Colorado's Response to the MEDICAL LIABILITY CRISIS

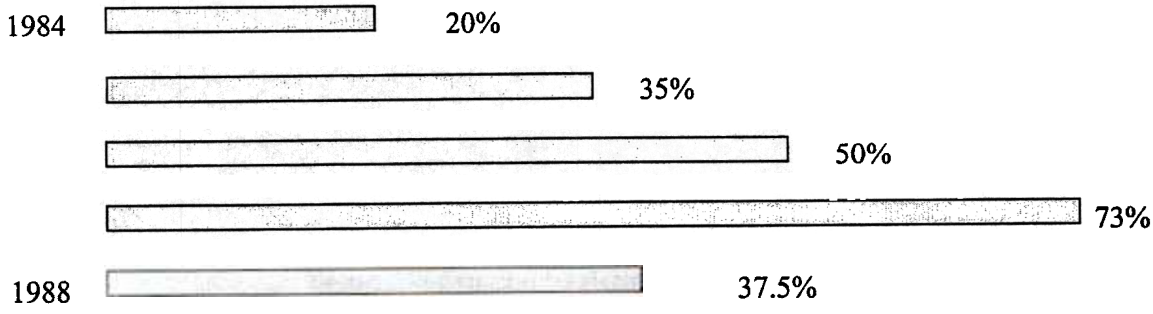
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Executive Vice President
Copic Insurance
July 2003

The 2003 Medical Liability Crisis – Deja Vu all over again

I. Colorado in the mid 1980's

- **A.** COPIC founded in 1981 as a self-insurance trust for physicians.
- **B.** Wrote first insurance company policy 1/1/85.
- **C.** No individual shareholders (owned by Trust for the benefit of medicine in Colorado).
- **D.** No Wall Street strategy.
- **E.** Price at an "underwriting break even".
- **F.** Investment income not a major influence.
- **G.** Return "unused" monies to our policyholders - $94.2 million 1990-2003. A 5-6 year lag.
- **H.** Rate increases – 1984 – 1988

Average Increase/Decrease in COPIC Premiums for Policy Years 1984-1988



II. What these rate increases do to patient access to care.

University of Colorado Health Sciences Center
Press Release – Tuesday, February 9, 1988

HIGH INSURANCE COSTS CAUSING OBSTETRICIANS TO DISCONTINUE DELIVERIES, UCHSC SURVEY SHOWS

Denver – A just-completed statewide survey of obstetricians and family physicians who deliver babies indicates that high malpractice insurance costs have caused 21 percent of survey respondents to discontinue the delivery of babies in the past five years.

The Study was released to the Colorado General Assembly and the Governor's Task Force on Medical Liability Tuesday in Denver. Calonge described other conclusions of the study:

-- While 21 percent dropped obstetrics in the past five years, 17 percent dropped such services before that, and another 30 percent reduced OB services. Only 15 percent increased OB services.

-- The three reasons cited as most important in dropping OB services were insurance premium increases, uncertainty about insurance availability and fear of malpractice suits.

-- Of the physicians providing OB care to medically indigent patients and medical patients more than 62 percent said they would drop all OB services if malpractice rates continue to rise.

-- The potential effect of large increases, as compared with modest increases or current premium status, would be that 6,269 Colorado women would have to drive an average of 52 miles to the nearest available medical obstetrical care.

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The survey also indicates that further premium increases will cause 63 percent of physicians still doing obstetrical (OB) work to drop those services. Particularly hard hit will be rural areas. If the trend continues, 42 of Colorado's 63 counties may be left without OB services.

The study, funded by the National Institutes of Health, was conducted by the University of Colorado Health Sciences Center's (UCHSC) Department of Family Medicine in cooperation with the Colorado Department of Health and the Maternal and Child Health Committee of the Colorado Medical Society.

Ned Calonge, M.D., UCHSC Department of Family Medicine assistant director of research and principal investigator of the study, said that 19 Colorado counties are or soon will be without medical obstetrical care. "Based on the response of physicians, more will be dropping medical OB care and more counties will be left without such care as premiums increase."

The 918 survey respondents represent more than 76 percent of urban OB care providers and at least 83 percent of rural providers. Also, 92 percent of respondents were Doctors of Medicine, eight percent, Doctors of Osteopathy. Also, 65 percent were family/general practitioners, 31 percent obstetricians/gynecologists, and the balance, related specialties.

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III. Why liability insurance rate increases impact physicians, particularly rural primary care physicians?

1. Medicare/Medicaid /free care.
2. No ability to cost shift.

IV. The 1980's Solution – TORT REFORM

A. Colorado enacts comprehensive medical malpractice Tort Reform The Healthcare Availability Act.
(see attached summary of Colorado Tort Reform Law)

COPIC INSURANCE

SUMMARY OF COLORADO TORT REFORM LAW
UPDATED THROUGH THE 2003 LEGISLATIVE SESSION

1. **Limitation of Liability,**
C.R.S. Section 13-64-302 (1988)(2003): Provides that the total amount recoverable in tort actions against health care professionals shall not exceed $1,000,000 present value, including derivative claims, [with a $300,000 present value cap on damages for non-economic loss or injury] for the past, present, and/or future damages, unless the court finds that imposition of the $1,000,000 limitation would be unfair due to the extent of the past, present, and future damages or loss of income. In that case, the court may award the present value of excess future earnings and/or medical costs only.

2. **Exemplary Damages,**
C.R.S. Section 13-64-302.5 (1989)(1991): Provides that exemplary damages may be imposed against a health care professional only as a result of the negligence claim itself. Exemplary damages may not be included in the initial complaint. Exemplary damages may be pleaded only after completion of substantial discovery and only after the court or arbitrator finds prima facie proof of a triable issue.

Reasonable exemplary damages may be imposed only if the action complained of was attended by circumstances of fraud, malice, or willful and wanton conduct, and providing such is proved beyond a reasonable doubt.

Exemplary damages shall not exceed actual damages awarded, although the court may reduce them if deterrent effect has been achieved or may increase damages up to three times actual damage if the behavior has continued or plaintiff's damages have been aggravated. No exemplary damages shall be imposed if injury arises from the use of any drug or product within approved federal or state standards, in accordance with standards of prudent health care professionals, or if there is written informed consent and the use is in accordance with prudent health care standards.

One-third of exemplary damages paid to the State General Fund (struck down by the Colorado Supreme Court) and no interest is payable on such damages.

3. **Joint and Several Liability**, C.R.S. Section 13-21-111.5 (1986): Provides that in an action alleging the death or injury of a person, a defendant shall be liable only for the degree of fault of negligence by that defendant that produced the injury or death. Joint liability will only be imposed upon two or more people when they conspire to commit a tortious act. In that case, any defendant shall be responsible for the degree of fault assessed to all those persons held jointly liable. Each such defendant shall have a right of contribution from the other defendants acting in concert.

Non-Party Negligence Determined:
Finders of fact may consider degree of fault of a non-party to a suit in determining degree of fault of parties. Negligence of a non-party may be considered if claimant made a settlement agreement with such a non-party or if the defending party gives notice within ninety (90) days of the fault of the non-party.

