in part, forbid a victim from recovering for its losses and injuries if it does not learn of and file suit against a defendant within 6 years of the defendant's injury-causing "act". This rule displaces the nationally uniform or near-uniform rule allowing a victim two or six years from the date it should learn of its injury to file suit. This radical rule will cost the State an enormous amount of money, and will place great strains on the general fund in a number of direct ways in the event the courts determine that it applies to the State as a plaintiff.

HB 292 is currently unclear as to whether it is intended to apply to "property damage" suits brought by the State just as it is to "property (and other) damage" suits brought by citizens and businesses. We assume below that the bill was not intended to discriminate against private citizens, and that it does not spare the State from the detriment of this provision when it seeks compensation for its losses, when it would deny compensation for those same losses to private citizens. However, if that is the intent behind the bill, then the citizens should be outraged. A rule that is too unfair to be applied to the State is also too unfair to be applied to its citizens.

A Few Examples Of the Great Expenses HB 292 Will Force The State to Incur.

First, the State will be required to rely on the General Fund, or on General Fund money appropriated to the 470 Fund, to pay for

a number of expensive hazardous substance clean-ups now paid for by those responsible for causing hazardous substance contamination. The State rarely discovers hazardous substance contamination within 6 years of the date a defendant committed the last "act" which ultimately led to the contamination. A truism of hazardous substance contamination is that leaks are not found for many years from the date they begin. Also, even where contamination continues currently, it is not known whether each particular defendant's substance began causing contamination more than 6 years back. The State will have to pay for the conduct of these defendants because it will not be able to succeed in the impossible task of proving whose hazardous substance began to leak when, or when the responsible party's last "act" leading to the leak occurred.

Under current law, the statute of limitations allows the State 6 years (or arguably 2 years) from the date it reasonably finds out about the contamination, or incurs expenses in cleaning it up, to seek recovery from the responsible parties. Numerous hazardous substance sites throughout the state have been cleaned up by responsible parties, and not at taxpayer expense, based on this widely accepted rule. It is known as the "date of discovery" rule.

Under HB 292 the State will not be able to order the clean up of many contaminated sites either because:

1) it will not find out of the contamination (normally invisible to the naked eye) within 6 years of the defendant's act which led to the contamination; or,

2) attorneys for each defendant will argue that their client's portion of the contamination was caused more than 6 years before the state files suit, and this new legal defense will be impossible to rebut.

As a result, the state will have to incur millions of dollars to clean up privately contaminated private and public property and waters, including contaminated groundwater and other natural resources. Contaminated site clean-ups regularly run into the hundreds of thousands or millions of dollars per site. Further, average citizens whose land has been contaminated by others will not be able to afford to clean their property up, and the defendants, most of whom have insurance to clean up these hazards, will have shifted their costs of doing business to the taxpayers. Innocent taxpayers will have to contribute to the general fund to clean up both private and public properties which have been rendered useless, and often hazardous, by the conduct of parties who escape responsibility under HB 292. These contaminated properties will remain serious public health hazards until the State conducts the necessary clean ups under AS 46.03, 46.04, and 46.09.

In addition to the millions of dollars the State will have to pick up in cleaning up properties which others have contaminated, the state will also be prevented from recovering for many other

losses. These include, for example, millions of dollars in faulty school, office building and other construction which it does not find out was defective until 6 years from the date of completion. This, too, will pose an expensive problem, as faulty construction rarely begins to deteriorate or otherwise show itself immediately. The State will often not be allowed to recover from parties responsible to faulty construction because it will not have found out about the faulty work for six or more years.

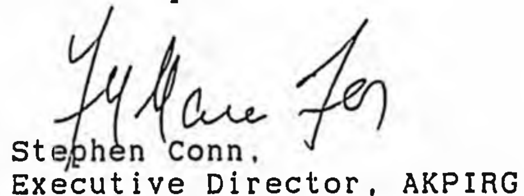
This Radical and Costly Experiment Should Not Be Attempted

The current statute of limitations rule is fair to both victims and wrongdoers. It is followed in federal court, and in all, or almost all states. A victim, including the State, should only be prevented from seeking compensation for its injuries if it does not timely file suit after it should have discovered its injury or the defendant's wrongdoing - the so-called "date of discovery rule". To advance this period under HB 292 so that victims will have to seek legal redress before they even find out they have been injured is both unjust, and will result in enormous costs to taxpayers and individual and business victims.

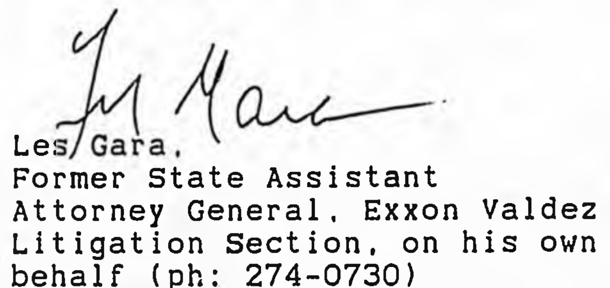
The fiscal impact of HB 292 should therefore be subjected to vigorous scrutiny in your committee. It should not be passed until the fiscal impacts are calculated with specificity, and the Committee decides the State can afford these costs to engage in a legislative experiment more radical than any attempted in the other 49 states. The costs to the public are of course multiplied when it is considered that all citizens, and not only the State, will be precluded from seeking compensation for significant losses under HB 292.

Thank you for your consideration of this matter.

Sincerely,



Stephen Conn,
Executive Director, AKPIRG



Les Gara,
Former State Assistant
Attorney General, Exxon Valdez
Litigation Section, on his own
behalf (ph: 274-0730)

REPORT OF THE
JOINT SUBCOMMITTEE STUDYING

Statutes of Limitation and Accrual of Actions

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 55

COMMONWEALTH OF VIRGINIA
RICHMOND
1989

September, 1988

State Statutes of Limitations/Repose

ALABAMA

PERSONAL INJURY	1 year for trespass on the case (6-2-38); 2 years malicious prosecution, libel, slander, fraud (from discovery) (6-2-38); 6 years for trespass (6-2-39).
WRONGFUL DEATH	2 years (6-2-38).
PROPERTY DAMAGE	1 year for trespass on the case (6-2-39).
BREACH OF WARRANTY	4 years (6-5-502(c)).
PRODUCT LIABILITY	1 year; 10 year statute of repose held unconstitutional (Lankford v. Sullivan, Long & Hagarty, 416 So.2d 996 (1982).

ALASKA

PERSONAL INJURY	2 years (09.10.070(1)); if fraud, accrues on discovery (09.10.230).
WRONGFUL DEATH	2 years (09.55.580(a)).
PROPERTY DAMAGE	6 years (09.10.050(1)).
BREACH OF WARRANTY	4 years (45.05.242).

ARIZONA

PERSONAL INJURY	2 years (12-542(1)); except 1 year (from discovery) for libel, slander, false imprisonment (12-541) and 3 years for fraud (12-543).
WRONGFUL DEATH	2 years (12-542(2)).
PROPERTY DAMAGE	2 years (12-542(3)-(5)).
BREACH OF WARRANTY	6 years - written (12-548); 3 years - oral (12-543(1)).
PRODUCT LIABILITY	2 years but no more than 12 years after the product was first sold for use and consumption (12-551).

ARKANSAS

PERSONAL INJURY	3 years (16-56-105); 1 year for assault, battery, false imprisonment, slander (16-56-104).
WRONGFUL DEATH	3 years ( ).
PROPERTY DAMAGE	3 years (16-56-105).
BREACH OF WARRANTY	4 years (85-725).

CALIFORNIA

PERSONAL INJURY	1 year - general (includes libel and slander) (CCP 340(3)); if med. mal. 3 years from injury or 1 year from discovery (CCP 340.5) but if injury to minor child received before birth, within 6 years of birth (CCP 29), fraud 3 years from discovery (CCP 338); legal malpractice, 1 year from discovery, maximum 4 years from wrong (CCP 340.6).
WRONGFUL DEATH	1 year (340(3)).
PROPERTY DAMAGE	3 years (338(2)-(3)).
BREACH OF WARRANTY	4 years (CUCC 2725) - does not apply to actions for personal injury, *Becker v. Volkswagon of America, Inc.*, 125 Cal. Rptr. 326 (1975).

COLORADO

PERSONAL INJURY	2 years for all torts (regardless of theory of recovery) (13-80-102).
WRONGFUL DEATH	See PERSONAL INJURY above.
PROPERTY DAMAGE	See PERSONAL INJURY above.
BREACH OF WARRANTY	4 years (4-2-7-25).

CONNECTICUT

PERSONAL INJURY	3 years for any action founded on tort (52-577); 2 years from date of injury or discovery, injury to person or property (negligence/recklessness,

	wanton misconduct or malpractice), maximum 3 years from act or omission (52-584).
WRONGFUL DEATH	2 years from date injury sustained or discovered, maximum 3 years from act or omission (52-555).
PROPERTY DAMAGE	See PERSONAL INJURY above.
BREACH OF WARRANTY	4 years (42a-2-75).
PRODUCT LIABILITY	3 years from injury or discovery, but no more than 10 years from date of sale, lease or bailment, unless still within "useful life" or express warranty present (1979 Conn. Pub. Act 483 Sect. 3).

