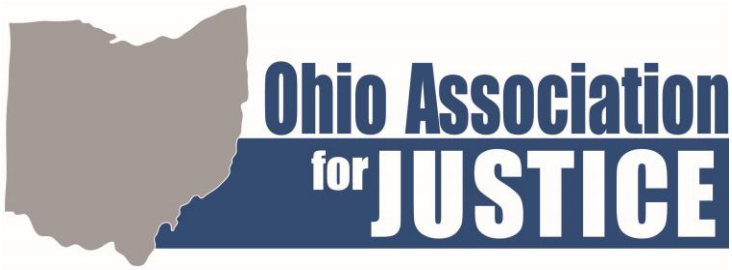
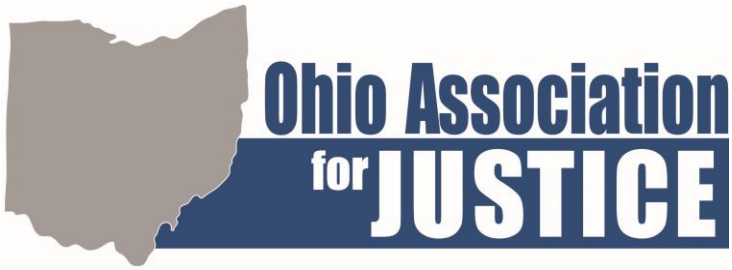


2015 Winter Convention
December 3, 2015

Medical Malpractice Session



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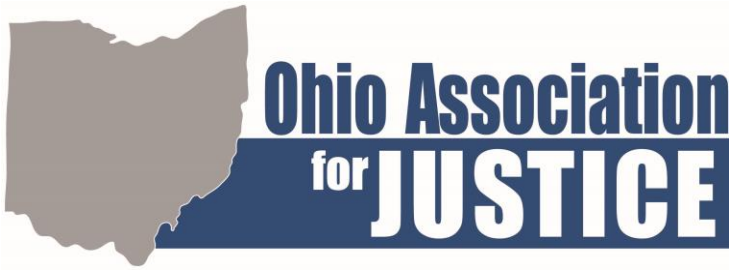
Nick DiCello
Cleveland, OH



2015 Winter Convention
December 3, 2015

Medical Malpractice Session

Telling the Story of Your Case: A Structural Framework for Telling Your Client's Story

James Casey
Mentor, OH

WITNESSES

(MAXIMIZING RECOVERY BY USING FACT WITNESSES TO TELL THE STORY)

People don't make decisions on what they think.
People make decisions on how they feel.
Our job is to let them feel.

What motivates a listener to feel?

A good story.

But what makes a good story?

Dramatic structure.

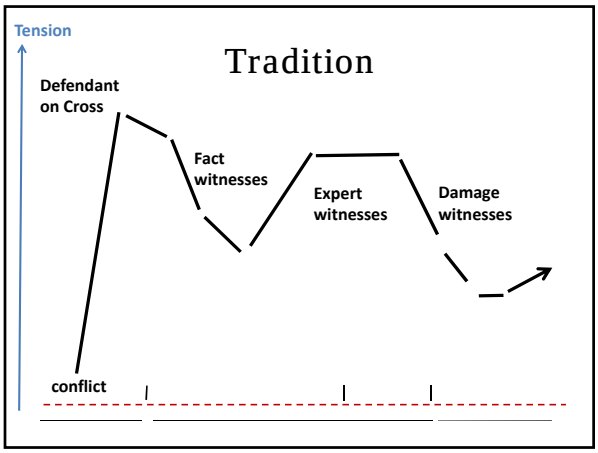
First: Make the story involve the listener

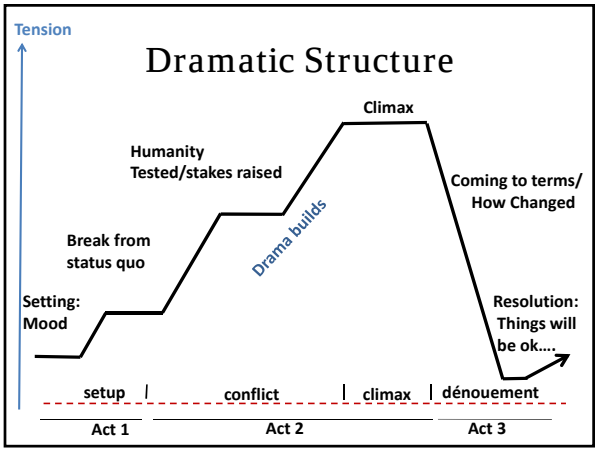
If the story is not about the hearer, he will not listen - Steinbeck

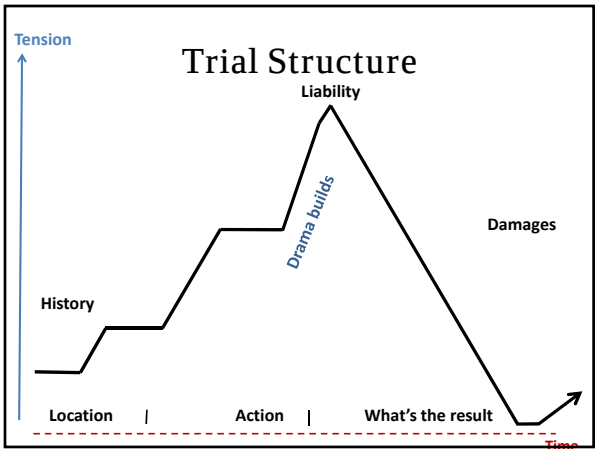
Here's an Example:

This is a brain damage baby case. My clients have a daughter who was permanently injured at the time of her birth.

