Summary and Analysis of SB 475
Illinois Hospital Association
June 16, 2005

This memo highlights the main provisions of Senate Bill 475, the medical liability reform legislation passed by the Illinois General Assembly on May 30, 2005. The bill contains reforms in three areas - litigation, physician regulation, and insurance regulation; the memo covers each of these areas separately, not necessarily in the order in which they appear in the bill.

SB 475 will be effective upon the governor's signature. The sections listed under the heading "Litigation Provisions" will apply to medical liability cases accruing on or after the effective date, i.e., to injuries occurring on or after the governor signs the bill. To obtain the full text of SB 475, access the Illinois General Assembly website at www.ilga.gov, and enter SB 475 in the first box on the left side of the screen. When the Bill Status page comes up, click on "Full Text." The "Enrolled" version should appear. That is the final version of the bill as it was passed by the General Assembly. Click on "Printer Friendly Version" before printing a copy.

In this memo, all commentary on Bill 475 appears in italics, so as to be easily distinguishable from the objective description of bill provisions. Boldface italics are used within the commentary sections, for ease in reading.

Litigation Provisions

Reasonable Caps on Non-economic Damages.

SB 475 caps non-economic damages at $1 Million for hospitals and $500,000 for doctors. These caps set a maximum liability for each defendant in a case but the amounts awarded are cumulative. For example, in a case involving three physicians, a plaintiff could recover up to $1.5 Million in non-economic damages or $500,000 per liable physician. No physician would be liable for more than $500,000 but the plaintiff could recover up to that amount from each physician found liable. Similarly, if the case involved one hospital and one physician the plaintiff could recover up to $1.5 Million in non-economic damages ($1 Million from the hospital and $500,000 from the physician).

> ***Almost 30 other states have caps***. *The majority of the states in this country have caps on non-economic damages in medical liability cases that range from a low of $250,000 to $1 Million. The limits in this bill fall squarely within this range. Other states have reasonably concluded that such amounts are fair and reasonable compensation for plaintiffs while protecting the public's access to health care.*

Caps strike a fair and reasonable balance between allowing litigants to recover substantial amounts for their non-economic losses and protecting the public health through greater access to health care*. There is no objectively correct amount for any particular non-economic loss. So there is nothing wrong or unfair about a legislatively determined range for juries to award damages for such losses. Such legislatively determined ranges are reasonable. Most states have enacted them without creating hardships for plaintiffs.*

This bill improves the situation for those with little or no economic loss*. This bill give plaintiffs who have little or no lost wage damages a presumed amount for such loss that is equal to the average weekly wage as determined under Illinois Workers' Compensation laws. This is an improvement over current law where people who have no lost wages get nothing.*

Non-economic damages are not related to the level of economic damage*. Non-economic damages are not supposed to be a substitute remedy for plaintiffs who suffer little or no economic harm. Under current law, non-economic damages do not go up automatically for plaintiffs that incur little or no economic loss. These are separate and distinct types of awards for separate and distinct forms of loss. The amount awarded in one area should not affect the amount awarded in the other area. Otherwise, people with high economic loss should get less (or zero) in non-economic damages. Recovery differences based on different circumstances of the plaintiff are an inherent part of the system –regardless of the presence of caps. Those differences do not make the current or reformed system unfair or unreasonable.*

The limitations on non-economic damages in this bill are also constitutional*. The Illinois Supreme Court decisions on caps do not apply to this bill, which is narrowly tailored to address our current medical liability crisis. In the mid-1980's – during a previous medical liability crisis – the Illinois General Assembly eliminated punitive damages in medical liability cases. An entire category of damages available in other tort cases was eliminated. The Illinois Supreme Court upheld that law in its 1987 Bernier decision. Why?*

Because (1) the legislature found that there was a medical liability crisis affecting access to health care by the public; and (2) the legislature tailored a solution directed only at medical liability cases. That's what the current bill does – it is directly tailored to address the public health problems caused by our medical liability crisis, which has been well established in numerous hearings in the Illinois House and Senate this session.

Annuities for Future Medical Expense.