DELAWARE

PERSONAL INJURY	2 years (10.8119); if Med. Mal. and not discoverable within 2 years, 3 years from injury (18.6856).
WRONGFUL DEATH	2 years (10.8107).
PROPERTY DAMAGE	2 years - Personal property (10.8107); 3 years - Realty (10.8106).
BREACH OF WARRANTY	4 years (6.2-725).

DISTRICT OF COLUMBIA

PERSONAL INJURY	3 years (12-301(8)).
WRONGFUL DEATH	1 year (16-2702).
PROPERTY DAMAGE	3 years (12-301(2)&(3)).
BREACH OF WARRANTY	4 years (28:2-725).

FLORIDA

PERSONAL INJURY	4 years for any action founded on negligence; professional malpractice accrues on discovery (due diligence) (95-11(3)(a)); 2 years from discovery (due diligence) but not more than 4 years from occurrence/incident for Med. Mal. (95-11(4)).

WRONGFUL DEATH	2 years (95-11(4)(d)).
PROPERTY DAMAGE	4 years (95-11(3)(g)&(h)).
BREACH OF WARRANTY	4 years (672.2-725).
PRODUCT LIABILITY	4 years, but must be within 12 years of date of delivery of completed product to original purchaser (95-11(3)(e)).

GEORGIA

PERSONAL INJURY	2 years for general injury to person; 1 year for injury to reputation; 4 years for Loss of Consortium (9-3-33).
WRONGFUL DEATH	2 years (9-3-33).
PROPERTY DAMAGE	4 years (9-3-32).
BREACH OF WARRANTY	4 years (109A-2-725).
PRODUCT LIABILITY	Maximum 10 years from first sale (105-106(b)(2)).

HAWAII

PERSONAL INJURY	2 years (657-7). Accrues when act, damage and causal connection discovered or should have been discovered (reasonable diligence), 648 P.2d 689; med. mal. subject to maximum of 6 years from act/omission (657-7.3).
WRONGFUL DEATH	2 years from death (663-3).
PROPERTY DAMAGE	2 years for personalty (657-1).
BREACH OF WARRANTY	4 years (490:2-725).

IDAHO

PERSONAL INJURY	2 years (5-219(4)) discovery accrual for fraud (5-218(4)), and med. mal. if fraudulent concealment or foreign object (5-219(4)).
WRONGFUL DEATH	2 years from occurrence, act, or omission (5-219).

PROPERTY DAMAGE — 3 years (5-218).

BREACH OF WARRANTY — 4 years - Sales (28-2-725). 2 years - Personal injury or death (5-219).

ILLINOIS

PERSONAL INJURY — 2 years (110-13-202); 1 year - slander or libel (110-13-201).

WRONGFUL DEATH — 2 years (70-2).

PROPERTY DAMAGE — 5 years (110-13-205).

BREACH OF WARRANTY — 4 years (26-2-725).

PRODUCT LIABILITY — 2 years from date of known injury or 8 years if unknown; in no case more than 12 years from date product leaves possession of manufacturer, or 10 years from date of first possession by initial owner, whichever period expires earlier (110-13-213); 12-year limitation not applicable to negligence actions, Dintelman v. Alliance Machine Co., 453 N.E.2d 128 (Ill. App., 1983). Constitutionality of statute of repose upheld, Thornton v. Mono Manufacturing Co., 425 N.E.2d 522 (1981)

INDIANA

PERSONAL INJURY — 2 years for injury to person, character or personal property (34-1-2-2(1)); 6 years for Fraud (34-1-2-1).

WRONGFUL DEATH — 2 years (34-1-1-2).

PROPERTY DAMAGE — 6 years - Realty (34-1-2-1(3)). 2 years - Personalty (34-1-2-2(2)).

BREACH OF WARRANTY — 4 years (26-1-2-725).

PRODUCT LIABILITY — 2 years after cause of action accrues or 10 years after delivery of the product to initial user, provided that if action accrues more than 8 but less than 10 years after initial delivery, it may be brought any time within 2 years of accrual (34-4-20A-5).

APPENDIX B

IOWA

PERSONAL INJURY — 2 years for injury to person or reputation, whether contract or tort (614.1(2)); discovery accrual for med. mal (614.1(9)).

WRONGFUL DEATH — 2 years (614.1(2)).

PROPERTY DAMAGE — [illegible] years (614.1(4)).

KANSAS

PERSONAL INJURY — 2 years from injury or discovery (reasonably ascertainable), maximum of 10 years from the act (60-513(4)); Med. Mal. - maximum of 4 years from act.

WRONGFUL DEATH — 2 years from injury or discovery, maximum of 10 years (60-513(5)).

PROPERTY DAMAGE — 2 years from injury or discovery, maximum of 10 years (60-513(1)&(2)).

BREACH OF WARRANTY — 4 years (84-2-7-25).

KENTUCKY

PERSONAL INJURY — 1 year (413.140(1)(a)); 5 years for fraud (413.120(12)). Accrues on discovery if fact of injury not reasonably ascertainable.

WRONGFUL DEATH — 1 year (413.140(1)(a)).

PROPERTY DAMAGE — 5 years (413.120(6)).

BREACH OF WARRANTY — 4 years (355.2-725).

PRODUCT LIABILITY — 1 ~~3~~ years (411.1).

LOUISIANA

PERSONAL INJURY — 1 year (3492).

WRONGFUL DEATH — 1 year (3492).

PROPERTY DAMAGE — 1 year (3492).

BREACH OF WARRANTY — 1 year - Sales.

APPENDIX B

MAINE

PERSONAL INJURY	6 years - all civil actions, except 2 years for assault and battery, false imprisonment, slander, libel and med. mal. (14 § 752).
WRONGFUL DEATH	2 years (18 § 2-804).
PROPERTY DAMAGE	6 years (14 § 752).
BREACH OF WARRANTY	4 years (11 § 2-725).
PRODUCT LIABILITY	6 years (14 § 752).

MARYLAND

PERSONAL INJURY	3 years for "all civil actions", except 1 year for assault, battery, libel, slander (5-105) and 5 years from injury or 3 years from discovery for med. mal. (5-101).
WRONGFUL DEATH	3 years (3-904).
PROPERTY DAMAGE	3 years (5-101).
BREACH OF WARRANTY	4 years (2-725).
PRODUCT LIABILITY	3 years (5-101).

MASSACHUSETTS

PERSONAL INJURY	3 years for tort, contract (personal injuries), replevin malpractice, assault, battery, libel, slander, false imprisonment, etc. (260 § 2A and 260 § 4).
WRONGFUL DEATH	3 years (229 § 2) (death must occur within two years of death--causing injury).
PROPERTY DAMAGE	3 years (260 § 2A).
BREACH OF WARRANTY	3 years (106 § 2-318).

MICHIGAN

PERSONAL INJURY	2 years, except 1 year for slander or libel (600.5805).

APPENDIX B

WRONGFUL DEATH	3 years (600.5805(8)).
PROPERTY DAMAGE	3 years (600.5805).
BREACH OF WARRANTY	4 years (440.2725).
PRODUCT LIABILITY	3 years (600.5805(9)).

MINNESOTA

PERSONAL INJURY	2 years - med. mal. and torts resulting in personal injury (541.05).
WRONGFUL DEATH	3 years from death, but no more than 6 years after act or omission (573.02) except, 2 years if med. mal.
PROPERTY DAMAGE	6 years (541.05).
BREACH OF WARRANTY	4 years (336-2-725).
PRODUCT LIABILITY	4 years (541.05).

MISSISSIPPI

Reduced to 3 yrs. in 1989

PERSONAL INJURY	~~6 years~~ (15-1-49) except 1 year for assault, battery, maiming, false imprisonment, slander, libel (15-1-35) and 2 years for med. mal.
WRONGFUL DEATH	6 years (15-1-49).
PROPERTY DAMAGE	6 years (15-1-49).
BREACH OF WARRANTY	6 years (75-2-725).

MISSOURI

PERSONAL INJURY	5 years for injury to person or rights of another (from discovery, if fraud, subject to 10 year maximum (516.120)), except 2 years for libel, slander, assault, battery, false imprisonment, etc. (516.140) and 2 years for med. mal. (from discovery if foreign object) (516.105).
WRONGFUL DEATH	3 years (537.100).
PROPERTY DAMAGE	5 years (516.120).
BREACH OF WARRANTY	4 years (400.2-725).