Imagine a baby in the womb ready to be delivered. On arrival to the hospital, the baby girl tells everyone she is happy and healthy. As labor progresses, the baby tells everyone things are getting worrisome, and finally that her situation is ominous. Today, that little girl needs your help to hold the doctor accountable for not listening to her pleas for help.


Tension
Tradition
Defendant on Cross
Fact witnesses
Expert witnesses
Damage witnesses
conflict


Tension
Dramatic Structure
Climax
Humanity Tested/stakes raised
Coming to terms/ How Changed
Break from status quo
Drama builds
Setting: Mood
Resolution: Things will be ok....
setup
conflict
climax
dénouement
Act 1
Act 2
Act 3


Tension
Trial Structure
Liability
Drama builds
Damages
History
Location
Action
What's the result
Time

Second: Simplify...

If it does not move the story ahead, you have to cut it, no matter how hard you had to work to find it.
- Elizabeth Ellis

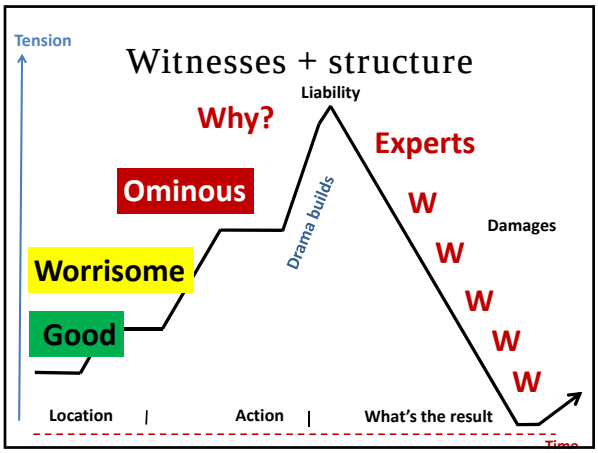
When you are in your brain it is a form of adsence.
- Michael Shickich

Third: Show... Don't tell

The biggest problem with communication is the illusion that is has been accomplished.
- George Bernard Shaw

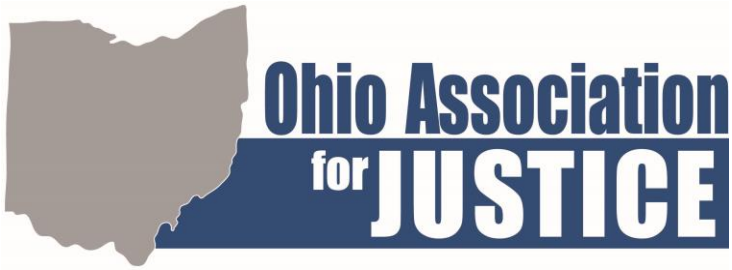
Fourth: Understand the roles

- Lawyer = Narrator (some say "director")
- Juror = listener
- Witnesses = characters positioned along the story in light of the structure.



Finally: Make them explain

If you're explaining, you're losing
- Robert Rose III



2015 Winter Convention
December 3, 2015

Medical Malpractice Session

Considering Alternatives to Medical Negligence Jury Trials: the rise of the new tort reform

Michael Shroge
Cleveland, OH

2015 WINTER CONVENTION PRESENTATION

CONSIDERING ALTERNATIVE TO MEDICAL NEGLIGENCE JURY TRIALS: THE RISE OF THE NEW TORT REFORM

Michael Shroge, Esq., Cleveland, Ohio

Over the last 12 to 15 years it is undeniable that forces wishing to reshape traditional tort law have continued to win the fight towards making it harder for those injured by the acts of others to seek justice. You need not look very far to see that in Ohio. Since the passage of tort "reform" we have continued to see a plethora of Bills and proposals seeking to continue to change the dynamic in favor of large insurers and their insured to the detriment of those injured by those insured. So what's next?

In the last 5 to 10 years we have seen an increasing number of immunity Bills passed, which we believe will only continue to increase. However, that only limits the exposure to insurance companies and their insured by a small margin over a long course. The question that has been asked on the other side of the bar is: How do we significantly transform the tort system to finally tilt the playing field in favor of the insurance company and their insured? The answer: Get rid of juries.