The jury or court will make special findings to determine the percentage of negligence attributable to each party and non-party and shall determine the amount of damages caused by each. Entry of judgment shall be based on the special finding and no general verdict shall be returned by the jury.

4. **Certificate of Review Required,** C.R.S. Section 13-20-602 (1989): Provides that in an action for damages based upon professional negligence of a licensed professional, the complainant's attorney shall file a Certificate of Review with the court for each professional named as a party within sixty (60) days of the service of the complaint, cross-claim, or counterclaim. The Certificate shall declare that

an expert in the area of the alleged negligent conduct who meets the requirements of C.R.S. Section 13-64-401 (expert witnesses, #16 herein) has reviewed the facts, records, documents, and other material relevant to the alleged negligent conduct and, based upon that review, has found the complaint does not lack substantial justification. Failure to file a Certificate of Review shall result in the dismissal of the action. While filing of a Certificate creates a presumption of substantial justification, attorneys are still required to comply with good faith obligations of Rule 11 of Colorado Rules of Civil Procedure related to frivolous lawsuits. Also, if a non-party defendant is designated, a Certificate of Review must be filed as to the non-party.

5. **Statute of Limitations,**
C.R.S. Section 13-80-102.5 (1988): Provides that tort or contract actions against a health care professional shall be instituted within two (2) years after the date an action accrues, but absolutely no later than three (3) years after the act or omission giving rise to the action occurred, unless a) the act was knowingly concealed, or a foreign object was left in the body, or the injury or its cause could not have been discovered with reasonable diligence, in which case action must be instituted within two (2) years after action was discovered or should have been discovered; b) a child under eight (8) years is injured prior to 6th birthday, action may be instituted any time up to the age of eight; c) an incompetent person under legal disability is injured and has no legal representation, action must be instituted two (2) years from date legal disability is terminated.

6. **Qualifications of Experts,**
C.R.S. Section 13-64-401 (1988): Provides that an expert witness testifying with regard to negligence in a medical malpractice action must be a licensed physician whose training, education, knowledge, and experience in evaluation, diagnosis, and treatment of disease makes him substantially familiar with the applicable standards of care relating to the act or omission which is the subject of the proceeding on the date of the incident. An expert in one medical sub-specialty may not testify against a physician in another sub-specialty unless the standards of care are similar in the two fields.

7. **Vicarious Liability**
C.R.S.12-36-134 (2003): Provides that a professional service corporation shall not be vicariously liable for the negligence of an employed physician.

8. **Admissions Against Interest**
C.R.S. 13-25-135 (2003): Provides that any statements made by a health care provider to a patient or relative or representative of a patient expressing apology, fault, sympathy, etc. can not be used as an admission against interest in subsequent litigation.

9. **Good Samaritan Statute,**
C.R.S. 13-21-108 (1990): Provides that any physician or surgeon who provides emergency care in good faith to a person not presently hispatient and without compensation shall not be liable unless his acts were grossly negligent, willful or wanton. This emergency care shall be rendered at the place of the emergency, including emergency care rendered in a health care institution, unless an obligation exists to "cover" that patient.

10. **Volunteer Services,**
C.R.S. Section 13-21-115.5 (1992)(1999): Provides that a volunteer physician who provides medical services for a "non-profit organization", "non-profit corporation," or a hospital without compensation shall be immune from civil liability for their acts or omissions performed in good faith and within the scope of their volunteer duties, but only if there was an absence of willful and wanton conduct or gross negligence by such volunteer. The patient must consent in writing to care by the volunteer. This does not relieve the hospital or non-profit organization from its liability for the conduct of the volunteer, nor does it relieve the physician from the need for liability insurance to establish good faith behavior.

11. **Directors, Officers and Trustees Immunity**, C.R.S. Section 13-21-115.7 (1992): Provides that directors, officers and trustees of non-profit organizations who are not compensated or salaried, (except reasonable expenses may be reimbursed and they may receive gifts not to exceed $1000 value in any

12 month period), shall be immune from civil liability for damages or injury incurred while acting within the scope of their duties and so long as any act or omission causing injury or damage was not willful and wanton.

12. **Collateral Source Reduction of Damages**, C.R.S. Section 13-21-111.6 (1986) (1990): Provides that in an action brought to recover damages for a tort resulting in injury or death, the court shall reduce the amount of damages awarded by the finder of fact by the amount that the person, his estate, or his representative has been indemnified or compensated for the loss by any person, company, or fund related to the injury. However, this does not include any amount by which the person, his estate, or representative is indemnified or compensated by a benefit paid out of a contract entered into and paid for by or on behalf of such person.

See #13 herein. The plaintiff must give statutory notice of suit to a third party payor within 60 days of filing the complaint. If the third party payor does not respond to the court or arbitrator within 90 days, the claim of the third party payor is barred.

13. **Collateral Source Evidence & Right of Subrogation**, C.R.S. Section 13-64-402 (1988)(1992): Provides that the plaintiff in a personal injury action against a health care provider must serve written notice on any third-party payor of any amount paid or payable as a medical benefit to the plaintiff from any health, sickness, or insurance plan, or any contract to provide, pay for, or reimburse health care services costs. The notice must be properly served on the insurance commissioner or pursuant to the Colorado Rules of Civil Procedure within sixty (60) days of the commencement of the suit. The notice must also be filed with the court or arbitrator.

If the third-party payor has a right of subrogation for such payments, it shall file a written claim within ninety (90) days of receiving notice. The claim shall not specify a definite amount. Failure to file the written claim constitutes a complete waiver of the third-party payor's claim.

14. **Interest**, C.R.S. 13-21-101 (1995): Amended to provide that prejudgment interest accrues only after the date the action is filed. Prejudgment interest no longer accrues from the date of the incident.

15. **Peer Review Immunity**, C.R.S. Section 12-36.5-101 et seq. (1989): Provides good faith immunity to physicians who participate in peer review in compliance with statutory requirements of due process. Creates a special BME committee to hear allegations of anti-competitive behavior in peer review. Should minimize Federal antitrust exposure under the U.S. Supreme Court case of Patrick v. Burget.

16. **Financial Responsibility**, C.R.S. Section 13-64-301 (1988)(1989)(1990)(1991): Provides that as a condition of active licensure, every physician or dentist (except public employees) providing health care in Colorado shall maintain commercial professional liability insurance coverage in a minimum indemnity amount of $500,000 per incident and $1.5 million annual aggregate per year, with an insurance company authorized to do business in Colorado.

If a physician has been reported two times or more to the Board of Medical Examiners regarding medical malpractice judgments or settlements against such physician in one year, the financial responsibility shall be twice as much. The physician shall have the right to present evidence that the reports did not represent a substantial failure to adhere to acceptable standards of care, and the Board may then reduce the amount of financial responsibility to the regular limits.