APPENDIX B

MONTANA

PERSONAL INJURY	3 years for actions on liability not founded upon an instrument (27-2-204); from discovery for med. mal. (27-2-205) except 2 years for libel, slander, assault, battery, false imprisonment or seduction and fraud or mistake (27-2-203).
WRONGFUL DEATH	3 years (27-2-204).
PROPERTY DAMAGE	2 years (27-2-207).
BREACH OF WARRANTY	8 years if written obligation (27-20-202) or 4 years if contract for sale (30-2-725).

NEBRASKA

PERSONAL INJURY	4 years for injury to rights not arising on contract (from discovery for fraud) (25-207(3)) except 1 year from discovery for professional malpractice and 1 year for libel, slander, false imprisonment, malicious prosecution and 2 years for other professional malpractice (25-208).
WRONGFUL DEATH	2 years (30-810).
PROPERTY DAMAGE	4 years (25-207(2)).
BREACH OF WARRANTY	4 years (2-725).
PRODUCT LIABILITY	4 years, but within 10 years of injury or first sale, or 2 years from "being informed" if asbestos-related disease (25-224).

NEVADA

PERSONAL INJURY	2 years (11.190(4)(e)) except 3 years from discovery if fraud or mistake (11.190(3)).
WRONGFUL DEATH	2 years (11.190(4)).
PROPERTY DAMAGE	3 years (11.190(3)).
BREACH OF WARRANTY	4 years (104.2725).

APPENDIX B

NEW HAMPSHIRE

PERSONAL INJURY	3 years for all personal actions (from discovery of injury and causal relationship) (508:4).
WRONGFUL DEATH	3 years (508:4).
PROPERTY DAMAGE	3 years (508:4).
BREACH OF WARRANTY	Sales contract - 4 years (382-A:725).
PRODUCT LIABILITY	3 years from injury, but not more than 12 years after product left control of manufacturer (507-D:2). 12-year statute of repose held unconstitutional, Heath v. Sears, Roebuck & Co., 464 A.2d 288 (N.H. 1983).

NEW JERSEY

PERSONAL INJURY	2 years for injury to person from wrongful act, neglect or default (2A:14-2).
WRONGFUL DEATH	2 years (2A:31-3).
PROPERTY DAMAGE	6 years (2A:14-1).
BREACH OF WARRANTY	4 years (12A:2-725).

NEW MEXICO

PERSONAL INJURY	3 years for injury to person or reputation (37-1-8).
WRONGFUL DEATH	3 years (41-2-2).
PROPERTY DAMAGE	4 years (37-1-4).
BREACH OF WARRANTY	4 years (55-2-725). But see, Chavez v. Kitsch, 374 P.2d 497 (1962) - court applied the 3-year period in a personal injury action prosecuted under warranty.

NEW YORK

PERSONAL INJURY	3 years (CPLR 214(5)); 1 year for assault, battery, false imprisonment,

slander, libel (CPLR 215); 2 years 6 months for med. mal. (from discovery for foreign object) (CPLR 214a).

WRONGFUL DEATH	2 years (EPTL 5-4.1).
PROPERTY DAMAGE	3 years. (CPLR § 214(4)).
BREACH OF WARRANTY	Sale - 4 years (2-725 UCC); Other - 6 years (CPLR 213(2)).

NORTH CAROLINA

PERSONAL INJURY	3 years for injury to person or rights of another; accrues when injury was or should have been apparent (1-52(5)&(16)).
WRONGFUL DEATH	2 years (1-53(4)).
PROPERTY DAMAGE	3 years from when damage is or should have been apparent (1-52(5)&(16)).
BREACH OF WARRANTY	4 years (25-2-725(1)).
PRODUCT LIABILITY	6 years from initial purchase for use or consumption.

NORTH DAKOTA

PERSONAL INJURY	6 years (28-01-16); 2 years for libel, slander, assault, false imprisonment (28-01-18) and 2 years for med. mal. (28-01-18).
WRONGFUL DEATH	2 years (28-01-18).
PROPERTY DAMAGE	6 years (18-01-16).
BREACH OF WARRANTY	4 years (41-02-104).
PRODUCT LIABILITY	Injury, death or damage occurred within 10 years from initial purchase for use or consumption or 11 years from date of manufacture (28-01.1-02).

OHIO

PERSONAL INJURY	2 years for bodily injury (2305.10); 1 year for slander, libel, malicious prosecution, false imprisonment and

	med. mal. (maximum 4 years from occurrence) (2305.11); 4 years for fraud.
WRONGFUL DEATH	2 years (2305.10).
PROPERTY DAMAGE	2 years (2305.10); 4 years for recovery (2305.09).
BREACH OF WARRANTY	4 years if contractual relationship (1302.98); other - 2 years (2305.10).

OKLAHOMA

PERSONAL INJURY	2 years for injury to rights of another (12-95(3)); 1 year for assault, battery, libel, slander, malicious prosecution, false imprisonment (12-95(4)).
WRONGFUL DEATH	2 years (12-1053).
PROPERTY DAMAGE	2 years (12-95(3)).
BREACH OF WARRANTY	5 years (12A-2-72_).

OREGON

"STATUTE OF ULTIMATE REPOSE"	Notwithstanding other longer statutory provisions as a result of tolling or delayed commencement of running of the statute of limitations, all actions for negligent injury to person or property must be brought within 10 years from the date of the act or omission complained of (12.115[1]). Constitutionality upheld, Josephs v. Burns, 491 P.2d 203 (1971). Action accrues when injury manifests if injury not previously discoverable by exercise of due diligence. O'Gara v. Kaufman, 726 P.2d 402 (1986).
PERSONAL INJURY	2 years (12.110(1)); from discovery if fraud, deceit or med. mal. (subject to 5 years max. unless fraud/deceit).
WRONGFUL DEATH	3 years from death-causing injury (30.020).
PROPERTY DAMAGE	6 years (12.080(3)&(4)).

BREACH OF WARRANTY	4 years (72.7250).
PRODUCT LIABILITY	2 years from date on which death, injury or damage occurs (from discovery if asbestos related), but not later than 8 years after first purchase of product (30.905).

PENNSYLVANIA

PERSONAL INJURY	2 years (42 § 5524).
WRONGFUL DEATH	2 years (42 § 5524).
PROPERTY DAMAGE	2 years (42 § 5524).
BREACH OF WARRANTY	4 years (12A § 2-725). But, 2 years for third-party personal injury actions based upon warranty. See Salvador v. Atlantic Steel Boiler Co., 319 A.2d 903 (Pa. Super. 1978).

RHODE ISLAND

PERSONAL INJURY	10 years for all civil actions (9-1-13); 3 years for injuries to the person (9-1-14) - from discovery for med. mal. (9-1-14.1); 1 year for actions for words spoken.
WRONGFUL DEATH	3 years (10-7-2).
PROPERTY DAMAGE	10 years (9-1-13(a)).
BREACH OF WARRANTY	4 years (6A-2-725).
PRODUCT LIABILITY	Personal injury - 3 years (9-1-14); Property damage - 6 years (9-1-13); Statute of Repose - 10 years from date of first purchase for consumption (9-1-13(b)) - Unconstitutional. Kennedy v. Cumberland Co., Inc., 471 A.2d 195 (R.I. 1984).

SOUTH CAROLINA

PERSONAL INJURY	6 years for injury to person or rights of another (15-3-530(5)); 3 years from reasonable discovery if med. mal. (15-3-545); 2 years for libel, slander, assault, battery, false imprisonment (15-3-550).

WRONGFUL DEATH — 6 years (15-3-530(6)).

PROPERTY DAMAGE — 6 years (15-3-530(3)&(4)).

BREACH OF WARRANTY — 6 years (36-2-725).

SOUTH DAKOTA

PERSONAL INJURY — 3 years for personal injury (15-2-14(3)); 6 years for other injury to rights of another not arising on contract and for fraud (15-2-13); 2 years for libel, slander, assault, battery or false imprisonment (15-2-15); 3 years for legal malpractice (15-2-14.2).

WRONGFUL DEATH — 3 years (21-5-3).

PROPERTY DAMAGE — 6 years (15-2-13(3)&(4)).

BREACH OF WARRANTY — 6 years (15-2-13(1)).

PRODUCT LIABILITY — 3 years from injury, death or damage (15-2-12.2).

TENNESSEE

PERSONAL INJURY — 1 year (28-3-104).

WRONGFUL DEATH — 1 year (28-3-104).

PROPERTY DAMAGE — 3 years (28-3-105).

BREACH OF WARRANTY — 4 years (47-2-725).

PRODUCT LIABILITY — Governed by personal injury and property damage limitations periods but must be brought within 6 years of date of injury, 10 years of first purchase or 1 year of expiration of anticipated life of products: whichever is shorter (29-28-103).

TEXAS

PERSONAL INJURY — 2 years (16.003(a)); 1 year for malicious prosecution, slander, libel (   ).

WRONGFUL DEATH — 2 years (16.003(b)).

PROPERTY DAMAGE	2 years (16.003(a)).
BREACH OF WARRANTY	4 years (2-725).