This presentation will cover a brief overview of several current proposals, either already passed into law or simply proposed as pending legislation, in this state and several others that seek to change the landscape of the current system of jury trials. While only one, but in conservative assessment the most radical, has been introduced in Ohio. However, several other states have moved in a direction to offer more than traditional tort "reform" and there is a belief that these will continue to take root across the country - especially in those states that have overwhelming conservative state legislatures and conservative governors.

I. OHIO

Introduction of the Medical Insurance Compensation System or "MICS"

House Bill 157 was introduced during the 131st General Assembly by its author, Representative James Butler from the Ohio House District 41. The following are the pertinent sections from that Bill that cover the MICS proposal"

Sec. 3965.01 . As used in this chapter and Chapter 3967. of the Revised Code:

(A) "Advanced practice registered nurse" means any certified nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, or certified nurse midwife who holds a certificate of authority issued by the boar d of nursing under Chapter 4723. of the Revised Code.

(B) "Chiropractic claim" means any claim under this chapter that lists a chiropractor or any employee or agent of a chiropractor and that arises out of the chiropractic diagnosis, care, or treatment of any person.

For purposes of sections 2305.234, 2317.02, 3929.302, and 3937.35 of the Revised Code, "chiropractic claim" includes derivative claims for relief that arise from the chiropractic diagnosis, care, or treatment of a person.

© "Chiropractor" means any person who is licensed to practice chiropractic by the state chiropractic board.

(D) "Claimant" means any individual who brings a claim under this chapter or who, if deceased, is the subject of a claim brought under this chapter.

(E) "Dental claim" means any claim under this chapter that lists a dentist or any employee or agent of a dentist and that arises out of a dental operation or the dental diagnosis, care, or treatment of any person.

For purposes of sections 2305.234, 2317.02, and 3929.302 of the Revised Code, "dental claim" includes derivative claims for relief that arise from the dental diagnosis, care, or treatment of a person.

(F) "Dentist" means any person who is licensed to practice dentistry by the state dental board.

(G) "Derivative claim" includes a claim of a parent , guardian, custodian, or spouse of an individual who was the subject of any medical diagnosis, care, or treatment, dental diagnosis, care, or treatment, dental operation, optometric diagnosis, care, or treatment, or chiropractic diagnosis, care, or treatment, that arises from that diagnosis, care, treatment, or operation, and that seeks the recovery of damages for any of the following:

(1) Loss of society, consortium, companionship, care, assistance, attention, protection, advice, guidance, counsel, instruction, training, or education, or any other intangible loss that was sustained by the parent, guardian, custodian, or spouse;

(2) Expenditures of the parent, guardian, custodian, or spouse for medical, dental, optometric, or chiropractic care or treatment, for rehabilitation services, or for other care, treatment, services, products, or accommodations provided to the individual who was the subject of the medical diagnosis, care, or treatment, the dental diagnosis, care, or treatment, the dental operation, the optometric diagnosis, care, or treatment, or the chiropractic diagnosis, care, or treatment.

(H) "Emergency medical technician-basic," "emergency medical technician-intermediate," and "emergency medical technician-paramedic" mean any person who is certified under

Chapter 4765. of the Revised Code as an emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, whichever is applicable.

(I) "Health care professional standards board" means the health care professional standards board created in section 4746.02 of the Revised Code.

(J) "Home" has the same meaning as in section 3721.10 of the Revised Code.

(K) "Hospital" includes any person, corporation, association, board, or authority that is responsible for the operation of any hospital licensed or registered in the state, including those that are owned or operated by the state, political subdivisions, any person, any corporation, or any combination of the state, political subdivisions, persons, and corporations. "Hospital" also includes any person, corporation, association, board, entity, or authority that is responsible for the operation of any clinic that employs a full-time staff of physicians practicing in more than one recognized medical specialty and rendering advice, diagnosis, care, and treatment to individuals. "Hospital" does not include any hospital operated by the government of the United States or any of its branches.

(L) "Insurer" and "liability insurer" include the medical liability underwriting association, unless the context clearly indicates otherwise.

(M) "Liability insurance" means coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death, disease, or injury of any person as the result of negligence or malpractice in rendering professional service or related to the credentialing

or accreditation of any medical professional or hospital by any provider or any employee or agent acting within the scope of their duties for a provider.

(N) "Licensed practical nurse" means any person who is licensed to practice nursing as a licensed practical nurse by the board of nursing pursuant to Chapter 4723. of the Revised Code.

(O) "Medical claim" means any claim under this chapter that lists a physician, podiatrist, hospital, home, or residential facility; any employee or agent of a physician, podiatrist, hospital, home, or residential facility; or a licensed practical nurse, registered nurse, advanced practice registered nurse, pharmacist, physical therapist, physician assistant, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician paramedic; and that arises out of the medical diagnosis, care, or treatment of any person. "Medical claim" includes both of the following:

(1) Claims that arise out of the medical diagnosis, care, or treatment of any person and to which either of the following applies:

(a) The claim results from acts or omissions in providing medical care.