Standards may be waived by the Board of Medical Examiners for: 1) class of license holders performing medical or dental services who are in the military or on federal government assignments and/or who render limited or occasional services because of non-clinical duties or retirement; or 2) those who provide uncompensated care to patients but do not otherwise provide any compensated care; or 3) for other reasons that would render the financial standards unreasonable or unattainable.

17. **Reporting Requirements**, C.R.S. Section 13-64-303 (1988): Provides that any judgment, settlement, or award against a health care professional or health care institution shall be reported within fourteen (14) days by the professional's or institution's medical malpractice insurance carrier or the practitioner's institution to the appropriate licensing agency for review, investigation, and appropriate action. If any health care professional or health care institution or insurance carrier knowingly fails to make such a report, they shall be fined not more than $2,500.

18. **Limitations on Action Re Genetic and Other Defects**, C.R.S. Section 13-64-502 (1989): Provides that a health care professional or health care institution will not be liable to an infant, his personal representative, parents or next of kin for an injury occurring from genetic counseling and screening, or arising from pre-natal care, or during labor, delivery or the immediate post delivery period in the institution if the injury was the result of a genetic disease or disorder, or other natural causes unpreventable or avoidable by ordinary care by a health care professional or health care institution, unless it can be shown by a preponderance of the evidence that the injury could have been avoided by ordinary standard of care by the physician or health care institution. Medical records of genetic siblings, parents and grandparents are available to the defense.

19. **Vaccine-Related Injury or Death-Limitations on Liability**, C.R.S. Section 25-4-909 (1988): Provides that no person administering a required vaccine to an infant or child more than 20 days old shall be held liable for any injuries sustained pursuant to such vaccine if the vaccine was 1) given using accepted clinical methods, 2) if the vaccine was given according to a schedule of immunization published by the federal government, and 3) if there were no symptoms of history present which would keep a prudent health care professional from administering the vaccine. A party shall exhaust his remedies under the National Childhood Vaccine Injury Act of 1986 before maintaining an action for vaccine-related injury or death. An injury or death which does not fall within the parameters of the federal vaccine injury table (42 USC 300aa-14) is presumed not to have been caused by the administration of a vaccine unless the preponderance of evidence shows otherwise.

20. **Rape Shield**, C.R.S. Section 13-25-131 (1991): Provides that evidence of a victim's past sexual history is not admissible in a civil suit against a medical professional unless the court finds such evidence to be relevant to the defense of the party seeking to use such evidence and that its probative value outweighs its prejudicial effect.

21. **Periodic Payments**, C.R.S. Section 13-64-203 (1988): Provides that in an action for damages against a health care professional or institution, the judge shall enter a judgment ordering awards for future damages exceeding $150,000 be paid by periodic payments. However, a party may petition the court to enter judgment for the present value of the periodic payments if it is found that the mechanism selected to fund the payments is not adequate. Or, if the individual plaintiff can show he is making an informed decision, is twenty-one years old, and is not incapacitated, he may elect to receive an immediate lump-sum payment of the present value of the future damages award. If the future damages are less than $150,000, the judge may order the award be paid by periodic payments.

22. **Special Damages Findings**, C.R.S. Section 13-64-204 (1988): Provides that jury shall make separate findings specifying for each claimant the amount of: 1) past damages for health care costs, economic loss, loss of earnings and non-economic loss; 2) future damages for health care costs, economic loss, future earnings incurred in work life expectancy, and non-economic loss incurred for the life of the claimant.

23. **Determination of Judgment**, C.R.S. Section 13-64-205 (1988): Provides that court will apply setoffs, credits, comparative fault, additurs, and remittiturs to special damages findings in calculating the amount of past and future damages due to the claimant from each party. A court shall preserve the rights of a subrogee to be paid in a lump sum.

The court shall specify payments of attorneys' fees and costs in a lump sum or periodic payments, but this shall be separate from the periodic installments payable to claimant. The court shall enter judgment in a lump sum for past damages and any damages payable in a lump sum.

The jury shall determine the present value of future damages and the court shall enter judgment for periodic payment, except that the court may enter judgment for payment advances if the need for future major medical services is demonstrated.

24. **Periodic Installment Obligations**, C.R.S. Section 13-64-206 (1988): Provides that 1) payments be fixed; 2) payments cannot be accelerated, deferred, increased, or decreased; 3) the recipient shall be a general creditor of the qualified insurer; 4) payment shall be scheduled at 1-month intervals unless the parties agree and the court directs otherwise, and are payable at the beginning of the intervals; 5) money damages for loss of future earnings shall not be reduced or terminated because of the death of the judgment creditor, but payment for other future damages shall cease at the death of the judgment creditor.

25. **Funding & Assignment of Periodic Payments**, C.R.S. Section 13-64-207, 208 and 209 (1988). C.R.S. Section 13-64-207 provides that periodic payments be funded by 1) an insurance annuity contract; 2) an obligation of the U.S.; 3) evidence of collectible liability insurance; 4) an agreement of liability assignee to assume obligation of the debtor; 5) an obligation of Colorado; 6) other satisfactory funding.

C.R.S. Section 13-64-208:
Provides that funding be provided within sixty (60) days of entry of the judgment. If funding has not been provided as required, the court, after motion by the creditor, shall order compliance within thirty (30) days, and if debtor does not comply, the court shall calculate present value of the obligation and enter judgment in that amount for the moving party. A co-debtor is entitled to the same rights as the creditor in moving for a debtor to comply with the funding provisions.

C.R.S. Section 13-64-209:
Provides that the right to receive periodic payment is only assignable to: 1) payment of alimony, maintenance, or child support; 2) costs of services for medical care; 3) attorneys' fees and costs.

26. **Satisfaction of Judgment**, C.R.S. Section 13-64-212 (1988): Provides that a court shall order the judgment satisfied and the debtor discharged after ordering that the funding complies with those funding forms necessary for periodic payments and that the funding obligation has been met as provided in the above section, "Funding & Assignment of Periodic Payments", #25.

27. **Alternative Arbitration/Medical Services Agreement**, C.R.S. Section 13-64-403 (1988)(1989)(1995): Provides that a physician and patient may enter into a pre-treatment agreement that any dispute regarding professional negligence shall be decided by binding arbitration. Such an agreement must be voluntary and not a condition to the provision of health care services or health care insurance to the patient. The agreement must state that submission of the claim to arbitration precludes reliance upon court processes, except as they relate to judicial review of arbitration proceedings. The patient has the right to seek legal counsel and has the right to rescind the agreement within ninety (90) days after execution of the agreement or patient discharge from the hospital. In addition, a health care provider may not refuse services to a patient who will not sign an agreement, and any such refusal shall constitute unprofessional conduct. A court may declare the agreement invalid if the execution was induced by fraud, it failed to conform to statutory standards, the patient's execution was a result of negligent disregard of the patient's right to refrain from execution, or the patient did not speak the language in which the agreement is written. Punitive damages may be considered in arbitration.