UTAH

PERSONAL INJURY	4 years for actions not otherwise covered (78-12-25(2)); 2 years for civil rights actions (78-12-28); 1 year for libel, slander, assault, battery, false imprisonment.
WRONGFUL DEATH	2 years (78-12-28(2)).
PROPERTY DAMAGE	3 years (78-12-26(1)&(2)).
BREACH OF WARRANTY	4 years (70A-2-75).
PRODUCT LIABILITY	Governed by personal injury and property damage limitations periods, but must be brought within 6 years of initial purchase or 10 years of manufacture (78-15-3).

VERMONT

PERSONAL INJURY	3 years from discovery (12-512(4)); Med. Mal. - 3 years from incident or 2 years from reasonable discovery (12-521).
WRONGFUL DEATH	2 years (14-1492(a)).
PROPERTY DAMAGE	3 years - Personalty (12-512(5)). 6 years - Realty (12-511).
BREACH OF WARRANTY	4 years (9A-2-725(1)).

WASHINGTON

PERSONAL INJURY	3 years for injury to person or rights of another (4.16.080(2)) - fraud accrues on discovery; 2 years for libel, slander, assault, battery, false imprisonment.
WRONGFUL DEATH	3 years (4.16.080(2)).
PROPERTY DAMAGE	3 years (4.16.080(1)&(2)).
BREACH OF WARRANTY	4 years (62A.2-725).

WEST VIRGINIA

PERSONAL INJURY	2 years (55-2-12).
WRONGFUL DEATH	2 years (55-7-6).
PROPERTY DAMAGE	2 years (55-2-12).
BREACH OF WARRANTY	4 years - Sales (46-2-275); 2 years - Personal injury (55-2-12).

WISCONSIN

PERSONAL INJURY	6 years for injury to character or rights of another (893.53); 3 years for injuries to the person (893.54); 3 years from injury or 1 year from reasonably diligent discovery, subject to maximum of 5 years from act for med. mal. (893.55); 2 years for intentional torts (893.57). Discovery rule adopted for all torts, Hansen v. A.H. Robins, 335 N.W. 2d 578 (1983).
WRONGFUL DEATH	3 years (893.54).
PROPERTY DAMAGE	6 years (893.52).
BREACH OF WARRANTY	4 years (402A.725).

WYOMING

PERSONAL INJURY	4 years for injury to rights (1-3-105[a][iv]); 1 year for slander, libel, assault, battery, false imprisonment ( ).
WRONGFUL DEATH	2 years (1-38-102).
PROPERTY DAMAGE	4 years (1-3-105[a][iv]).
BREACH OF WARRANTY	4 years (34-21-299.5).

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LIMITS ON NONECONOMIC DAMAGES

As os February 1994

Alaska	$500,000	noneconomic damages, *excluding cases of disfigurement* or severe physical impairment.
California	$250,000	noneconomic damages in medical liability actions.
Colorado	$250,000	noneconomic damages in medical liability actions unless court finds clear justification to exceed, but in no event more than $500,000; total recovery not to exceed $1 million.
Florida	$250,000/ $350,000	noneconomic damages *in medical liability actions* ; $250,000 limit applies to binding arbitration and $350,000 *limit* applies to arbitration cases which proceed to trial.
Hawaii	$375,00	pain and suffering (does not include mental anguish, disfigurement, loss of enjoyment of life, loss of consortium). Sunsets 1995.
Idaho	$400,000	noneconomic damages in personal injury cases, increases/decreases annually according to state's adjustment of average annual wage.
Kansas	$250,000	noneconomic damages in all personal injury cases.
Maryland	$350,000	noneconomic damages in all personal injury actions, *except wrongful death.*
Michigan	$225,000	noneconomic damages in medical liability actions, limit increased annually by increase in consumer price index.
Minnesota	$400,000	intangible losses in all civil actions (embarrassment, emotional distress, loss of consortium, not pain and suffering or disfigurement).

Missouri	$350,000	noneconomic damages in medical liability actions, increased or decreased annually according to figures determined by U.S. Department of Commerce.
Oregon	$500,000	noneconomic damages in all personal injury cases.
Utah	$250,000	noneconomic damages in medical liability actions.
West Virginia	$1 million	noneconomic damages in medical liability actions.

LIMITATIONS ON AWARDS OF

NON-ECONOMIC DAMAGES

1986

Alaska
$500,000 cap (except for physical impairment or disfigurement)

Colorado
$250,000 cap (unless court finds justification by "clear and convincing evidence" for a larger award which cannot exceed $500,000)

Hawaii
$375,000 cap but cap applies only to actual physical pain and suffering; other non-economic damages have no limit

Maryland
$350,000 cap

Minnesota
$400,000 cap on all awards based on loss of consortium, emotional distress, or embarrassment (not pain and suffering)

1987

Idaho
$400,000 cap -- adjusted for annual wage increase

Kansas
$250,000 cap on pain and suffering (not other non-economic losses)

Oregon
$500,000 cap on non-economic damages

April 1985

STATUTE OF LIMITATIONS

A statute of limitations is a law cutting off a cause of action, including medical liability actions, after the expiration of a specified time period. With respect to medical liability, the statute usually begins to run from either the date of occurrence or the date the alleged medical injury was or should have been discovered.

The primary purpose of a statute of limitations is to require that a claim be asserted within a specified time period while the pertinent evidence is available, and while witnesses are still available. Also, it is generally believed that the spectre of a lawsuit should not continue for an indefinite time. In the medical liability area, a shorter, more definite statute of limitations eliminates a "long tail" in claims, thereby making the writing of medical liability insurance more actuarially predictable.

a) Specific medical liability statutes of limitations

Every state has a statute of limitations applicable to medical liability actions. However, in some states the statute is a general one, applicable in all tort actions. States establishing a specific statute of limitations for medical liability cases are as follows:

1. Alabama*
2. Arizona (repealed 1985)*
3. Arkansas
4. California
5. Colorado*
6. Connecticut*
7. Delaware
8. Florida
9. Georgia*
10. Hawaii
11. Idaho
12. Illinois*
13. Indiana*
14. Iowa
15. Kansas*
16. Kentucky
17. Louisiana
18. Maine*
19. Maryland
20. Massachusetts
21. Michigan
22. Minnesota
23. Mississippi
24. Missouri
25. Montana
26. Nebraska
27. Nevada
28. New Hampshire*
29. New Mexico
30. New York
31. North Carolina
32. North Dakota
33. Ohio*
34. Oklahoma*
35. Oregon
36. Rhode Island
37. South Carolina
38. South Dakota
39. Tennessee*
40. Texas*
41. Utah*
42. Vermont
43. Washington
44. Wisconsin
45. Wyoming

b) Maximum statute of limitations period

In many stat-s the statute of limitations for medical liability actions begins to run ily upon discovery of the injury. Since such injuries may be discovered several years after the treatment was rendered, the time period for filing an action may be very uncertain under such statutes. This period of uncertainty is often referred to as the "long tail." The "long tail" is often cited by insurance companies as a major difficulty in establishing medical liability insurance premiums on an actuarially sound basis.

* See section entitled *Court Decisions: Statute of Limitations*

Some states have sought to eliminate the "tail" by placing an absolute maximum time period within which medical liability suits may be brought ("statute of repose"). Such statutes commonly provide for bringing an action within a certain number of years after the occurrence of the alleged injury and within an additional number of years (beyond the regular limitation period) where the injury could not have been discovered through the reasonable diligence of the injured person.

An exception to the time period is provided in some of these statutes where foreign objects are left in the body, or where the health care provider has fraudulently concealed the fact of injury.

States providing some form of definitive maximum time limitations are as follows:

1. Alabama*
2. Arizona (repealed 1985)*
3. Colorado*
4. Connecticut*
5. Delaware
6. Florida
7. Hawaii
8. Illinois*
9. Iowa
10. Louisiana
11. Missouri
12. Nebraska
13. New Mexico
14. New York
15. North Carolina
16. North Dakota
17. Ohio*
18. Oregon
19. South Dakota
20. Tennessee*
21. Utah
22. Vermont
23. Washington
24. Wisconsin

c) Minors

Most state statutes of limitations provide that if an injury is incurred by a minor, the statute is tolled (i.e., stops running) on the minor's cause of action until he reaches the age of majority.

Several states have amended their statutes of limitations in medical injury cases where minors are involved, typically by providing that the statute applies to a minor upon reaching a certain age. For example, if a two-year statute of limitations is provided, a state may provide that actions which accrue to a minor before the age of six must be brought before his eighth birthday. In statutes of this type, after the minor reaches the age of six the general two-year time limitation becomes applicable for minors as well as for adults. Most of the state statutes which have been modified relative to minors are of this variety.

However, the states of Louisiana and Utah provide that there is no special treatment for minors in their statutes of limitations, applicable to medical liability, so that minors are subject to the same statutory limitation period as applies to adults.