(b) The claim results from the hiring, training, supervision, retention, or termination of caregivers providing medical diagnosis, care, or treatment.

(2) Claims that arise out of the medical diagnosis, care, or treatment of any person and that are brought under section 3721.17 of the Revised Code.

For purposes of sections 2305.234, 2317.02, 3929.302, and

3937.35 of the Revised Code, "medical claim" includes derivative claims for relief that arise from the medical diagnosis, care, or treatment of a person.

(P) "Medical injury compensation panel" means a panel established pursuant to section 3967.02 of the Revised Code.

(Q) "Medical liability underwriting association" has the same meaning as in section 3929.62 of the Revised Code.

® "Optometric claim" means any claim under this chapter that lists an optometrist, or any employee or agent of an optometrist, and that arises out of the optometric diagnosis, care, or treatment of any person.

For purposes of sections 2305.234, 2317.02, 3929.302, and 3937.35 of the Revised Code, "optometric claim" includes derivative claims for relief that arise from the optometric diagnosis, care, or treatment of a person.

(S) "Optometrist" means any person licensed to practice optometry by the state board of optometry.

(T) "Pharmacist" means a person who is licensed to practice pharmacy under Chapter 4729. of the Revised Code.

(U) "Physician" means a person who is licensed to practice medicine and surgery or osteopathic medicine and surgery by the state medical board or a person who otherwise is authorized to practice medicine and surgery or osteopathic medicine and surgery in this state.

(V) "Physician assistant" means any person who holds a valid certificate to practice issued pursuant to Chapter 4730. of the Revised Code.

(W) "Physical therapist" means any person who is licensed to practice physical therapy under Chapter 4755. of the Revised Code.

(X) "Podiatrist" means any person who is licensed to practice podiatric medicine and surgery by the state medical board.

(Y) "Provider" means a dentist, chiropractor, emergency medical technician-basic, emergency medical technician intermediate, emergency medical technician-paramedic, home, hospital, licensed practical nurse, optometrist, pharmacist, physician, physician assistant, physical therapist, podiatrist, registered nurse, or registered facility.

(Z) "Registered nurse" means any person who is licensed to practice nursing as a registered nurse by the board of nursing pursuant to Chapter 4723. of the Revised Code.

(AA) "Residential facility" means a facility licensed under section 5123.19 of the Revised Code.

Sec. 3965.02 . (A) No provider shall fail to obtain liability insurance.

(B)(1) Except as otherwise provided in division (D) of this section, a provider who complies with division (A) of this section shall not be liable to respond in damages at common law or b y statute for any of the following occurring during the period covered by the premiums paid by the provider to the insurer:

(a) An injury received by an individual that arises out of the chiropractic diagnosis, care, or treatment of the individual;

(b) An injury received by an individual that arises from a dental operation or the dental diagnosis, care, or treatment of the individual;

© An injury received by an individual that arises out of the medical diagnosis, care, or treatment of the individual;

(d) An injury received by an individual that arises out of the optometric diagnosis, care, or treatment of the individual;

(e) For the death of an individual resulting from an injury described in division (B)(1)(a), (b), ©, or (d) of this section;

(f) For a derivative claim that results from an injury described in division (B)(1)(a), (b), ©, or (d) of this section from the death of an individual resulting from such an injury.

(2) Division (B)(1) of this section applies to a common law or statutory claim as described in that division regardless of whether an injury or death is compensable under this chapter .

© No employee of any provider shall be liable to respond in damages at common law or by statute for any injury, death, or derivative claim, a s described in division (B) of this section on the condition that the injury, death, or derivative claim is found to be compensable under this chapter or Chapter 3967. of the Revised Code.

(D) The immunity provided under division (B) or © of this section is not applicable in either of the following claims:

(1) A claim that a provider or an employee of a provider intentionally caused an injury to or the death of an individual that arises out of any of the following:

(a) The chiropractic diagnosis, care, or treatment of the individual;

(b) A dental operation or the dental diagnosis, care, or treatment of the individual;

© The medical diagnosis, care, or treatment of the individual;

(d) The optometric diagnosis, care, or treatment of the individual.

(2) A claim that lists a provider who violates division (A) of this section for an injury or death arising out of any of th e following :

(a) The chiropractic diagnosis, care, or treatment of the individual;

(b) A dental operation or the dental diagnosis, care, or treatment of the individual;

© The medical diagnosis, care, or treatment of the individual;

(d) The optometric diagnosis, care, or treatment of the individual.

(E) As used in division (D) of this section , "intentionally caused" means that a provider acted with deliberate intent t o cause another individual to suffer an injury or death.

(F) Except as provided in division (D) of this section, a claim brought under this chapter and Chapter 3967. of the Revise d Code shall be the exclusive remedy against a provider or th e provider's liability insurer for any injury, death, or derivative claim , as described in division (B) of this section, including any action by the health insurer or employer of the individual wh o is the subject of the claim .