B. Court upholds Colorado's $250,000 non-economic damage cap (see attached).

HCAA of 1988 Affirmed:

State High Court Upholds Malpractice Award Limits

Constitutionality of the Health Care Availability Act of 1988 was upheld on April 26 by the Colorado Supreme Court, an action which affirmed the $1 million total damages cap and rejected plaintiff attorneys' contentions that the law violates "equal protection" and "due process."

George W. Dikeou, **Copic**'s General Counsel, noted that the Supreme Court opinion was somewhat troublesome because it held that the $1 million cap does not include prejudgment interest, "thereby permitting certain recoveries to go above the $1 million figure when interest is added to compensatory damages.

"While not perfect in doing what we had hoped for, the opinion lends strong constitutional credibility to the key elements of the Health Care Availability Act almost exactly five years after legislative enactment. That's about half the time for California's counterpart to HCAA to pass constitutional muster at the appellate court level."

Copic was a major participant in the 1988 effort by organized medicine to bring the medical malpractice loss spiral under control through passage of HCAA.

The constitutional test came about in appeal of a $1.6 million jury award in 1991 which subsequently was reduced by the trial judge to $1 million because of the 1988 law.

According to Dikeou, the opinion also affirmed that:

- The provisions of HCAA are applicable to the unlicensed paraprofessional employees of physicians.
- The damages provision in HCAA limiting non-economic damages to $250,000 does not limit a plaintiff's right to a jury trial, since the Colorado Constitution does not create a "right" to jury trial in civil matters.
- Damages limitations do not violate the right to equal protection of the law; applying the rational basis test the court found the statute reasonable and bearing a rational relationship to a legitimate state objective—the effort to increase the availability of health care to Colorado citizens.
- Damages limitations do not violate the right to due process of the law; the constitutional guarantee is applicable to rights, not remedies.

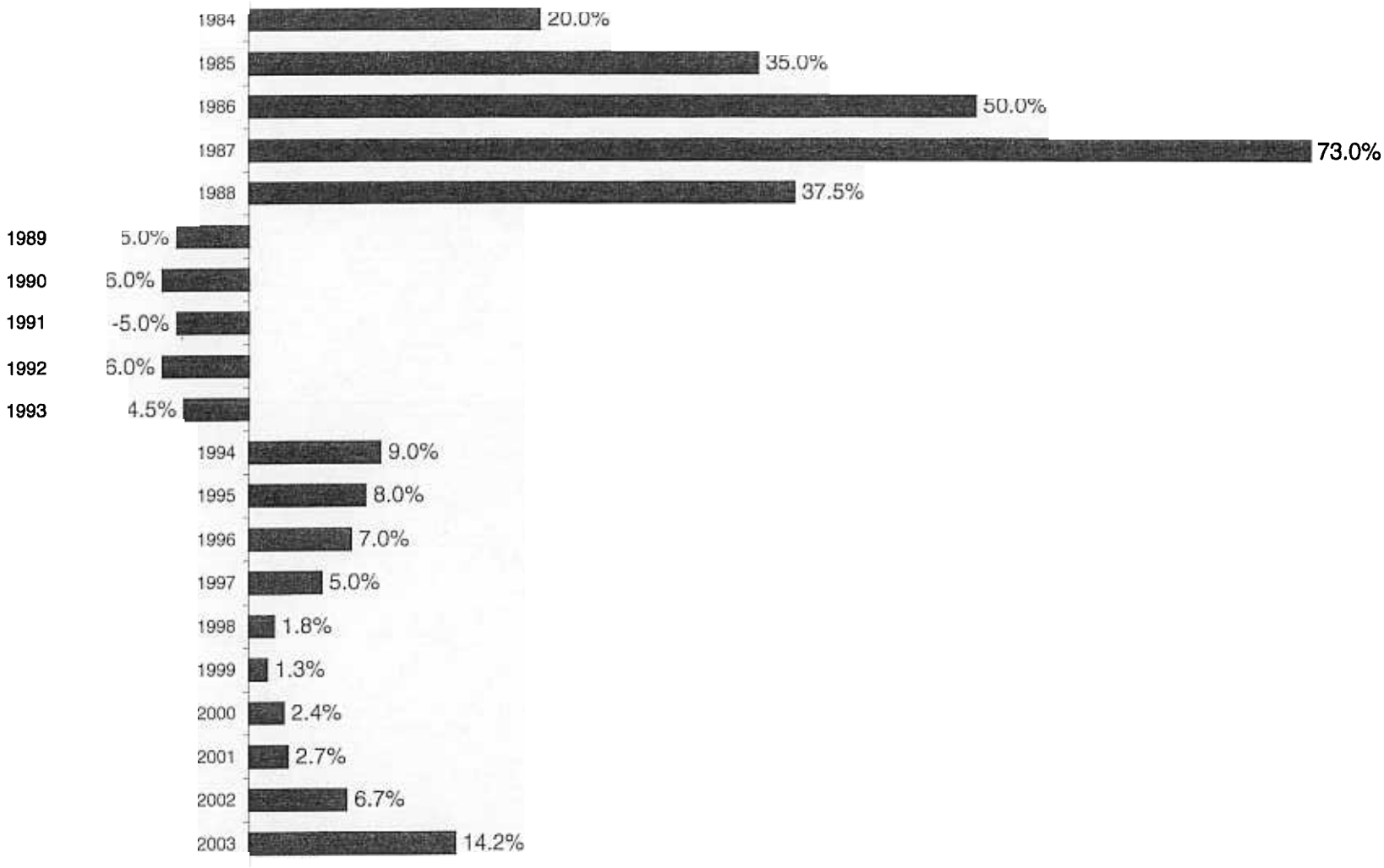
Colorado's plaintiff attorneys were not pleased with the work of the Supreme Court. According to Denver Business Journal, Victoria Swanson, of Colorado Springs, President of the Colorado Trial Lawyers' Association, said:

"I guess that our reaction is that we're really disappointed in the decision," all the more because she believes that the opinion also shored up other damage caps which have been set by Colorado laws in previous tort reform legislation.