Under this bill, either party in a medical liability case may elect to use an annuity to pay for 80% of the plaintiff's future medical and life care. Under this option, the defendant would pay the plaintiff 20% of the present cash value of the lump sum award for future medical care immediately and purchase an annuity contract that guarantees to pay for the remaining 80% of the cost of the plaintiff's medical care for the rest of the plaintiff's life. This option must be selected within five days of the verdict in the case.

Buying an annuity will cost the defendant a lot less than paying the full amount of the awarded lump sum*. Why? Because the lump sum award is based on the life expectancy of the average person, not the individual plaintiff. The annuity company will estimate life expectancy based on the plaintiff's actual medical condition. If the actual life expectancy is less than that of an average person, the cost of an annuity will be less than the lump sum awarded for future medical care.*

The annuity provisions of this bill also give plaintiffs the following protections:

1. Financial Hardship Protection. A plaintiff receiving payment for medical expenses under an annuity can "cash out" the annuity – that is, sell the right to receive the future payments in exchange for the present value of the contract in the case of hardship, subject to the approval of the court.

2. Protection from Default. If the annuity company defaults, the defendant will purchase a new annuity to make such payments for the rest of the plaintiff's life.

The benefits of using annuities for future medical care include:

1. ***For Plaintiffs****. Through the use of high quality annuities offered by well-funded institutions, plaintiffs are assured that all their medical needs will be covered for as long as the need exists. Studies show that, on average, plaintiffs who receive a single lump sum payment dissipate their funds within five years, while their medical or other needs (and costs) continue.*
2. ***Public Benefits****. Plaintiffs who have spent their single lump sum payment for medical care on other items may not have the means to pay for their future medical care. These health care costs inevitably become an obligation that is borne by society through Medicaid or some other safety net health care program. Annuities provide a secure and guaranteed long-term source of payment for medical care as long as the care is needed. The people of Illinois will never be asked to pay for such care.*
3. ***Benefits For Defendants****. Physicians and hospitals are looking for ways to lower medical liability costs. Compensating a plaintiff through an annuity offers*

substantial savings to defendants while still guaranteeing the plaintiff all the compensation that the jury finds necessary.

4. ***Improving the Liability Insurance Market**. Using annuities to pay for a plaintiff's future medical expense will improve the liability insurance market by giving insurers greater certainty in assessing the cost of claims and reducing their costs. These benefits will help to stabilize the high cost of liability coverage in Illinois.*

Expert Witness Standards.

An expert witness must be board certified or eligible in the same specialty as the physician-defendant and devote most of his time to the type of care at issue in the case.

Certificate of Merit Reform.

In filing a meritorious claim, the plaintiff must file an affidavit based on the opinion of an expert reviewer who satisfies the expert witness standards for medical liability cases. The reviewer must be identified by name, address and state license number.

Today, medical malpractice cases may not proceed without a certificate of merit from an anonymous medical reviewer, who claims that the case has merit. This requirement is designed to remove frivolous cases from the liability system as soon as possible. Anonymous reviewers are not accountable for their opinions and may deem a frivolous case meritorious with impunity. By doing so they drive up the cost of resolving cases that have no merit. These reviewers should meet minimum qualifications and be responsible for their opinions to improve the elimination of claims that lack merit as soon as possible.

The certificate of merit reform in this bill is useful for the following reasons:

1. ***Current Screening of Claims is Inadequate**. Approximately 70 percent of claims result in no payment to the claimant. This claim "failure rate" is pure waste on the liability system and this reform is needed to ensure that only meritorious claims get to the judicial process.*

2. ***Expert Reviewers Should Be Experts**. Current law allows for reviewers who lack sufficient expertise in a claim to certify that it has merit. To ensure proper review of claims, experts should be required to meet more exacting expert review requirements.*

3. ***Expert Reviewers Should Be Identified.** Current reviewer anonymity denies providers the ability to contest the qualifications of the reviewer who rendered the opinion that the claim has merit. It effectively denies the provider the right to confront his accuser.*

Apology Protection.

Any expression of a provider's apology for a medical outcome is not discoverable or admissible in a trial for malpractice.

