

SRJ 35: Study of Health Care

Medical Malpractice: Montana's Approach to Limiting Liability

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Background

The months-long debate over changing the nation's health care and health insurance systems has touched on numerous topics, including possible changes to medical liability laws. Supporters of tort reform say limiting a health care provider's exposure to malpractice claims and costs may reduce overall health care spending — partly by reducing malpractice insurance costs and partly by reducing such "defensive" medicine practices as the ordering of additional tests or procedures.

The two health care reform bills pending in Congress both include funding for states to take up medical liability issues. In addition, President Obama in September 2009 made \$25 million in grant funds available to states or health care systems that submit proposals for projects that would reduce medical liability and improve patient safety.

The arguments being made at the national level both for and against tort reform echo those that have been heard in some state legislatures over the years. Many states have already made at least some changes to their medical liability laws.

This briefing paper summarizes the measures the Montana Legislature has put into place to improve the state's medical liability climate.

Tort Reform: A Long History in Montana

Changes to Montana's general liability and medical malpractice laws have occurred on a fairly regular basis since the 1970s. In addition, interim studies in each of the past three decades have reviewed either general liability or medical liability issues. Each resulted in legislative proposals, many of which were adopted. Lawmakers also enacted other changes not related to a specific study. As a result, the more recent interim studies have concluded that Montana's laws provide many of the elements sought by advocates of tort reform in the health care arena.

Following is a brief summary of each study.

- In 1986, lawmakers approved an interim study of liability issues after failing in a March special session to pass proposed constitutional amendments

involving liability limits. The special session was called to deal with concerns related to rising liability insurance costs and with a Montana Supreme Court ruling that overturned limits on liability for governmental entities.

The study resulted in seven proposals involving various aspects of the liability issue, including comparative negligence and joint liability, mandatory arbitration for certain cases, and periodic payment of damages.

- The 1993 Legislature approved a study of medical malpractice and tort reform issues because of concerns that many Montana communities were having trouble recruiting or retaining health care providers. The difficulty was attributed in part to the costs of obtaining or renewing malpractice insurance.

The study resulted in two proposals for minor changes to the statute of limitations in medical malpractice cases and to the procedures used by the Montana Medical Legal Panel, which reviews all medical malpractice claims before they're filed in court. The final report on the study noted that the interim committee did not find evidence of a medical malpractice crisis or that tort reforms would result in health care cost savings, adding: "*...the recommendations reflect an attempt to fine-tune a process that, in the Subcommittee's view, is currently working.*"¹

- The 2003 Legislature approved a study of medical liability insurance issues that began to emerge during the legislative session that year. The study resulted in four bills that were approved in 2005, changing some aspects of medical liability laws. However, the final report of the study noted that the 1995 Legislature had approved many tort reforms that were favored by health care providers and the liability insurance industry. The report added: "*...it is debatable whether additional tort reforms can or will visibly affect (medical malpractice liability insurance) premiums in Montana.*"²

Liability, Health Care Costs, and the Congressional Budget Office

The nonpartisan Congressional Budget Office (CBO) has tried to assess the potential savings that tort reform could create in the health care system, by periodically analyzing the effects of a specified package of reforms. The office had

¹ Connie F. Erickson and Susan Byorth Fox, "Medical Malpractice and Tort Reform: Issues of Insurance Costs, Coverage, Caps, and Compensation," *Montana Legislative Council*, November 1994, P. 64.

² David D. Bohyer, "Diagnosing the Ailment — Prescribing a Cure," *Montana Legislative Services Division*, Sept. 17, 2004, P. 86.

concluded in the past that those reforms could lower national health care spending by 0.2% by reducing the premiums that health care providers pay for medical malpractice insurance. But until recently, the office was reluctant to say that the changes would also reduce a provider's use of health care services; it believed past studies on the topic were inconclusive.³

However, the results of several recent studies prompted the CBO to conclude in October 2009 that the package of reforms could save an additional 0.3% in national health care spending. The savings would occur because providers would reduce their use of tests and other health care services. The combined savings of 0.5% would equal \$11 billion in 2009.⁴

Montana Laws and the CBO Benchmark

The Montana Legislature has passed some version of nearly every proposal included in the package of reforms the CBO uses as a benchmark in its analyses. Following is a list of those reforms⁵ and the Montana law most closely related to each item.