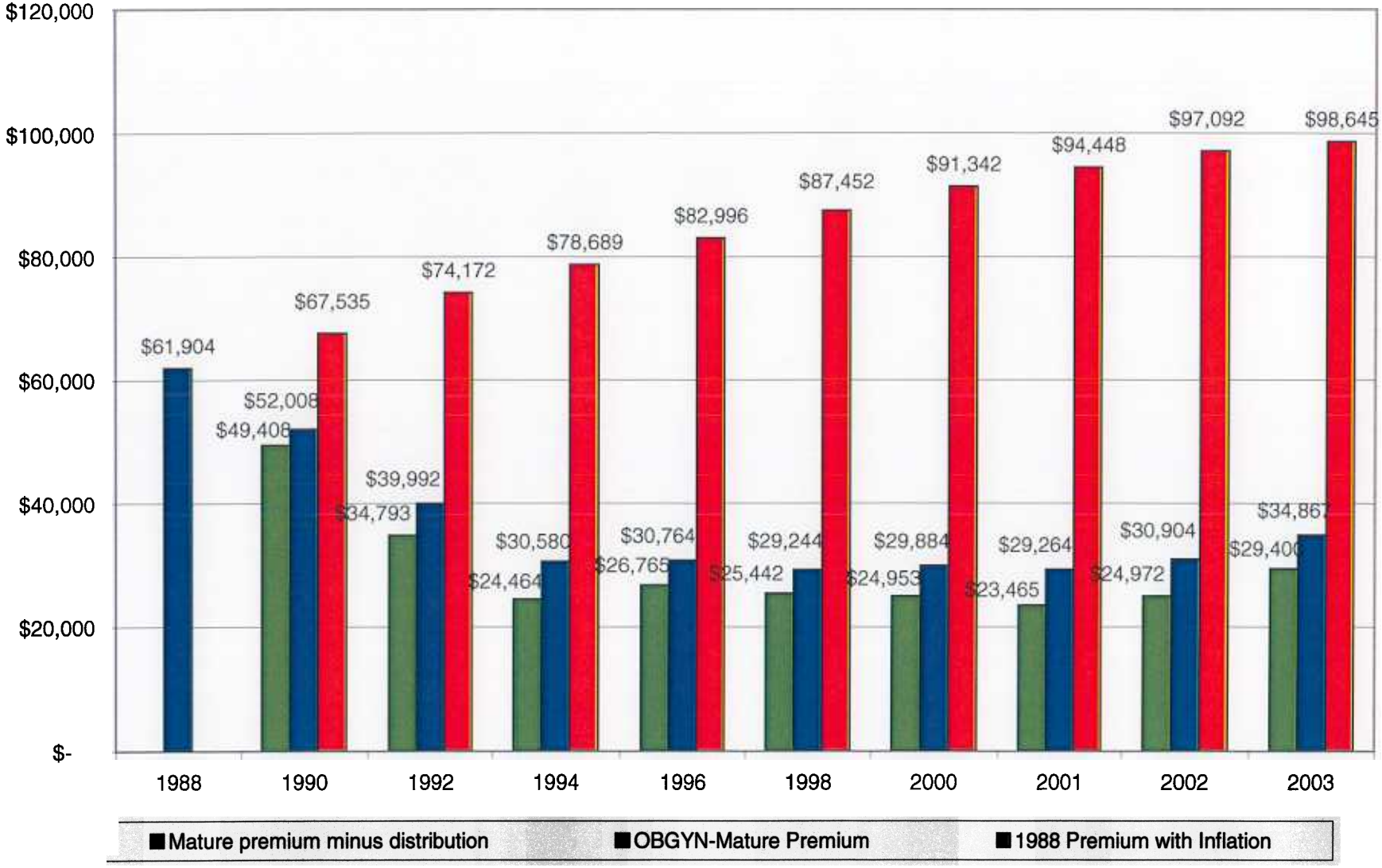
V. Has Colorado Tort Reform worked?

COLORADO MALPRACTICE PREMIUM STABILITY THREATENED BY WEAKENING OF 1988 TORT REFORM

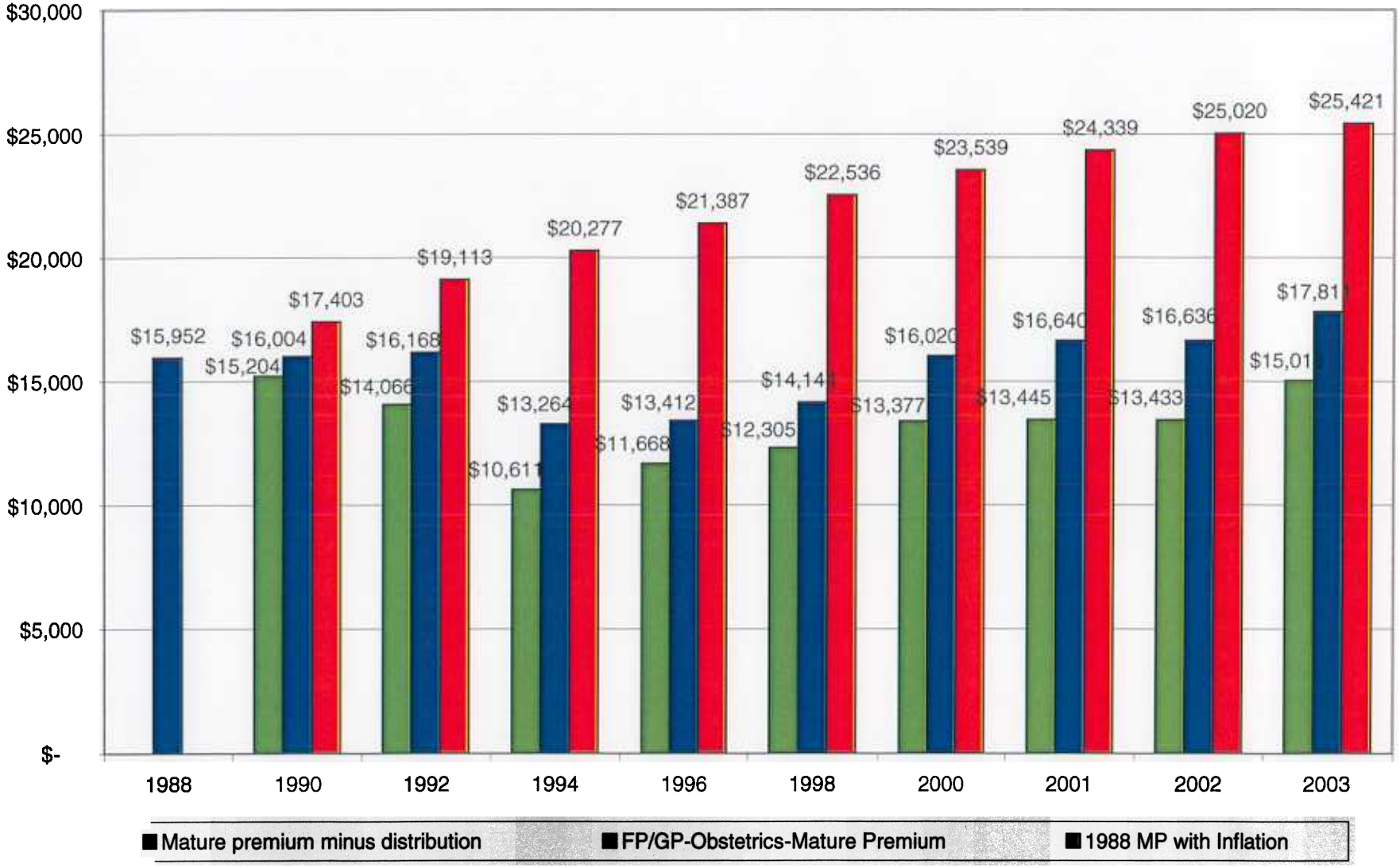
Average Increase/Decrease in COPIC Premiums for Policy Years 1984-2003