Today, health care providers fear communicating openly with patients and their loved ones for fear that their words will come back to haunt them. Many claims are brought precisely to learn what went wrong in a particular instance. This provision will improve and encourage greater communication between patients and providers about adverse health care outcomes. It will also reduce the desire for patients to file claims simply to learn what went wrong with their care.

This bill improves the medical liability system for the following reasons:

1. ***Patients Want Adverse Outcomes Explained***. *Patients often initiate litigation in an effort to get an explanation of what went wrong with their care and what the provider is doing to make sure it never happens again. They want closure to help them in dealing with and recovering from their treatment. Ironically, given the current reluctance of providers to discuss adverse outcomes, litigation becomes the only avenue for patients to learn about the error.*

2. ***Providers Want To Explain Adverse Outcomes***. *Providers are devastated when their care fails to meet patient expectations. They naturally wish to do what they can to address the patient's physical and emotional needs. The emotional healing process also helps the provider to cope with an adverse outcome, which under today's litigation environment causes providers to internalize error silently.*

3. ***Liability Concerns Prevent Patient Safety Discussions***. *Today, many errors may remain hidden because of the pressure on providers to appear flawless to colleagues and patients. If providers feel safe to discuss adverse outcomes with patients and their families, they will be more likely to discuss opportunities for improving patient safety with their colleagues. When fallibility is recognized and discussed more openly, the opportunity to learn from mistakes and to improve the health care system will increase tremendously.*

Sorry Works Pilot Program.

One hospital in Illinois may agree to be the site for a study of whether "promptly apologizing for mistakes" and "promptly offering fair settlements" reduces its total liability costs. A new state nine-member committee would decide if the hospital's liability costs under the "sorry" program are higher than they would have been without the program. If such is the case, the committee shall also decide how much it will pay the hospital to make up for this difference, but the total payment to a hospital in any year may not exceed $2 Million. The program may be expanded to include one additional

hospital in the second year of the program. Data from the program would be publicly available.

Good Samaritan Act for Free Medical Clinics.

Retired physicians who provide free care in free medical clinics would only be liable for willful and wanton misconduct.

Physician Discipline Provisions

SB 475 amends the Medical Practice Act with respect to the following:

Medical Disciplinary Board Composition and Investigations.

1. Expands the Medical Disciplinary Board from nine to eleven members, with a stated goal of having among the five physician members at least one practicing in each of the following specialties: neurosurgery, obstetrics/gynecology and cardiology. The Board shall also include one osteopath and one chiropractor. The number of members of the public is doubled, from two to four. Six voting members, at least four of whom are physicians, shall constitute a quorum.
2. Doubles the number of medical investigators, so that there will be not less than one full time investigator for every 2,500 physicians licensed in the State
3. Adds “refuse to renew” to the list of disciplinary actions the Department of Financial and Professional Regulation (IDFPR) may take against a physician’s license
4. Doubles potential fines from $5,000 to $10,000 for violations of the Medical Practice Act
5. Extends immunity from prosecution to any individual who serves as a member of the Disciplinary Board or a peer review committee or provides information or reports to either of those bodies

Mandatory Reports to the Disciplinary Board.

1. Reports must contain additional identification information, including the name of the hospital or other healthcare facility where the care at issue in the report was rendered
2. Provides that the Disciplinary Board or IDFPR may subpoena copies of hospital or medical records in mandatory report cases alleging death or permanent bodily injury without patient consent
3. Within 30 days of being notified of the existence of a report, the subject of the report shall submit a written statement responding to the report and include any related medical records
4. IDFPR may request the plaintiff’s attorney to provide patient records, without patient consent

Statutes of Limitation for Bringing Disciplinary Action Against a Physician.

1. Extends the statute of limitations in most cases from three to five years after receipt of the complaint, but no later than ten years after the incident
2. In investigating a pattern of practice violation, IDFPR may consider all incidents that occurred within the 10-year period preceding the filing of the complaint that are alleged to be a part of the pattern of practice

3. Extends from one to two years the time period in which IDFPR may commence disciplinary proceedings based on adverse settlements and judgments arising from negligence claims

Physician Profiling Provisions

Internet Profiles.