Sec. 3965.03 . A provider who fails to comply with division (A) of section 3965.02 of the Revised Code is not entitled to th e benefits of this chapter in relation to chiropractic, dental, medical, optometric, or derivative claims that arise during the period of that noncompliance and is liable to an individual, and the individual's personal representatives, for

damages suffered by reason of injury or death arising out of the circumstances described in division (B) of section 3965.02 of the Revised Code. In such a civil action, the defendant shall not avail the defendant's self of either of the following common law defenses:

(A) The defense of the assumption of risk;

(B) The defense of contributory negligence.

Sec. 3965.04 . (A) If an individual files a chiropractic, dental, medical, optometric, or derivative claim for compensation under this chapter that lists a provider who was violating division (A) of section 3965.02 of the Revised Code at the time the claim arose , and it is determined under this chapter or Chapter 3967. of the Revised Code that the individual is entitled to compensation under this chapter, the administrator of medical injury compensation shall make and file for record in the office of the county recorder in the counties where the provider's real or tangible personal property is located, an affidavit that includes all of the following information:

(1) The date on which the application was filed with the administrator;

(2) The name and address of the provider listed in the claim;

(3) The fact that the provider had not complied with section 3965.02 of the Revised Code .

(B) The recorder shall accept and file the affidavit and record the same as a mortgage on real estate and shall file the same as a chattel mortgage, and the recorder shall index the same as a mortgage on real estate and as a chattel mortgage. A copy of the application or other record documenting the claim

shall be filed with the affidavit. A copy of the affidavit shall be serve upon the provider by the administrator .

The following then is a list of highlights from the Bill:

Introduced in the Ohio House of Representatives in April, 2015, House Bill 157 dismantles all statutory, procedural, common law and Constitutional rights and protections regarding medical negligence and replaces them with a Medical Injury Compensation System (MICS). The MICS creates a large state agency headed by an administrator appointed by the governor. The administrator will hire physicians who will determine whether an injured patient is entitled to compensation and actuaries who will decide the amount of that compensation. The MICS covers all medical negligence cases including hospital, nursing home and wrongful death cases.

The MICS System

The following is a step by step analysis of the system:

1. All health care providers, including physicians, nursing homes, hospitals, podiatrists, pharmacies, optometrists, and dentists are covered by the system as long as they purchase insurance and their tortuous act is not intentional.
2. An injured patient or the family of a deceased patient (referred to as the claimant) must file a claim for compensation within six months of the injury, the discovery of the injury, or death.

   a. There is a four year all-encompassing statute of repose.

b. There is no affidavit of merit requirement or any requirement of a review by a medical expert. A claimant can bring their own claim.

c. The claimant must name all health care providers. If the claimant fails to name one or more of the providers, their compensation will be reduced by the percentage of the unnamed providers' negligence.

3. Once the claim is received, the administrator assigns the claim to a physician reviewer. The physician reviewer must be a member of the same area of practice as the provider, must practice in the same geographic area, and 50% of his/her practice must be in the same clinical practice as the provider.

a. Upon request of the physician reviewer or the provider's insurance company, the claimant must sign medical releases for their records and statements, must submit to a statement if requested, and must undergo a medical examination if requested. There are no boundaries on these requests and a claimant's claim can be dismissed for failure to submit.

b. The physician reviewer can obtain statements from the provider and any medical personnel who treated the claimant including those who treated patient after the injury. The physician reviewer can also obtain expert opinions, including another physician to determine proximate cause.

c. During the review process, the provider's liability insurance company can compel the claimant to submit to a medical exam and can require the claimant to sign medical releases. There is no restriction as to relevance of the records sought.

d. The Claimant has no right to submit expert reports, medical opinion letters, or to take depositions of the providers.

e. The physician reviewer makes a determination whether the claimant is entitled to be compensated. The Claimant is entitled to compensation if the physician reviewer determines "whether clear and convincing evidence does not exist that the provider did not breach the standard of care." There is no burden of proof set forth regarding the issue of proximate cause.

4. If the physician reviewer determines that the Claimant is entitled to compensation, the case goes to an actuary for the determination of both economic and non-economic damages, set forth as "wage loss, the life care expenses, other expenses, pain and suffering, disfigurement, and loss of society."

a. During the damages determination, both the actuary and the providers' insurance company can order medical exams.

b. There is no provision that states a Claimant may provide any economic, medical, life care plan, or extent of loss damages information to the actuary.

c. The assumption is that the law will allow an actuarial determination of wrongful death and pain and suffering damages in a one size fits all manner rather than on a case-by-case basis.

d. The actuarial award then will be reduced by an actuarial computation called the "compensation modifier." This is a reduction based on prior claims experience.

5. If either party is dissatisfied with the physician reviewer's decision on whether to allow the

Claimant to participate in the system, that party may appeal.

a. Please note that the actuary's decision is final. Neither party can appeal that decision.

b. The appeal panel is a three-member panel consisting of physicians with the same qualifications as the physician reviewer. Essentially, the provider's colleagues are the ones who are determining whether the provider's care fell below the standard of care. The only evidence that can be submitted by the Claimant or the insurance company is an expert report. No discovery can be conducted by the parties.