In addition, the North Carolina and Kansas statutes provide that a person who has incurred a cause of action as a minor must pursue his claim either within the general limitation period applicable to adults or within one year after reaching the age of majority, whichever period is the longer.

States which have amended their statutes of limitations (for medical liability cases) relative to minors are as follows:

1. Alabama*
2. Arizona (repealed 1985)*
3. Arkansas
4. California
5. Colorado
6. Delaware
7. Indiana*
8. Kansas*
9. Louisiana
10. Maryland
11. Massachusetts
12. Mississippi
13. Missouri
14. New Hampshire
15. New Mexico
16. New York
17. North Carolina
18. Ohio*
19. Rhode Island (repealed 1984)
20. South Dakota
21. Texas*
22. Utah
23. Wisconsin
24. Wyoming

Court Decisions: Statute of Limitations

Alabama

In Reese v. Rankin Fite Memorial Hospital, the Alabama Supreme Court found that the statute of limitations applicable to minors did not violate the state or federal constitutions. The Alabama statute prohibits commencement of a cause of action more than four years after the occurrence of the act complained of, except that a minor under four years of age has until his eighth birthday to bring a cause of action. The plaintiff argued that the statute violates the due process and equal protection provisions of both the state and federal constitutions in that it treats minors with medical injuries differently from minor victims of other torts. The court stated that it need only find that the classification made by the legislature was not arbitrary or unreasonable in order for the statute to withstand the equal protection challenge. It found that other statutory provisions favored minors and that the court could not say that the equal protection provision of the constitution restricts the legislature's authority to withdraw the legislative grace given minors. The court stated that it cannot substitute its judgment for that of the legislative branch, whose enactments come clothed in a presumption of validity. The court also held that the medical liability act is not a "special law" (which would violate the state constitution) because the act is a law which applies to the whole state, operating alike on all the people or all the people of a class. [403 So. 2d 158 (Ala. 1981)]

In Bowlin Horn v. Citizens Hospital, the Alabama Supreme Court upheld the medical liability statute of limitations which provides that in no event may an action be commenced more than four years after the alleged negligent act. The court found that fraudulent concealment or the act of leaving a foreign object in a patient's body did not toll the statute of limitations unless the legislature specifically so provided. The court found that the statute of limitations was not unconstitutional. [425 So. 2d 1065 (Ala. 1982)]

Arizona

In Kenyon v. Hammer, the Arizona Supreme Court held that the three year statute of limitations for medical injuries violated the equal protection clause of the state constitution in cases where an injured person could not have known of his injury.

The statute of limitations provided that a cause of action for medical injury accrues as of the date of injury and must be prosecuted within three years after the date of injury. It further provides exceptions to the three year limit for actions involving foreign objects, intentional concealment, and minors. The statute legislatively abolished the common law discovery rule which provided that the statute of limitations did not begin to run until the date the claimant discovers, or reasonably should have discovered, that he had been injured.

The court stated that the statute of limitations discriminates between claims against health care providers and other malpractice claims and also discriminates between classes of medical liability claimants. Because the court found that the right to pursue an action is a "fundamental right" guaranteed by the state constitution, it applied the "strict scrutiny" test in reviewing the constitutionality of the statutes. Under this test, a statute can be held valid only if it serves a compelling state interest and is necessary to the attainment of that interest.

The court noted that the statute was intended by the legislature to be a remedial act in response to the difficulties the medical profession had had in obtaining liability insurance. The court found that the state had neither a compelling nor legitimate interest in providing economic relief to one segment of society by depriving those who have been wronged of access to, and remedy by, the judicial system.

Defendants argued that the statute was necessary in order to decrease the costs of medical care and to increase the availability of medical services. In considering this argument, the court questioned whether the abolition of the discovery rule was necessary to reduce liability insurance premiums. The court stated that if actuarial certainty is required, reduction of the statute of limitations would have been a more rational method of achieving the compelling state interest than abolition of the discovery rule and consequent abrogation by select exceptions. No evidence was provided to support the necessity of the legislative discrimination between most medical claimants and those claimants coming within the statute's exceptions.

The court held that given the lack of either legislative or adjudicative record to demonstrate the effect that abolition of the discovery rule might have on liability premiums, it could not find that the abolition of the discovery rule was a necessary step to achieve the compelling state interest of reducing the cost of medical care or increasing the availability of such care.

The court held that the imposition of an absolute bar three years from the date of injury on most, but not all, medical injury claimants, the abolition of the general tolling provisions recognized for all other tort claims, and the internal distinctions among medical liability claimants all discriminate against and among medical liability claimants in a manner which infringes upon fundamental rights. As a result, the statute of limitations was found to violate the state constitution insofar as it purports to abolish or limit the discovery rule. The three year statute of limitations remains in effect subject to the application by the courts of the discovery rule. [688 P.2d 961 (Ariz. 1984)]

In Barrio v. San Manuel Division Hospital, the Arizona Supreme Court held unconstitutional the statute of limitations applicable to minors in medical injury lawsuits. The statute had provided that, in actions against licensed health care providers, minors who are injured and are under the age of seven must bring the cause of action for damages before reaching the age of ten.

The Arizona state constitution provides that "[t]he right of action to recover damages for injury shall never be abrogated, and the amount recovered shall not be subject to any statutory provision." Pursuant to this provision, the court deemed the right to bring a suit for medical injury a constitutionally guaranteed "fundamental right." [The Arizona constitutional provision is stronger and more explicit than "open courts" provisions contained in other state constitutions.]

The court found that the medical injury statute of limitations applicable to minors "abrogates the right of action" and therefore the statute was held to be an unconstitutional violation of a fundamental right. [No. 17165-PR (December 10, 1984)]

Colorado

In Mishek v. Stanton, the plaintiff argued that the absolute maximum statute of repose provision applicable only to medical professionals violated the constitutional guarantee of equal protection and constitutes impermissible special legislation since "no reasonable basis exists for separating medical and healing professionals from other professionals and lay persons and granting them the special protection afforded by the [absolute] maximum statute of limitations." The Colorado Supreme Court rejected the argument outright, relying on its previous decision in McCarty v. Goldstein, 376 P.2d 691 (1962) which found that the health care provider statute of limitations constituted neither special legislation nor violated equal protection principles. [616 P.2d 135 (Colo. 1980)]

In Austin v. Litvak, the Supreme Court of Colorado held that the absolute maximum on the time within which a medical liability suit may be brought was unconstitutional insofar as it applies to persons whose claims are premised on negligent misdiagnosis. The court created an

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Background Paper

Impact of Legal Reforms on Medical Malpractice Costs

U.S. Congress
Office of Technology Assessment

IMPACT OF LEGAL REFORMS ON MEDICAL MALPRACTICE COSTS

Background Paper
prepared by the

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PAGE.003
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[illegible]

State	Medical Malpractice Arbitration Provisions[b]	Attorney Fee Limits[c]	Caps on Damages	Collateral Source Offset	Periodic Payment of Awards	Pretrial Screening Panels
				M = Mandatory	D = Discretionary	V = Voluntary
Alabama			O	D	M	
Alaska	√		√	D	D	M
Arizona		√		D	M	
Arkansas					D	V
California	√	√	√	D	M	
Colorado	√		√	M	M	
Connecticut		√		M	D	V
Delaware		√		D	D	V
D.C.						
Florida	√		√O	M	D	O
Georgia	√			O		
Hawaii	√	√	√			M
Idaho			√O	M	D	M
Illinois	√	√	O	M	M	O
Indiana		√	√	D	D	M
Iowa		√		M	D	
Kansas		√	√O	MO	O	V
Kentucky				D		
Louisiana	√		√		M	M
Maine		√		M	M	M
Maryland		√	√	D	D	M
Massachusetts		√	√	M		M
Michigan	√	√	√	M	M	M
Minnesota				M	D	
Mississippi						
Missouri			√		M	O
Montana				M	D	M
Nebraska		√	√			M
Nevada						M
New Hampshire		√	O	O	O	V
New Jersey	√	√		M		
New Mexico			√	M	M	M

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State	Medical Malpractice Arbitration Provisions[b]	Attorney Fee Limits[c]	Caps on Damages	Collateral Source Offset	Periodic Payment of Awards	Pretrial Screening Panels
				M = Mandatory	D = Discretionary	V = Voluntary
New York	√	√		M	D	
North Carolina						
North Dakota			O	D[O]	D	
Ohio	√		O	M	M	
Oklahoma		√				
Oregon			√	D	D	
Pennsylvania		O		O		O
Rhode Island				M	D	O
South Carolina					D	
South Dakota	√		√	D	M	
Tennessee		√		M		M
Texas			O			
Utah	√	√	√	M	M	M
Vermont						M
Virginia	√		√			V
Washington		√	O		M	
West Virginia			√			
Wisconsin		√	√			
Wyoming						O

Abbreviations:
M = Mandatory
D = Discretionary
V = Voluntary
O = A malpractice specific provision was overturned by Court. In certain States, the legislature corrected the constitutional deficiency.

