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HEALTH POLICY BULLETIN

FOCUS: WHERE DO WE GO FROM HERE?

A well-attended Michigan Health Policy Forum heard Robben W. Fleming, the governor's special factfinder on medical liability, discuss his final report to Governor James Blanchard (dated November 1990). His basic conclusions? "The problem cannot be solved unless we accept that there is more than enough blame to spread around," and "the changes made in 1986 were not enough to reform the system properly." To those who argue that the drop in the number of suits filed suggests the reforms are working, he responded "The pattern, in looking at the history of legislative changes, is an initial drop-off and then a surge again."

Does he see any solutions? Yes. He suggests four major steps that must be undertaken together. First, reduce the incidence of malpractice by adopting a system of licensure and discipline that requires the relicensing and retesting of physicians whose patterns of practice suggest a higher-than-standard risk for his/her specialty. Relicensing and retesting of physicians would include not only written examinations but also an audit of a physician's practice. The state, acting cooperatively with medical specialty societies, would be responsible for this function.

Second, hospitals would have to put into place objective and uniform standards for risk management so that patients around the state would be protected equally. Standards would be set by the state, which would report to the public on the system. Hospitals would fund the system. Insurers would be required to provide risk management services to their insureds and to apply a common set of sanctions to those who did not comply with standards.

Third, reform the adjudicatory system so that early settlement of claims is more likely, transaction costs are lowered, damages are limited, and small claims can be adjudicated. The plaintiff could proceed from a mandatory settlement conference to arbitration to trial. Disincentives to discourage either party from proceeding to trial would be built into the system. Damages would be limited by category. Fleming proposes collapsing the nine categories of injury currently used by the Michigan Insurance Bureau into three: Damages for minor or temporary injuries would be limited to $300,000, damages for major and permanent injuries would be limited to $1.5 million, and damages for deaths would be limited to $600,000. The $1.5 million limit could be exceeded by another $500,000 if it was conclusively demonstrated that this amount would not cover the costs of future medical or custodial care for the injured person. (These limits do not include prejudgment interest.) In return for limits on damages, physicians would be required to carry coverage of $200,000/$600,000 and hospitals at least $1.5 million.

Finally, Fleming would like to see rate filings by insurers subject to a second opinion from an independent actuary selected by the Insurance Commissioner but paid for by the insurer. He proposes that rate filings be monitored in this fashion for five years, thereby, it is hoped, increasing the visibility of and public confidence in rate-making by insurers and regulation by the insurance bureau. Michael Franck, executive director, State Bar of Michigan, and moderator of the meeting, noted that the proposals did not suggest limiting attorney fees. Fleming indicated that attorney fees are a function of court rules.

Representatives from four organizations commented on the Fleming Report. Victor Adamo, president, Physicians Insurance Company of Michigan, did not see much of a public policy role for insurers. He did observe that the proposals made sense and would introduce stability into the system; however, he felt the caps were too high and that allowing exceptions to the $1.5 million limit was bad policy. Susan Adelman, M.D., president, Michigan State Medical Society, commented that physicians' objectives were to make insurance affordable, that the limits in the Fleming proposals did not jibe with current insurance limits, and that mandating insurance was not a good idea.

David Getto, a plaintiff's attorney representing the Michigan Trial Lawyers Association, said that the implicit criticism of the jury system was elitist. He said the main problem with the proposals was that they always talked about the broad picture: "It is the details that caused the talks to break down." Noting that the only consumer advocates present were the trial lawyers, he reflected his group's steadfast opposition to limits on damages. Dennis Paradis, group vice president for governmental relations, Michigan Hospital Association, regarded the Fleming Report as "an excellent starting point, but it contains no indication of the problems facing the hospital industry."

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FOCUS: THE PROVIDER SOLUTION

A coalition of health care providers—the Michigan State Medical Society (MSMS), the Michigan Hospital Association (MHA), and the Michigan Association of Osteopathic Physicians and Surgeons (MAOPS)—is ready to have Senator Dan DeGrow, R-Port Huron, introduce within the next two weeks a bill known as the Michigan Medical Liability Determination Act. The proposed legislation is designed to remedy the gaps that providers feel were left when the 1986 medical liability tort reforms were passed.