6. The review panel's determination can be appealed by either party to the Court of Common Pleas for a jury to decide, but the jury may decide only whether the physician fell below the standard of care. The Court cannot consider the amount of damages to be awarded. Any depositions taken in the proceedings below can be used regardless of who participated in the depositions. None of the physicians whose depositions have been taken can be subpoenaed for trial or for a further deposition. Should the insurance company appeal and lose, the modifier which reduced the initial award will be taken away.

7. The system is ad ministerial in nature. The Common Pleas Court takes a back seat to the entire process.

The MICS System is the most radical approach to the complete eradication of our current jury system of determining medical negligence in the state of Ohio. A similar (really exactly the same if you go and look at the other Bills) legislation has been offered in Florida, Georgia and Tennessee. Although no state has yet adopted this legislation, there is clearly a momentum that's built around this type of proposal. Interestingly, this type of proposal seems to meet opposition not only from groups like OAJ but also from the insurance industry for mostly

obvious and some not so obvious reasons which I will highlight in the presentation.

II. NEW HAMPSHIRE

New Hampshire Law: Chapter 519-C: Early Offers for Medical Injury Claims (effective November 1, 2020)

New Hampshire took steps in 2012 to pass "early offer" legislation. Proponents of the legislation justified the need for this law by convincing the lawmakers New Hampshire's medical negligence legal system was broken and in need of reform. They pointed very specifically to the lengthy delays to get to a jury, frivolous claims and the need for more tort reform. The big hospitals, who employ most New Hampshire physicians, were the major proponents. Most significantly, the Bill sets forth an early offer process, that if not accepted by the injured patient or the family, within certain calculations, and they move forward towards litigation, **the loser pays.** While this system does not completely do away with a jury, the disincentives to moving forward towards litigation are so overwhelming that it's likely that the state will see a dramatic drop, if not the elimination, of medical negligence cases being filed in the courts.

The pertinent sections of the law are as follows:

288:1 Findings and Purpose.

I. The general court finds that the legal system for resolving claims for medical injury requires reform to encourage the fast and efficient payment of meritorious claims. Under the current system individuals with meritorious claims are either unable to litigate their claims or wait for an uncertain recovery while medical providers are often deprived of a fair and reasonable opportunity to address and resolve claims in a timely manner. In addition, the general public is adversely affected because significant resources are spent on litigation costs and defensive medicine or on coverage for those unable to litigate claims. The result is a system that has higher than necessary health care costs, higher liability insurance

premiums, and higher health insurance premiums.

II. These overarching conclusions are based upon the following factual findings:

(a) Inconsistent results: Recent data presented to the general court by the New Hampshire insurance department pursuant to RSA 519-B:14, II shows that the current medical injury liability system produces inconsistent results with average indemnity payments on similar claims varying substantially from year to year.

(b) Long waits for the parties: The testimony before the general court demonstrates that medical injury cases are highly complex, requiring specialized medical evidence and testimony. This complex medical evidence and testimony requires additional discovery and case preparation that results in a particularly lengthy process for resolving cases.

© Costly litigation: Recent data presented to the general court by the New Hampshire insurance department pursuant to RSA 519-B:14, II shows that the aggregate administrative and litigation costs for all claims for medical injury nearly exceed the amount that claimants receive for their injuries.

(d) Defensive medicine: Data from the American Medical Association, Gallup, Harvard School of Public Health, Health Affairs Magazine, and other reliable sources estimate that defensive medicine, practiced in response to the current medical injury system, increases the annual health care expenditures in the United States by billions of dollars. These organizations consider defensive medicine to be diagnostic tests or treatments that have little or no expected benefit to the patient, ordered primarily as a means to guard against claims of liability.

III. The legislature further finds that the slow, inconsistent, and costly nature of the existing medical injury litigation system has a detrimental impact upon injured claimants, whose medical and economic needs require rapid resolution of their claims with less uncertainty, risk, and costs, as well as upon medical providers whose provision of patient care is disrupted by lengthy and costly litigation of medical injury claims.

IV. Therefore, the important governmental objective of this act is to supplement the existing medical injury compensation system with an alternative system that will provide fast and certain results for those who use it, while preserving access to the court system and medical injury screening panels for parties that choose to resolve claims under the current system. The general court further finds that the early offer process set forth in RSA 519-C as inserted by this act to resolve medical injury claims is substantially related to this important governmental objective.

V. The general court further finds that medical injury claimants will benefit from the early offer process set forth in RSA 519-C as inserted by this act as it provides

the option of a simple, clear process defined in statute that provides prompt and sure recovery of all economic losses associated with meritorious claims settled pursuant to RSA 519-C. The early offer process, if elected, would be more efficient and cost effective in many cases than the high risk, high cost traditional litigation process.

VI. In exchange for the benefits of the early offer process established in this act, the claimant agrees to participate fully in the process, which may affect the damages the claimant can recover, the fees the claimant's attorney may receive, and other important rights or claims that may exist under the existing system.