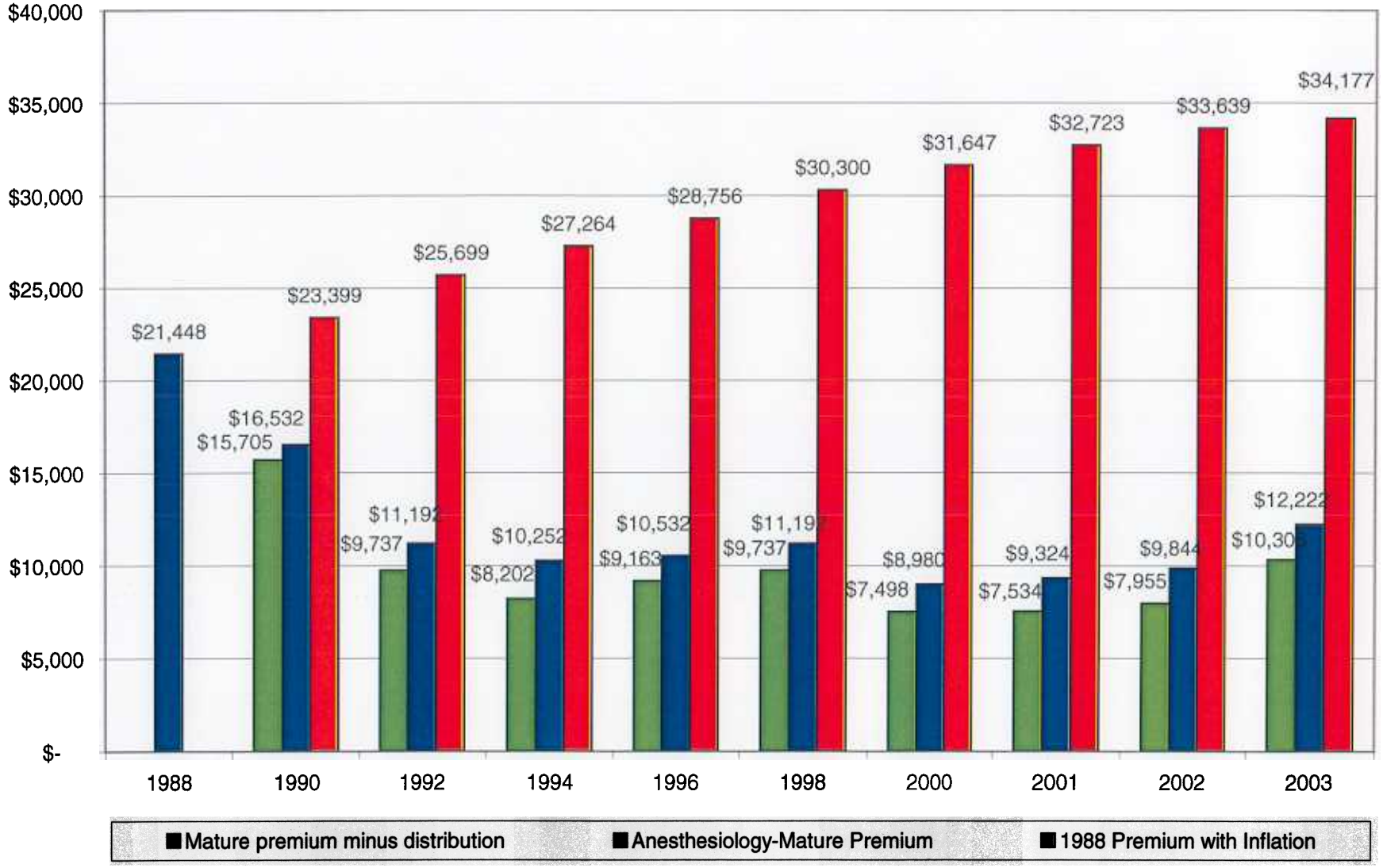
OBSTETRICS AND GYNECOLOGY PREMIUM TREND



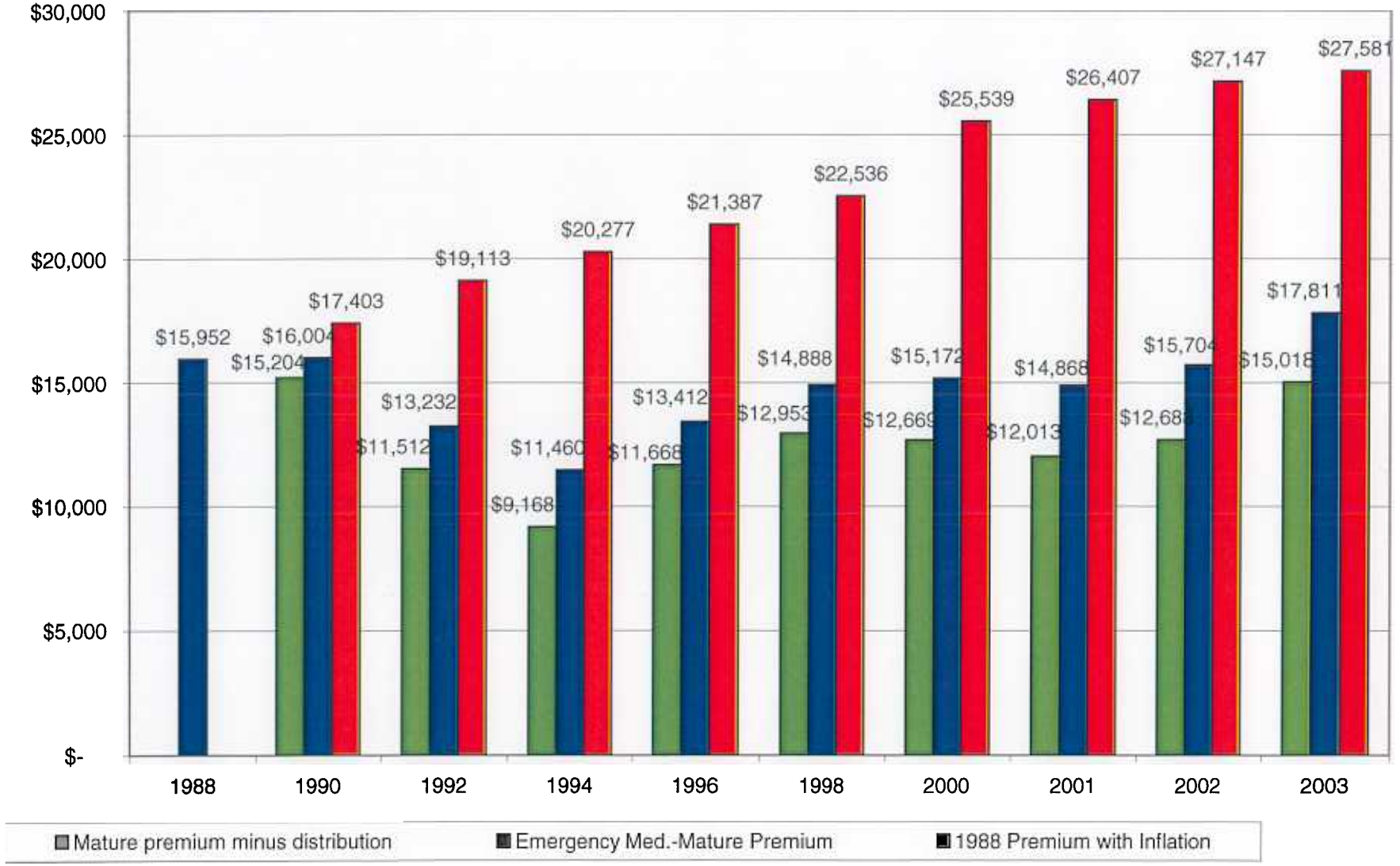
FAMILY PRACTICE - OBSTETRICS



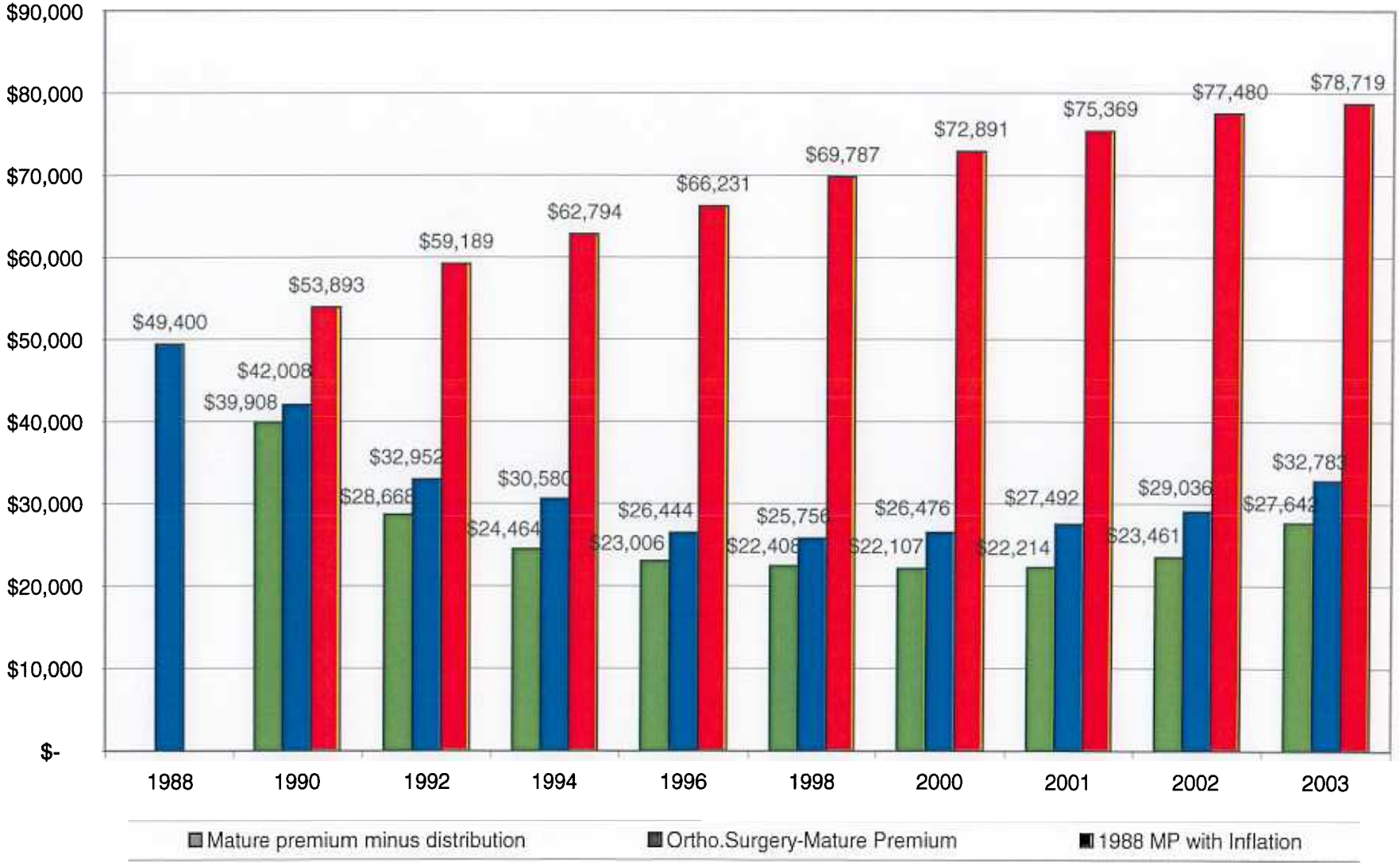
ANESTHESIOLOGY PREMIUM TREND



EMERGENCY MEDICINE PREMIUM TREND



ORTHOPAEDIC SURGERY PREMIUM TREND



WHA NEXT?

A. s Program Recognize, Respond, Resolve

What is the 3Rs Program?

The 3Rs Program is a structured, patient-centered approach for addressing **medical injury and complications** in a way that preserves the physician-patient relationship and compensates the patient for related unreimbursed expenses. The 3Rs stand for *Recognize*, *Respond*, and *Resolve*.

The 3Rs Program has two components:

- A physician-patient interaction process determined by COPIC Risk Management staff and triggered by a qualifying incident report.
- The Post-Incident Risk Management Program, which is separate from your medical professional liability coverage. It is through the Post-Incident Risk Management Program that funds are made available to reimburse the patient, subject to the following limits:
  - Disability: $100 per day, beginning 72 hours after the event, for up to 50 days
  - Medical expenses not covered by patient insurance
  - Overall reimbursement capped at $30,000 per incident
  - These payments may be taxable to the patient, so he/she should consult a tax advisor.

What are the Goals of the 3Rs Program?

The goals of the 3Rs Program are to:

- **Recognize** medical injury and complications and respond promptly
- **Communicate** with the patient in an empathetic manner
- **Ensure** that the patient receives prompt evaluation and consultation
- **Arrange** for additional care or services that the patient might need as a result of the injury or complication
- **Reimburse** the patient for related incurred expenses that are not covered by his or her health insurance (subject to the limits shown above)

Why is COPIC Sponsoring the 3Rs Program?

The 3Rs Program is part of COPIC Insurance Company's continuing quest to improve quality of care, treat injured patients fairly, and reduce the exposure of its insured physicians to malpractice litigation. However, it is NOT a goal of the program to interfere with any litigation or third-party claim process.

How is it Different from Incident Reporting?

In terms of your day-to-day practice, there's no difference at all. You will continue to report incidents promptly, just as you always have. Your practice is impacted only if a treatment-caused injury has occurred. Then, the 3Rs Program requires your participation in physician-patient interaction(s) as appropriate. You may also need to make changes in your practice so that the medical injury or complication will be less likely to occur again.

What are My Responsibilities under the 3Rs Program?

In day-to-day practice, you are responsible for

- Calling in all incident reports promptly.