- **CBO:** A cap of \$250,000 on awards for noneconomic damages.
Montana: A cap of \$250,000 on awards for past and future noneconomic damages, for a single incident of malpractice (25-9-411, MCA).
- **CBO:** A cap on awards for punitive damages of \$500,000 or two times the award for economic damages, whichever is greater.
Montana: A cap on punitive damages of no more than \$10 million or 3% of a defendant's net worth, whichever is less, for any type of liability action (27-1-220, MCA). Punitive damages may be awarded only when the defendant is found guilty of actual fraud or malice (27-1-221, MCA).
- **CBO:** Modification of the "collateral source" rule to allow evidence of income from sources such as health and life insurance, workers' compensation, and automobile insurance to be introduced at trials or to require that such income be subtracted from awards decided by juries.

³ Letter to Sen. Orrin G. Hatch from Douglas W. Elmendorf, Director of the Congressional Budget Office, Oct. 9, 2009, P. 3.

⁴ Ibid.

⁵ Ibid, P. 2.

Montana: In any liability action involving bodily injury or death, an award of more than \$50,000 must be reduced by any amount that is paid by or payable from another source (27-1-308, MCA).

- **CBO:** A statute of limitations of one year for adults and three years for children from the date of discovery of an injury.

Montana: A statute of limitations of three years from the date of injury or three years from the discovery of the injury, up to a maximum five years between the injury and the filing of the claim. An exception is allowed for the death or injury of a child under age 4; the statute of limitations begins running when the child reaches his or her eighth birthday or dies, whichever occurs first (27-2-205, MCA).

- **CBO:** Replacement of joint-and-several liability with a fair-share rule, under which a defendant in a lawsuit is liable only for the percentage of the final award that is equal to his or her share of responsibility for the injury.

Montana: A defendant in a liability claim may be held liable only for the percentage of negligence attributable to that defendant, if the defendant's negligence is found to be 50% or less of the combined negligence of all persons involved in the claim (27-1-703, MCA). However, if a person's negligence is found to be more than 50% of the combined negligence, that person could be held liable for all or a higher percentage of the damages.

Montana Laws and the Federal Reform Legislation

Both the House and Senate health care reform bills contain provisions encouraging states to act on medical liability issues. The bills don't contain specific requirements but do suggest possible approaches. Those approaches are described below, followed by Montana laws that could be considered relevant to the federal proposals.

- **Federal Reforms:** The House bill (HR 3962) would provide incentive payments to states for medical liability reforms that meet certain criteria; the amount of the payment would be determined at a future date. The Senate bill (HR 3590) would provide up to \$500,000 to a state to plan for demonstration projects that offer alternatives to the filing of lawsuits for alleged malpractice. The bills vary in some details but both require that the reforms or alternatives:
 - ▶ make the medical liability system more reliable through prevention or prompt and fair resolution of disputes;
 - ▶ encourage disclosure of health care errors; and
 - ▶ maintain access to affordable liability insurance.

- **Montana:** The federal bills would not provide incentives or planning grants for existing state laws or programs that meet the criteria set out in the bills. But Montana has enacted two efforts that could be seen as meeting some aspect of the incentives for dispute resolution and disclosure of health care errors:
 - ▶ A health care provider's apology or expression of condolence may not be used as evidence in a malpractice claim (26-1-814, MCA).
 - ▶ The Montana Medical Legal Panel, made up of health care providers and attorneys, must review of any medical malpractice claim before it is filed in court (Title 27, chapter 6, MCA).

Montana Medical Legal Panel

The 1977 Legislature created the Montana Medical Legal Panel with a goal that sounds strikingly similar to the language the federal bills use in discussing medical liability. The Legislature stated its goal in 27-6-102, MCA:

"The purpose of this chapter is to prevent where possible the filing in court of actions against health care providers and their employees for professional liability in situations where the facts do not permit at least a reasonable inference of malpractice and to make possible the fair and equitable disposition of such claims against health care providers as are or reasonably may be well founded."

The statutes require that a panel of three health care providers and three attorneys be appointed to handle each malpractice claim that is submitted. The members have access to all medical and hospital records related to the claim and hold a hearing at which the claimant presents information about the alleged malpractice. Both the claimant and the health care provider may call witnesses and submit written materials, but the hearing is informal and no transcript is kept.

The review panel must determine whether:

- the claimant has presented substantial evidence of the alleged acts;
- the acts constitute malpractice; and
- a reasonable medical probability exists that the acts injured the patient.