VII. The general court finds that the benefits to the public and to the parties to medical injury claims from the process established in this act far exceed the burdens imposed on the general public and medical injury claimants.

288:2 New Chapter; Early Offers for Medical Injury Claims. Amend RSA by inserting after chapter 519-B the following new chapter:

CHAPTER 519-C

EARLY OFFERS FOR MEDICAL INJURY CLAIMS

519-C:1 Definitions. In this chapter:

I. "Claim for medical injury" means any claim against a medical care provider, whether based in tort, contract, or otherwise, to recover damages on account of a medical injury.

II. "Claimant" means an individual who, in his or her own right, or on behalf of another as otherwise permitted by law, is seeking compensation for a medical injury, due to alleged sub-standard medical care or treatment.

III. "Early offer" means an offer to pay an injured person's economic loss related to a medical injury, and reasonable attorney's fees and costs incurred in representing the injured person under this chapter. No other damages of any kind shall be included in an early offer under this chapter.

IV. "Economic loss" means monetary expenses incurred by or on behalf of a claimant reasonably related to a medical injury and its consequences, including actual out-of-pocket medical expenses, replacement services, additional payment to the claimant pursuant to RSA 519-C:7, and 100 percent of the claimant's salary, wages, or income from self-employment or contract work lost as a result of the medical injury. Economic loss does not include: pain and suffering, punitive damages, enhanced compensatory damages, exemplary damages, damages for loss of enjoyment of life (hedonic damages), inconvenience, physical impairment, mental anguish, emotional pain and suffering, and loss of the following: earning capacity,

consortium, society, companionship, comfort, protection, marital care, parental care, attention, advice, counsel, training, guidance or education, and all other non-economic damages of any kind.

V. "Hearing officer" means a person of judicial and/or legal training, common sense, and a respect for the law, chosen by agreement of the parties from a list of neutral persons maintained by the judicial branch office of mediation and arbitration. If the parties cannot agree on the choice of a hearing officer, one will be selected at random from the list by the insurance department. Fees paid to the hearing officer for presiding at hearings under this chapter shall be paid by the medical care provider at a rate of $200 per hour and shall be reviewed for reasonableness by the insurance department. No hearing officer shall be employed by the insurance department or shall serve if such service would constitute a conflict under the New Hampshire Rules of Professional Conduct, or would require disqualification under the Code of Judicial Conduct.

VI. "Medical care provider" means a physician, physician's assistant, registered or licensed practical nurse, hospital, clinic, or other health care provider or agency licensed by the state, or otherwise lawfully providing medical care or services, or an officer, employee, or agent thereof acting in the course of and scope of employment.

VII. "Medical injury" or "injury" means any adverse, untoward, or undesired consequences caused by professional services rendered by a medical care provider, whether resulting from negligence, error, or omission in the performance of such services; from rendition of such services without informed consent or in breach of warranty or in violation of contract; from failure to diagnose; from premature abandonment of a patient or of a course of treatment; from failure properly to maintain equipment or appliances necessary to the rendition of such services; or otherwise arising out of or sustained in the course of such services.

VIII. "Notice of injury" means written notice by certified mail provided to the medical care provider alleged to have caused a medical injury, and containing:

(a) The name, address, and telephone number of the claimant;

(b) The believed date and place of the alleged medical injury;

© The nature of the alleged injury;

(d) An explanation, if known, as to how the alleged injury was caused;

(e) A description of the severity of the alleged injury, including the claimant's opinion of where the injury is located on the National Practitioner Data Bank severity scale;

(f) Medical records and medical bills associated with the alleged injury or a limited

authorization allowing the medical care provider to obtain medical records and medical bills associated with the alleged injury;

(g) Evidence of lost wages or income from self-employment or contract work for the individual suffering from an alleged medical injury, which may be supplied through income tax returns or paycheck stubs for the year prior to the alleged injury and any subsequent records up to the date of the notice of alleged injury, or a limited authorization allowing the medical care provider to obtain such records;

(h) A demand for economic loss resulting from the alleged injury, that includes only medical expenses, replacement services, reasonable attorney fees, and lost wages, or income from self-employment or contract work;

(I) The name, address, and telephone number of claimant's attorney; and

(j) A request that the medical care provider extend an early offer of settlement of the claim.

IX. "Personal representative" means an executor, administrator, successor personal representative, or special administrator of a decedent's estate or a person legally authorized to perform substantially the same functions.

X. "Reasonable attorney fee" means 20 percent of the present value of the claimant's economic loss and the reasonable costs incurred in representing the injured person under this chapter.

XI. "Replacement services" means expenses reasonably incurred in obtaining ordinary and necessary services from others, who are not members of the injured person's household, in lieu of those the injured person would have performed for the benefit of the household, but could not because of the injury.