When contacted by COPIC following a qualifying incident, you are responsible for:

- Participating in the physician-patient interaction(s) as appropriate.
- Working with COPIC to determine who will contact the patient to arrange a meeting if necessary.
- Determining appropriate follow-up medical or rehabilitative care.
- Working with COPIC to identify and implement any necessary changes to prevent the occurrence of the same injury in future patients.

COPIC is responsible for:

- Determining whether an incident possesses the qualities necessary to trigger the 3Rs Program.
- Contacting you to let you know that the incident qualifies for the 3Rs Program.
- Working with you to determine who will contact the patient to arrange any necessary meeting(s).
- Working with you to determine what changes, if any, are necessary to prevent the occurrence of the same injury or complication in future patients.
- Coaching your interaction(s) with the patient at any arranged meeting(s) if appropriate.
- Explaining to the patient the benefits available through the Post-Incident Risk Management Program.
- Determining which of the patient's expenses are eligible for reimbursement.
- Coordinating the reimbursement of the patient's eligible expenses.

Are Payments Under This Program Reportable to the BME or NPDB?

No. Because the payments do not constitute a final settlement and because no waiver or final release is required of the patient, payments are exempt from reporting to the Board of Medical Examiners (BME). Because there is no attorney representing the patient and because no written claim or demand is presented, payments are exempt from reporting to the National Practitioner Data Bank (NPDB).

Can a Patient Who Receives Payment through this Program Still Take Legal Action Against Me?

Yes. Nothing in this program prevents a patient from taking legal action. The patient retains at all times his or her right to bring a liability claim or suit. Nothing will be asked of the patient -- no releases, no waivers, no verbal promises not to bring suit, etc.

If a claim or suit does arise in respect to a patient who has received payments through this program, it will be handled like any other and will be subject to normal BME and NPDB reporting requirements depending on its outcome.

What Effect Does My Participation Have on My Malpractice Coverage?

Participation in the 3Rs Program and the reporting of qualifying incidents will have no effect per se on either your premium or your coverage. However, COPIC evaluates physician performance in each and every incident, claim, and suit, and takes action if deemed necessary by the COPIC Underwriting Committee.

Physicians who participate in the 3Rs Program will receive one point under COPIC's Experience Rating System (ERS) for each complete 24-month ERS cycle during which you participate. This point counts toward the six ERS points that physicians must earn every two years to maintain Preferred premium status, which carries a 10% discount.

How Long Will the 3Rs Program Run?

COPIC intends to operate the 3Rs Program for a period of 24 to 36 months from its inception (October 1, 2000). At the end of the pilot, the program will be evaluated on an actuarial basis to determine whether or not to continue or modify the program.

What Do I Do if I Want to Stop Participating?

You may discontinue your participation in the 3Rs Program at any time with written notice to COPIC Insurance Company, Attention: Underwriting and Policyholder Service, P.O. Box 17540, Denver, CO 80217-0540.

B. I'm Sorry Legislation (see attached)

C. New Systems –

1. Litigation does <u>not</u> improve the quality of patient care.

2. Compensation for injury goes to the wrong people.

An Act

HOUSE BILL 03-1232

BY REPRESENTATIVE(S) Stafford, Spradley, Frangas, Johnson R., Mitchell, Spence, and Stengel;
also SENATOR(S) Johnson S.

CONCERNING EVIDENCE OF ADMISSIONS IN CIVIL PROCEEDINGS RELATED TO THE PROVISION OF MEDICAL CARE.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Article 25 of title 13, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

13-25-135. Evidence of admissions - civil proceedings - unanticipated outcomes - medical care. (1) IN ANY CIVIL ACTION BROUGHT BY AN ALLEGED VICTIM OF AN UNANTICIPATED OUTCOME OF MEDICAL CARE, OR IN ANY ARBITRATION PROCEEDING RELATED TO SUCH CIVIL ACTION, ANY AND ALL STATEMENTS, AFFIRMATIONS, GESTURES, OR CONDUCT EXPRESSING APOLOGY, FAULT, SYMPATHY, COMMISERATION, CONDOLENCE, COMPASSION, OR A GENERAL SENSE OF BENEVOLENCE WHICH ARE MADE BY A HEALTH CARE PROVIDER OR AN EMPLOYEE OF A HEALTH CARE PROVIDER TO THE ALLEGED VICTIM, A RELATIVE OF THE ALLEGED VICTIM, OR A REPRESENTATIVE OF THE ALLEGED VICTIM AND WHICH RELATE TO THE DISCOMFORT, PAIN, SUFFERING, INJURY, OR DEATH OF THE ALLEGED

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

VICTIM AS THE RESULT OF THE UNANTICIPATED OUTCOME OF MEDICAL CARE SHALL BE INADMISSIBLE AS EVIDENCE OF AN ADMISSION OF LIABILITY OR AS EVIDENCE OF AN ADMISSION AGAINST INTEREST.

(2) FOR PURPOSES OF THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "HEALTH CARE PROVIDER" MEANS ANY PERSON LICENSED OR CERTIFIED BY THE STATE OF COLORADO TO DELIVER HEALTH CARE AND ANY CLINIC, HEALTH DISPENSARY, OR HEALTH FACILITY LICENSED BY THE STATE OF COLORADO. THE TERM INCLUDES ANY PROFESSIONAL CORPORATION OR OTHER PROFESSIONAL ENTITY COMPRISED OF SUCH HEALTH CARE PROVIDERS AS PERMITTED BY THE LAWS OF THIS STATE.

(b) "RELATIVE" MEANS A VICTIM'S SPOUSE, PARENT, GRANDPARENT, STEPFATHER, STEPMOTHER, CHILD, GRANDCHILD, BROTHER, SISTER, HALF BROTHER, HALF SISTER, OR SPOUSE'S PARENTS. THE TERM INCLUDES SAID RELATIONSHIPS THAT ARE CREATED AS A RESULT OF ADOPTION. IN ADDITION, "RELATIVE" INCLUDES ANY PERSON WHO HAS A FAMILY-TYPE RELATIONSHIP WITH A VICTIM.

(c) "REPRESENTATIVE" MEANS A LEGAL GUARDIAN, ATTORNEY, PERSON DESIGNATED TO MAKE DECISIONS ON BEHALF OF A PATIENT UNDER A MEDICAL POWER OF ATTORNEY, OR ANY PERSON RECOGNIZED IN LAW OR CUSTOM AS A PATIENT'S AGENT.

(d) "UNANTICIPATED OUTCOME" MEANS THE OUTCOME OF A MEDICAL TREATMENT OR PROCEDURE THAT DIFFERS FROM AN EXPECTED RESULT.

SECTION 2. Applicability. This act shall apply to actions filed on or after the effective date of this act.

SECTION 3. Safety clause. The general assembly hereby finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Lola Spradley
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

John Andrews
PRESIDENT OF
THE SENATE

Judith Rodrigue
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Mona Heustis
SECRETARY OF
THE SENATE

APPROVED April 17, 2003 at 9:58 A.

Bill Owens
GOVERNOR OF THE STATE OF COLORADO