Footnotes:
[a]For additional details on all categories, see app. A.
[b]A "√" indic[illegible]s States with voluntary, binding arbitration provisions that are designed specifically for medical malpractice cases. Voluntary, binding arbitration is an optio[illegible] [illegible]very State under general arbitration statutes. In Hawaii the provision applies to mandatory non-binding arbitration.
[c]A "√" in [illegible]orney Fees" means the statutory provision limits attorney fees to a specific percent of award. In a few States the courts are given the authority to determine or approve attorney fees (see app. A).

SOURCE: Office of Technology Assessment, 1993.

EXPLANATION OF METHODS USED BY OTA TO COMPILE DATA

The tables, figures, and accompanying notes in appendix A were derived from a variety of sources and synthesized by OTA to reflect the most recent information available on selected State medical malpractice reforms.

The primary published sources were 1991 and 1993 editions of a compendium developed for the Federal Agency for Health Care Policy and Research (AHCPR),[1] selected State statutes, and judicial cases. Two additional sources were used to update, cross-check, and supplement the AHCPR compendia.[2]

After compiling information from these sources into summary tables, OTA sent draft copies of the information to the attorneys general in all 50 States on March 24, 1993, for confirmation or amendment. Information was changed to reflect respondents' comments. Where conflicts arose between the attorney general response and information found elsewhere, the attorneys general's responses were favored. Unresolved questions were addressed through follow-up phone conversations with attorney general respondents and statutory research. The revised drafts were sent again to all 50 State attorneys general on June 25, 1993, for a final review and any corrections were incorporated.

For States that responded to the first survey only, information is current to March 1993. For States that responded to the second survey, information is current to June 1993. For the 10 States[3] that did not respond to either review and the District of Columbia, information was cross-checked and supplemented through followup telephone calls and/or review of the relevant State codes where possible. Where confirmation was not possible, information in this appendix reflects that presented in the 1993 edition of the AHCPR compendium.

[1]U.S. Department of Health and Human Services, Agency for Health Care Policy and Research, "Compendium of State Systems for Resolution of Medical Injury Claims," prepared by S.M. Spernak, Center for Health Policy Research, The George Washington University (Rockville, MD: AHCPR, April 1993), AHCPR Pub. No. 93-0053; U.S. Department of Health and Human Services, Agency for Health Care Policy and Research, "Compendium of State Systems for Resolution of Medical Injury Claims," prepared by S.M. Spernak and P.P. Budetti, Center for Health Policy Research, The George Washington University (Rockville, MD: DHHS, February 1991), DHHS Pub. No. (PHS)91-3474.

[2]These sources were: Fisk, M.C., "The Reform Juggernaut Slows Down," The National Law Journal 15(10):1,34-37, Nov. 9, 1992; American Nurses Association, "Report to ANA Board of Directors on Tort Reform, Part 3: Presentation of Selected Summary of State and Local Legislation Related to Tort Reform and Review of Insurance Company Practices and Policies Related to Nursing Negligence with Recom-mendations," December 1991.

[3]DE,FL,HI,KS,KY,MS,NJ,NM,TX,WV.

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Table A-1—Collateral Source Offset Provisions,[a] by State, 1993

Mandatory	Discretionary	No provision
CO*	AK*	AR
CT	AL	DC
FL	AZ	GA^O
IA	CA	HI
IL*	DE	LA
ID	IN	MO*
KS^O*	KY	MS
MA*	MD*	NC
ME	ND^O*	NE
MI	OR	NH^O
MN*	SD	NV*
MT*		OK
NJ		PA^O
NM		SC
NY		TX
OH*		VA
RI*		VT
TN		WA*
UT		WI
		WV
		WY

[a]The traditional collateral source rule forbade evidence of the plaintiff's collateral sources of income and reimbursement (e.g., medical insurance, disability payments) from being entered into evidence. States classified as "mandatory" or "discretionary" in this table have modified the traditional evidence rule to allow certain types of collateral sources to be admitted as evidence. Statutes which require that the plaintiff's award be offset by certain collateral sources are classified as mandatory. Statutes that leave the decision of whether to offset to the jury or judge are classified as discretionary. States with no provision have not modified their traditional collateral source rules. It is of note that a number of States reduce the malpractice award by the collateral source payments, but credit the plaintiff with any premiums he or she has paid or will pay to obtain the insurance (e.g., MN, MI, CT, RI, IL and NY).

O = Provision overturned.

* See additional notes on following pages.

SOURCE: Office of Technology Assessment, 1993.

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ADDITIONAL NOTES FOR TABLE A-1

Cases Overturning Collateral Source Offset Rules:

Georgia--Denton v. Con-Way Southern Express Inc., 402 S.E.2d 269 (Ga. 1991) (statute mandating evidence of collateral sources violates guarantee of impartial and complete governmental protection).

Kansas--see explanation below.

New Hampshire--Carson v. Maurer, 424 A.2d. 825 (N.H. 1980).

North Dakota--Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978) held an earlier statute for collateral source offsets unconstitutional.

Pennsylvania--The Pennsylvania Supreme Court struck down as unconstitutional the State statute providing for pretrial screening panels. The collateral source provision was a part of that statute and was nullified. Mattos v. Thompson 421 A.2d. 190 (1980).

Selected Additional Information:

Alaska--Collateral source offset determined by the court (Alaska Stat. Supp. Secs. 9.55.548; 9.17.070 (1992)).

Colorado--Collateral source offset determined by the court (Colo. Rev. Stat. Sec. 13-64-402 (1992)).

Illinois--Reduction of collateral source is for 50 percent of collateral payments for lost wages or disability benefits and 100 percent of medical benefits (with exceptions), but no more than 50 percent of the total verdict (735 ILCS 5/2-1205 (West 1992)).

Kansas--When claimant demands $150,000 or more, evidence of collateral sources admissible. Reduction of award by collateral source amount is subject, however, to certain limitations (KSA Secs. 60-3801 - 3807 (Supp. 1992)). This statute applies to all personal injury suits. The original statute abrogating collateral source for medical malpractice suits only was struck down (Farley v. Engelken 740 P.2d 1058 (1987)). Also, in Wentling v. Medical Anesthesia Services, P.A., 701 P.2d 939 (Kan. 1985), court held that collateral source offsets were unconstitutional in wrongful death medical malpractice cases.

Maryland--An award of damages by a medical malpractice arbitration panel may be reduced by the amount of damages reimbursed by certain collateral sources (Md. Cts. & Jud. Proc. Code Ann. Sec. 3-2A-05(*h*) (Michie 1989)). (See table A-5 and Additional Notes to table A-5 for description of Maryland's arbitration panel provision.)

Massachusetts--Collateral source offset determined by the court (Mass. Gen. Laws Ann. ch. 231, Sec. 60G (Lexis 1992)).

Minnesota--*Offset is mandatory if defendant* brings in evidence of payments made to plaintiff by collateral sources (Minn. Stat. Sec. 548.36 (1992)).

Missouri--Damages paid by defendant (or his insurer or any authorized representative) prior to trial may be introduced as evidence. Such introduction shall constitute a waiver of any right to a credit against a judgment (R.S.Mo. Sec. 490.715 (1991)).

Montana--Collateral offset determined by judge after jury verdict (Mont. Code Ann. Sec. 27-1-308 (1992)).

Nevada--In actions against providers of health care, damage awards must be reduced by the amount of any prior payment made by health care provider to the injured person or claimant to meet reasonable expenses and other essential goods or reasonable living expenses (Nev. Rev. Stat. Sec. 42.020 (Supp. 1991)).

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ADDITIONAL NOTES FOR TABLE A-1 (Continued)

North Dakota--Under North Dakota law, collateral source "does not include life insurance, other death or retirement benefits, or any insurance or benefit purchased by the party recovering economic damages" (N.D.C.C. Sec. 32-03.2-06 (Lexis 1991). (An earlier collateral source offset provision was overturned in the courts--see above.)

Ohio--Collateral sources do not include insurance benefits paid for by plaintiff or employer (Ohio Rev. Code Ann. Sec. 2305.27 (Baldwin 1992)).

Rhode Island--Collateral source is mandatory if evidence is admitted (R.I. Gen. Laws Sec. 9-19-34 (1992)).

Washington--Washington's statute allows information on collateral source to be entered into trial, except the collateral source rule excludes insurance purchased by the plaintiff or insurance purchased by the employer for t' ; plaintiff (RCW Sec. 7.70.080). However, offset of collateral sources is governed by case law, and in practice there is no offset for collateral sources. See Sutton v. Shufelberger, 643 P.2d 920 (Ct. App. Wash. 1982); Bowman v. Whitelock, 717 P.2d. 303 (Ct. App. Wash. 1986).

SOURCE: O :ce of Technology Assessment, 1993.