The plan would create a nine-member Medical Liability Determination Board appointed by the governor and confirmed by the Senate. The board would have the power to pick panels consisting of one circuit court judge (the panel chair), one physician, and one public member. A person filing a medical liability suit could have the complaint heard by the board through one of the panels or in court; that choice would be mutually exclusive—the plaintiff could not use material presented before the board in a court case. The board also would have the authority to set a schedule of defined benefits for noneconomic damages for injuries that would apply to cases decided by the board and by the courts. Decisions of the panels could be appealed to the board, and then to the Michigan Appellate Court.

Definitions of such terms as *collateral benefits, net economic and net noneconomic loss, lost income, permanent impairment, severe temporary impairment, life expectancy,* and *expert witness* are tight, and there are limits on the amount of damages a plaintiff can recover as well as on attorney fees. The heart of the proposal lies in the relationships between the definitions and the formulas used to calculate benefits and establish caps for recovery in medical liability suits.

The formula for determining lost income for someone employed prior to the alleged injury is 70 percent of income minus 70 percent of income derived from substitute work actually performed or that the plaintiff unreasonably refused to perform. All collateral benefits are subtracted for purposes of determining lost income. Lost income minus collateral benefits is capped at four times the state average weekly wage times the number of weeks of lost income. Life expectancy is calculated using the reduced life expectancy resulting from some injuries. Death benefits payable to dependents are limited to 500 times the state's average weekly wage. Surviving spouses would receive payments until remarriage or seven years from the plaintiff's death, whichever came first. Clauses allowing for the effect of inflation are built in. Attorney fees are capped at a maximum of 25 percent of all damages plus reasonable out-of-pocket expenses. Attorneys would be required to document the number of hours, their reasonable hourly fees, and their out-of-pocket expenses.

Kevin Kelly, assistant director, MSMS, is optimistic. He said, "We (MSMS, MHA, and MAOPS) have made medical liability our number one priority. This is only the beginning. Most legislators will tell you that the environment [for tort reform] is as good as it has ever been, based on concerns for cost and access." Kelly added that the group intends to petition the Michigan Supreme Court for changes in contingency fees and is looking at ways to make high-risk and obstetrical care available to high-risk individuals.

Dennis Paradis, group vice-president for governmental relations, MHA, thinks that the proposal "addresses most of the issues that are necessary to make our adjudicatory system efficient. The Fleming research clearly shows that we are mired in an inefficient system. With some changes the system can be made to compensate victims in a timely, efficient, and equitable manner. We think the proposal makes the changes that will let this happen." Paradis also pointed out, "if Michigan hospitals were paying the national average per bed [for medical liability insurance] instead of three and a half times the average, that would free up $115 million for services to the poor."

Others are less enthusiastic. Jane Bailey, executive director, Michigan Trial Lawyers' Association, notes that the proposal is a spinoff of an American Medical Association model that has been rejected in most of the states where it has surfaced. In her view, "there is no need for it. It is an attempt to take the focus off the fact that there is no medical malpractice insurance crisis in the state. The number of doctors is up, the number of suits is down, and the net incomes of physicians are up." Forced to choose, Bailey prefers the Fleming proposals.

The proposal is silent on some issues. For example, while the Medical Liability Determination Board has the authority to define benefits for categories of injury, there appear to be no provisions for oversight or review. The definition of collateral benefits is expanded beyond the current law but does not make any provision for the subrogation rights of health insurers and federal and state programs. Joint and several liability is abolished for health care providers but not for nonhealth-care providers involved in the same suit, a situation that implies a nonhealth-care defendant could become responsible for an insolvent provider's liability.

OF INTEREST

The legislature expects to be preoccupied with the budget and the deficit for the next few months. HBs 4038–4039 and SBs 31–32 (assisted suicide legislation) are in committee and hearings are being held. No health care legislation is likely to emerge from committee this month.

—Frances L. Faverman, Editor