1. Section 24.1 may be cited as the "Patients' Right to Know Law."
2. Requires IDFPR to post profiles of physicians on the Internet, and if requested, in writing. Profiles must include, for the most recent five years:

   - Criminal history
   - IDFPR disciplinary actions
   - History of licensure disciplinary actions in other states
   - Hospital disciplinary actions
   - Medical litigation judgments, settlements, and arbitration awards in which a payment was made to a complaining party

3. Information concerning settlements shall be accompanied by the following statement:

   "Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred."

4. Profiles must contain education, specialty board certification; practice experience and locations; the location of the physician's primary practice setting; identification of any translating services that may be available at the primary practice location; whether the physician participates in the Medicaid program.

5. A physician may elect to include or omit medical school faculty appointments; information regarding publication in peer-reviewed medical literature within the most recent five years; and information regarding professional or community service activities and awards.

To the extent that the medical liability debate has included concerns about the possibility of "bad doctoring," the physician disciplinary and profiling reforms address those issues.

Insurance Regulation Provisions

Synopsis: SB 475 amends the Illinois Insurance Code as it pertains to medical liability insurers by transferring power from the Director of Insurance to the Secretary of Financial and Professional Regulation; increasing the availability of rate review hearings; lowering the standard for finding that rates are excessive; expanding the entities required to report malpractice claims and suits to include non traditional insurers such as risk retention groups, religious and charitable risk pooling trusts, etc.; imposing longer notice to exit the market; and requiring that more detailed loss, actuarial and reserve information be filed.

Rate review.

While rates are currently prohibited from being excessive, inadequate or unfairly discriminatory, "excessive" and "inadequate" are difficult to establish, "excessive" being defined as unreasonably high, without a reasonable degree of competition and "inadequate" as unreasonably low, so as to endanger the solvency of the company. The bill deletes these definitions, leaving the determination to the discretion of the Secretary of Financial and Professional Regulation, after public hearing. A public rate hearing is to be called (i) at the request of 1% of a company's insureds within a specialty or 25 of the company's insureds (whichever is greater), (ii) at the Secretary's discretion, or (iii) when a company's rate is increased greater than 6%. The company has the burden of proving the rates are not excessive, inadequate or unfairly discriminatory. After the hearing, the Secretary may adjust the rate and, if the company is found to have willfully or repeatedly violated the rate provision of the Code, suspend or revoke its certificate of authority and assess a penalty. In addition, the Secretary may request information necessary to determine the manner used in setting filed rates and their reasonableness, which information will be available to the public.

Claims/Suit Reporting.

The current requirement that insurers report all claims and suits alleging liability on the part of any physician, hospital or other health care provider for medically related injuries is expanded to include stop loss insurers, captive insurers, risk retention groups, county risk retention trusts, religious or charitable risk pooling trusts, surplus line insurers, and other entities authorized or permitted by law to provide medical liability insurance in Illinois. The Secretary is required to establish the form for reporting, which shall include the nature, amount and disposition of claims, and categorize them by verdict, settlement, dismissal or other method of disposition and type of damages awarded, including economic and non-economic damages. This information will be available to the public without the names or addresses of the parties to the claims or suits. The penalty for failure to timely file complete and accurate reports could be $1,000 per day per noncompliant report.

Loss and Actuarial Information Reporting.

Medical malpractice insurers will be required to report specified loss, actuarial and reserve information, which information will be available to the public. The loss information includes ten years of paid and incurred losses by county and earned exposures. The reserve information includes copies of the company's reserve and surplus studies, the consulting actuarial report and data supporting the company's rate filing.

Miscellaneous Provisions. The bill imposes additional requirements and recommendations as follows:

- Companies writing medical liability insurance will be required to offer insureds the option of making quarterly premium payments.
- Companies are encouraged, but not required, to offer deductibles and premium discounts for participation in risk management activities. Any such plans must be filed with the Department of Insurance.
- Companies will be required to provide 180 days, rather than the current 90 days, notice to discontinue writing medical liability insurance in Illinois.
- The Secretary will be required to establish, and update annually, a website containing the name, telephone number and base rates of each licensed company providing medical liability insurance and the name, address and telephone number of each producer selling such insurance.

To the extent that the medical liability crisis is caused by insurer mismanagement or misconduct, the Insurance Code reforms address those issues.

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