FEB 18 '94 13:59 FROM NORCAL S F PAGE.009

Table A-2—Caps on Damages[a] and State Patient Compensation Funds, by State, 1993

Noneconomic cap	Economic and noneconomic	No statutory limits	PCF (Patient Compensation Fund)
AK: $500,000*	AL:[o] Total recovery capped at $1 million.*	AR AZ CT DC	FL: Physicians may participate in fund by obtaining liability coverage of $250,000 per claim and $500,000 per occurrence. Fund will pay malpractice awards exceeding maximum physician liability of $250,000 per claim, up to $1 million per claim and $3 million aggregate per policy.
CA: $250,000			
FL:[o] $350/250,000	CO: Total recovery capped at $1 million. $250,000 cap on noneconomic.*	DE GA IA IL[o] KY ME	
HI: $375,000			
ID:[o] $400,000*			
KS:[o] $250,000*	IN: $750,000	MN[n] MS MT NC	IN: Provider not liable for that portion of any malpractice award which exceeds $100,000. Any amount due the plaintiff which is in excess of the total liability of all health care providers, shall be paid from the PCF, with total payments from the PCF not to exceed $750,000.
MD: $350,000	LA: $500,000*		
MA: $500,000	NE: $1,250,000	*ND[o] NH[o]	
MO: $465,000*	NM: $500,000*	NJ NV	
OR: $500,000	SD: $1,000,000*	NY OH[o]	
UT: $250,000	VA: $1,000,000	OK[R] PA	
WV: $1,000,000		RI SC	KS: Physicians must carry $200,000 in malpractice insurance per claim ($600,000 per annum) then can choose one of three options for excess coverage from PCF. For each option, the physician pays the initial $200,000 in damages and then the fund will pay some portion of the remainder depending on how the physician chooses to distribute fund liability across potential claims: 1) fund liable for next $100,000 per claim ($300,000 aggregate per provider); 2) fund liable for next $300,000 ($900,000 aggregate per provider); and 3) fund liable for up to $800,000 per claim.
WI: $1,000,000		TN *TX[o] VT WA[o] WY	

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Table A-2–Caps on Damages[a] and State Patient Compensation Funds, by State, 1993 (Continued)

Noneconomic cap	Economic and noneconomic	No statutory limits	PCF (Patient Compensation Fund)
			LA: Provider liability limited to $100,000 for injuries or death to plaintiff. Fund will pay total amount recoverable for all injuries or death of a plaintiff exclusive of future medical care and related benefits, up to $400,000 for private providers. The State pays all damages up to $500,000 for State health care providers.
			NE: The PCF shall cover liability exceeding $200,000 up to $1.25 million.
			NM: Health care provider liability is capped at $100,000, with the remainder to be paid by the PCF. Total payment from PCF not to exceed $500,000 per occurrence per year.
			PA: The fund shall pay any amount exceeding $100,000 per occurrence, up to $1 million per claim.
			SC: The fund will pay awards in excess of $100,000 per claim (no upper limit).
			WI: Physicians must have $400,000 of malpractice coverage per incident and $1,000,000 in coverage per annum. The fund will pay for damages exceeding the physician's coverage. Each health care provider is also assessed an annual fee to help finance the fund.

[a]NOTE: OTA's review did not include caps that apply only, or separately, to claims against State-employed or State-owned health care providers.

O = Provision overturned.
R = Provision repealed.

*See additional notes on following pages.

SOURCE: Office of Technology Assessment, 1993.

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ADDITIONAL NOTES FOR TABLE A-2

Cases Overturning Caps on Damages:

Alabama–Moore v. Mobile Infirmary, 592 So.2d 156 (Ala. 1991) ($400,000 cap on noneconomic and punitive damages overturned, but $1 million cap on total recovery not challenged–see notes below).

Florida–Smith v. Department of Insurance, 507 So.2d 1080 (Fla. 1987).

Idaho–Jones v. State Board of Medicine 555 P.2d 399 (Idaho 1976) *cert denied* 431 U.S. 914 (1977).

Illinois–Wright v. Central DuPage Hospital, 347 N.E.2d 736 (Ill. 1976).

Kansas–Kansas Malpractice Victims Coalition v. Bell, 757 P.2d 251 (Kan. 1988) (cap on total damages and noneconomic damages in medical malpractice cases overturned).

New Hampshire–Brannigan v. Usitalo, 587 A.2d 1232 (N.H. 1991).

North Dakota–Arneson v. Olson, 270 N.W.2d. 125 (N.D. 1978).

Ohio–Morris v. Savoy, 576 N.E.2d 765 (Ohio 1991).

Texas–Lucas v. U.S., 757 S.W.2d 687 (Tex. 1988); Baptist Hospital of S.E. Texas v. Barber, 672 S.W.2d 296 (Tex. App. 1984), *aff'd*. 714 S.W.2d 310 (Tex. 1986).

Washington–Sophie v. Fibreboard Corporation, 771 P.2d 711 (Wash. 1989).

Selected Additional Information:

Alabama–Total recovery in medical malpractice cases must not exceed $1 million. If jury returns a verdict in excess of $1 million, judge must reduce it to $1 million or lesser amount as deemed appropriate. Mistrial declared if jury is informed of cap beforehand. Total cap is adjusted annually to reflect changes in the consumer price index. (Ala. Rev. Stat. Sec. 6-5-547 (1987)) Separate cap on noneconomic damages was overturned (see above).

Alaska–Limit does not apply to damages for disfigurement or severe physical impairment (Alaska Stats. Supp. Sec. 9.17.010 (1992))

Colorado–Court has some discretion to exceed cap limit (Colo. Rev. Stat. Sec. 13-64-302 (1992)).

Florida–In arbitration, noneconomic damages limited to $250,000 per incident. Economic damages limited to 80 percent of wage loss and loss of earning capacity and medical expenses, offset by collateral sources. If defendant refuses to arbitrate, the claim will proceed to trial and there will be no limit on damages. In addition, if plaintiff wins at trial, she will be awarded prejudgment interest and attorney fees up to 25 percent of award. If claimant rejects arbitration, noneconomic damages at trial limited to $350,000. Economic damages limited to 80 percent of wage losses and medical expenses (Fla. Stat. Secs. 766.207-209 (1993 Supp.)). This provision was recently challenged. The trial court found the provision unconstitutional, as did the District Court of Appeals. However, the Supreme Court of Florida reversed holding the limitation on damages imposed if the plaintiff does not accept arbitration is not unconstitutional. University of Miami v. Echarte, 585 So.2d 293 (Fla. App. 3 Dist. 1991) *reversed and remanded* University of Miami v. Echarte, 618 So.2d 189 (Fla. 1993).

Idaho–Original cap applied to malpractice suits only and was overturned (see above). Existing cap applies to all torts. Cap increases or decreases yearly ac-

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ADDITIONAL NOTES FOR TABLE A-2 (Continued)

cording to the State's adjustment of the average annual wage (Idaho Code Sec. 6-1603 (Lexis 1993)).

Kansas--Original cap for malpractice suits only was overturned (see above). Existing cap applies to all personal injury suits.

Louisiana--The total amount of damages for a medical malpractice claim against a "qualified provider" may not exceed $500,000, plus interest and costs, exclusive of future medical care and related benefits. Qualification under the patient compensation fund requires a private health care provider to pay into the fund and provide evidence of insurance up to $100,000 per claim. "Qualified providers" exclude State health care providers. For qualified providers, the provider is liable for up to $100,000 and the State patient compensation fund for the remaining amount not to exceed $400,000 exclusive of future medical care and related benefits. For State health care providers, total damages, exclusive of future medical care and related benefits, may not exceed $500,000 (LA-R.S. Sec. 40:1299.42-45; LA-R.S. Sec. 40: 1299.39-39.1) Future medical expenses and related benefits in excess of $500,000 are paid as submitted.

Massachusetts--Pain and suffering capped at $500,000 unless there is substantial or permanent loss or impairment of bodily function o substantial disfigurement or other circumstances making limitation unfair (Mass. Gen. Laws Ann. ch. 231, Sec. 60H (Lexis 1992)).

Michigan--Noneconomic damages limited to $225,000 unless there has been a death, intentional tort, injury to reproductive system, foreign body wrongfully left inside the patient's body, concealment o injury by health care provider, limb or organ wrongfully removed or patient has lost vital bodily function. The limit on damages increases each year by the increase in Consumer Price Index (M.C.L. Sec. 600.1483 (1990)). The exceptions to the cap are so extensive that, as of August 1993, the cap had yet to be applied to a single case (154).

Missouri--Noneconomic damages recoverable by injured party capped at $465,000 per defendant per occurrence (1993 limit). Original limit was $350,000, but this is adjusted annually to reflect changes in the implicit price deflator for personal consumption published by the U.S. Department of Commerce (R.S.Mo., Sec. 538.210 (1986)).