The panel may recommend an award and approve and discuss settlement agreements. However, its decision is not binding on either party and is not admissible as evidence in court, if a lawsuit is filed.

The panel's 2008 Annual Report shows that from 1998 to 2008, an average of 255 health care providers of one type or another were named in medical malpractice

claims. (One claim may involve more than one provider.) The number of providers named in claims ranged from a high of 288 in 2005 to a low of 194 in 2008.

The majority of the claims filed each year were against physicians, with an average of 169 physicians named in claims during the 11-year period.

Because claims may take several years to work their way through the full legal process, statistics showing the final resolution of claims filed in any one year are not available in the report. Thus the figures do not add up to 100%. However, the report shows that during the 11-year period, an average of 250 providers a year were named in claims that either went to a hearing or were resolved in one way or another before the hearing. The resolution of those claims averaged out as follows:⁶

- the claims against 54 providers were either abandoned, settled or subject to a special ruling without a hearing before the panel, thus resolving claims against 20% of the providers;
- the claims against 80 of the remaining 196 providers, or 41%, were dropped or settled after a hearing before the review panel but before a lawsuit was filed; and
- lawsuits were filed in court against 88 of these remaining 196 providers, or 45%.

For the 88 providers who were named in court actions:

- the claims against 64 of the providers, or 73%, were dropped or settled after the suit was filed but before a trial;
- the claims against 3.5 of the providers, on average, resulted in a summary judgment by the court or a dismissal of the case; and
- the claims against 2 providers went to a jury trial.

Of those lawsuits that went to trial, two-thirds were decided in favor of the health care provider. When the provider is a doctor, juries have almost always found in favor of the physician.

⁶ "2008 Annual Report," *Montana Medical Legal Panel*, June 22, 2009, P. 3.

Additional Montana Laws Affecting Medical Liability

The Montana Legislature has enacted several other laws designed to eliminate or reduce a health care provider's liability in certain instances or to provide other protections in tort actions, including laws to:

- limit liability for doctors, volunteer firefighters, volunteer emergency medical services providers, and other individuals who provide emergency medical care at the scene of an accident or emergency (27-1-714, MCA);
- limit liability for doctors, nurses, or hospitals that provide emergency care to the patient of a direct-entry midwife (27-1-734, MCA);
- limit liability for medical practitioners or dental hygienists who provide free care in clinical or community-based programs for uninsured persons (27-1-736, MCA);
- require periodic — rather than lump-sum — payment of future damages in medical malpractice cases where more than \$50,000 in future damages is awarded and one of the parties to the suit asked for periodic payment before the judgment was entered (25-9-412, MCA);
- require that expert witnesses in medical malpractice cases meet several criteria, including a requirement that the person be a licensed health care provider who in the past five years has either:
 - routinely treated the diagnosis or condition that is the subject of the malpractice claim; or
 - been an instructor in an accredited medical education or research program related to the diagnosis or condition (26-2-601, MCA);
- provide immunity from liability for a health care provider for an act or omission by a person alleged to have been an ostensible agent of the provider at the time of occurrence, unless the provider does not have a policy requiring that persons providing independent professional services must have insurance (28-10-103, MCA);
- provide immunity to a health care provider in a malpractice claim for an act or omission by a person or entity that was not an employee or agent of the provider at the time of the act or omission (27-1-738, MCA); and
- limit the damages that may be awarded for a reduced chance of recovery due to malpractice to only the percentage of reduced chance that was attributable to the negligent act or omission and not to the initial injury that may have led to medical intervention (27-1-739, MCA).

Medical Malpractice Insurance: A Fallback Position

Although the most recent legislative studies on medical liability concluded that Montana does not have a problem with availability of malpractice insurance, lawmakers in 2005 set up a mechanism for dealing with any future problems that may occur. The Legislature approved a bill creating a medical malpractice insurance joint underwriting association if market forces — such as insurer insolvency or withdrawal from the market — make it difficult for health care providers to obtain malpractice insurance.

Under Title 33, chapter 23, part 5, the state Insurance Commissioner must form a market assistance plan for medical malpractice insurance if it appears that the insurance is not reasonably available. Under this plan, insurers could voluntarily underwrite the risks for health care providers. If the plan cannot be formed because too few insurers are willing to participate or if the plan does not achieve desired results, the commissioner could put into effect a joint underwriting association that consists of all insurers authorized to provide casualty insurance in the state. The association could then begin issuing malpractice policies.

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