New Mexico--The limitation on caps on damages does not apply to past and future medical care and related benefits (N.M. Stat. Ann. Sec. 41-5-6, 41-5-7 (Michie 1989)). These expenses will be paid on an ongoing basis. In 1995, the cap on damages will be increased to $600,000 and the Patient Compensation Fund will require the physician to be responsible for the first $200,000 of a malpractice claim (N.M. Stat. Ann. Sec. 41-5-6 (Michie 1989)).

North Dakota--Awards in excess of $250,000 may be reviewed for reasonableness (N.D. C.C. Sec. 32-03.2-08 (Lexis 1991)).

South Dakota--South Dakota's medical malpractice cap is currently being challenged in the court on constitutional grounds (Schultz, J.S., Legal Counsel, Division of Administration, Office of Administrative Services, Department of Health, South Dakota, letter to the Office of Technology Assessment, U.S. Congress, Washington, DC, April 2, 1993).

Texas--The $500,000 limit on damages in medical malpractice (Vernon's Texas Civil Stat. Art. 4590i, Sec. 16.02-11.03 (Supp. 1992)) was struck down as unconstitutional in Lucas v. U.S., 757 S.W.2d 687 (Tex. 1988). The Texas Supreme Court subsequently decided that the damage limitation was constitutional in wrongful death cases o ly (Rose v. Doctors Hosp., 801 S.W.2d 841 (Tex. 1990)).

SOURCE: Office of Technology Assessment, 1993.

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Table A-3—Periodic Payment of Awards,[a] by State, 1993

Mandatory	Discretionary	No provision
AL > $150,000*	AK*	DC
AZ	AR > $100,000	GA
CA > $50,000	CT > $200,000*	HI
CO > $150,000	DE	KS°
IL > $250,000*	FL > $250,000	KY
LA ≥ $500,000*	IA	MA
ME ≥ $250,000	ID > $100,000	MS
MI	IN	NC
MO > $100,000*	MD	NE
NM	MN > $100,000	NH°
OH > $200,000	MT > $100,000	NJ
SD > $200,000	ND*	NV
UT > $100,000	NY > $250,000*	OK
WA > $100,000*	OR	PA
	RI > $150,000*	TN
	SC > $100,000	TX
		VA
		VT
		WI
		WV
		WY

[a]Periodic payment provisions are often not triggered unless the award reaches a threshold amount. The specific thresholds are noted parenthetically in the table. Periodic payment provisions apply only to future damages. The schedule of payments is either negotiated by the parties or determined by the court. Some statutes offer guidelines for determining the schedule. The mandatory category includes statutes in which periodic payment is mandatory upon reaching the threshold or upon unilateral request by defendant or plaintiff.

° = Provision overturned.

* See additional notes on following page.

SOURCE: Office of Technology Assessment, 1993.

ADDITIONAL NOTES FOR TABLE A-3

Cases Overturning Periodic Payment Provisions:

Kansas--Kansas Malpractice Victims Coalition v. Bell, 757 P.2d 251 (Kan. 1988).

New Hampshire--Carson v. Maurer, 424 A.2d 825 (N.H. 1980).

Selected Additional Information:

Alabama--A recent Alabama Supreme Court case overturned a periodic payment provision that applied to personal injury suits, excluding malpractice. This provision was similar to the medical malpractice periodic payment provision, thereby calling its constitutionality into question (Clark v. Container Corp., 589 So.2d 184 (Ala. 1991)).

Alaska--Periodic payment of future damages is discretionary in personal injury cases except if requested by injured party (Alaska Stat. Supp. Sec. 09.17.040 (1992)).

Connecticut--When award reaches $200,000 or more, parties have 60 days to negotiate periodic payment agreement. If no agreement reached, a lump sum award will be awarded (Conn. Gen. Stat. Sec. 52-225d).

Florida--Mandatory periodic payment of future losses exceeding $250,000, but defendant may elect to pay lump sum for future economic loss and expenses, reduced to future present value (Fla. Stat. Sec. 766.78 (1986)).

Illinois--Both parties can agree to elect periodic payment, or, if future damages exceed $250,000, plaintiff can unilaterally elect periodic payment. Defendant can elect periodic payment if: 1) the future economic damages are in excess of $250,000, 2) defendant can produce a security (e.g. bond, annuity) in the amount of the claim for both past or future damages, or $500,000, whichever is less, and 3) future damages likely to occur over a period of more than one year (735 ILCS Sec. 5/2-1705 (West 1992)).

Louisiana--If damages exceed $500,000, the PCF or the State pays future medical care and related benefits as they are submitted. (See table A-2 for a description of Louisiana's cap on damages provision.)

Missouri--Mandatory periodic payment of future damages at request of any party (R.S.Mo. Sec. 538.220, (1991)).

New York--Any requirement to pay periodically applies to no more than the portion of future damages in excess of $250,000. The parties may agree to lump sum payments of future damages otherwise payable periodically (N.Y. CPLR Sec. 5031 (McKinney 1992)).

North Dakota--The court has discretion to permit the trier of fact to make a special finding regarding future economic damages if an injured party claims future economic damages for continuing institutional or custodial care that will be required for a period of more than two years (N.D.C.C. Sec. 32-03.2-09 (1989)).

Rhode Island--Mandatory conference for purposes of determining viability of voluntary agreement for periodic damage (R.I. Gen. Laws Secs. 9-21-12; 9-12-13 (Lexis 1991)).

Washington--Mandatory at the request of parties (Wash. Rev. Code Sec. 4.56.260 (1986)).

SOURCE: Office of Technology Assessment, 1993.

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Table A-4–Statutes of Limitations,[a] by State, 1993

	Years within date of injury	Years within date of discovery	Maximum number of years	Foreign object exception**
AL:	2 years	6 months	4 years	-
AK:	-	*2 years	-	-
AR:	2 years	-	-	1 year
AZ:	-	[illegible] years	-	-
CA:	3 years	1 year	3 years	1 year
CO:	-	2 years	3 years	2 years
CT:	-	2 years	3 years	-
DC:	3 year	-	-	-
DE:	2 years	3 years	-	-
FL:	2 years	2 years	4 years	-
GA:	2 years*	-	5 years	1 year
HI:	-	2 years	6 years	-
ID:	2 years	-	-	1 year*
IN:	-	2 years	-	-
IL:	-	2 years	4 years	-
IA:	-	2 years	6 years	2 years
KS:	-	2 years	4 years	-
KY:	-	1 year	5 years	-
LA:	1 year*	1 year	3 years	-
MA:	3 years	-	7 years	General Exception
ME:	3 years	-	3 years	Upon "reasonable discovery"
MD:	5 years	3 years	-	Exception for minors only
MI:	2 years*	6 months	6 years	6 months
MN:	2 years*	-	-	-
MS:	-	2 years	-	-
MO:	-	2 years	10 years	2 years after discovery, 10 years max.
MT:	3 years	3 years	5 years	-
NE:	2 years	1 year	10 years	-
NV:	4 years	2 years	-	-
NH:	3 years	3 years	-	-
NJ:	-	2 years*	-	-
NM:	3 years*	-	-	-
NY:	2 years, 6 months	-	-	1 year
NC:	3 years	-	4 years	1 year after discovery, 10 year max
ND:	-	2 years	6 years	-
OH:	-	1 year	-	-
OK:	-	2 years	3 years O*	-
OR:	-	2 years	5 years	-
PA:	2 years	2 years	-	-
RI:	3 years	3 years	-	-
SC:	3 years	3 years	6 years	2 years
SD:	2 years	-	-	-
TN:	-	1 year	3 years	1 year
TX:	2 years*	-	-	-
UT:	-	2 years	4 years	1 year

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Table A-4--Statutes of Limitations,[a] by State, 1993 (Continued)

Years within date of injury	Years within date of discovery	Maximum number of years	Foreign object exception**
VT: 3 years	2 years	7 years	2 years
VA: 2 years	-	10 years	1 year
WA: 3 years	1 year	8 years	1 year
WV: 2 years	2 years	10 years	*
WI: 3 years	1 year	5 years	1 year
WY: 2-2.5 years	2 years	*	-

Explanatory Notes for Table A-4

Column 1: Statutory time limit for bringing a suit is measured from the time the injury occurs or from the date of termination of the medical treatment that led to the claim.

Column 2: The statutory time limit for bringing suit is measured from the time at which the plaintiff could have reasonably discovered the injury. Often States allow the time limit to run from either the time of injury or the time of discovery, depending on the nature of the injury.

Column 3: The maximum period in which a claim can be brought, regardless of whether the limit is measured from the date of injury or act or the date of discovery. In most States, this maximum does not apply to the foreign body exception (see column 4).

Column 4: Because of the difficulty of discovering a foreign body (e.g., a surgical sponge) left inside a patient during invasive procedures, a number of States make special exceptions to the statute of limitations for these cases.

[a]This table does not cover special provisions for minors, disabled plaintiffs or cases involving fraud or concealment on the part of the healthcare provider.

O = Provision overturned.

* See additional notes on following page.

** Within year of discovery, maximum number of years do not apply unless stated.

SOURCE: Office of Technology Assessment, 1993.

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