XII. "Wages" means monetary payment for services rendered, and the reasonable value of board, rent, housing, lodging, fuel, or a similar advantage received from the employer and gratuities received in the course of employment from others than the employer; but "wages" shall not include any sum paid by the employer to the employee to cover any special expenses incurred by the employee because of the nature of the employment. For individuals receiving unemployment benefits pursuant to RSA 282-A:25 at the time of the injury, wages shall equal the wage rate used to determine the unemployed individual's unemployment benefit pursuant to RSA 282-A:25. For a minor who is injured prior to reaching the age of 18 and who is unable to perform any gainful work as a result of the medical injury, upon reaching the age of 18 wages shall equal the mean New Hampshire per capita income as shown by the American Community Survey's 1-year Estimate (inflation adjusted), produced by the United States Census Bureau.

519-C:2 Procedure.

I. After a medical injury, the claimant may:

(a) Pursue resolution of a claim for medical injury pursuant to this chapter; or

(b) Pursue an action for medical injury as provided in RSA 507-E and RSA 519-B.

II. For as long as the claimant and medical provider are proceeding under this chapter, this section shall govern the procedure for resolving the medical injury claim at issue between the 2 parties, notwithstanding any other provision of law.

III. If the claimant elects to pursue a remedy under this chapter, the claimant shall serve a notice of injury to the medical care provider alleged to be responsible for the injury and an executed notification and waiver of rights in the form set forth in RSA 519-C:13, by certified mail, return receipt requested.

IV. Upon the receipt by the medical care provider of a notice of injury and an executed notification and waiver of rights, the medical care provider may elect to:

(a) Extend an early offer of settlement; or

(b) Decline to extend an early offer of settlement.

V. A claimant's failure to submit a notice of injury requesting an early offer, or a provider's failure to extend an early offer, shall not be subject to review in any hearing, court, or other proceeding of any kind.

VI. The medical care provider shall respond to the claimant's notice of injury in writing, within 90 days, setting forth the details of its early offer, or indicating that the medical care provider has decided not to extend an early offer of settlement. The medical care provider's written response shall be sent by certified mail, return receipt requested, to the address provided in the claimant's notice of injury.

VII. The medical care provider may request in writing that the individual alleging a medical injury submit to an independent medical examination by a qualified and board certified physician chosen by the medical care provider and agreed to by the claimant at a time and place reasonably convenient for the claimant. If the parties cannot agree on a physician to conduct the examination within 30 days of the request, the hearing officer shall select the physician. The physician conducting the examination shall not be affiliated directly or indirectly in any way, with the medical care provider alleged to have caused the injury. The cost of the examination, including reasonable travel expenses for the claimant, shall be paid by the medical care provider's professional liability insurance company. Within 5 days of receipt, the medical provider or its insurer shall, at no cost to the claimant, provide the claimant with all reports and documents originating from the

examination. The claimant shall also be entitled to obtain a transcript and/or audio-video recording of the examination at the claimant's expense. Any physician conducting medical examinations under this section shall be certified by the appropriate specialty board as recognized by the American Board of Medical Specialties and in good standing with the New Hampshire board of medicine.

VIII. If the medical care provider requests that the claimant submit to a physical examination as set forth in paragraph VII, the time allowed for a medical care provider to respond to the claimant's notice of injury shall be extended by 30 days.

IX. If the medical care provider extends an early offer, the claimant shall accept or reject the medical care provider's written offer in writing within 60 days of receipt of the offer. If the claimant requests a hearing pursuant to RSA 519-C:10, to resolve any dispute with respect to the content of an early offer, the time frame within which the claimant may accept or reject the early offer shall be extended until 10 days after the decision on the disputed issue is issued by the hearing officer.

X. If the claimant accepts the medical care provider's early offer, the claimant shall notify the medical care provider in writing by certified mail, return receipt requested, and thereafter, the claimant is barred from pursuing any claim for the same medical injury against any medical care provider.

XI. If the claimant rejects the medical care provider's early offer or does not accept the medical care provider's early offer within the time constraints provided by paragraph IX, the early offer shall be considered rejected. A claimant who rejects an early offer may pursue an action for medical injury against the medical care provider pursuant to RSA 507-E and RSA 519-B.

XII. A claimant who rejects an early offer and who does not prevail in an action for medical injury against the medical care provider by being awarded at least 125 percent of the early offer amount, shall be responsible for paying the medical care provider's reasonable attorney's fees and costs incurred in the proceedings under this chapter. The claimant shall certify to the court that a bond or other suitable security for payment of the medical care provider's reasonable attorney's fees and costs has been posted before the court shall consider the case.

519-C:3 Unrepresented Claimant.

I. If the claimant is not represented by legal counsel, upon receiving a notice of injury, the medical care provider shall provide a neutral advisor who is a member of the New Hampshire Bar or a retired judge, at the medical care provider's expense, to offer assistance to the claimant and medical care provider under this chapter. Among other things, the neutral advisor shall encourage the claimant to consider retaining an attorney, and shall ensure the claimant is aware of the differences between proceeding under this chapter or as provided in RSA 507-E and RSA 519-

B.

II. A claimant who was unrepresented at the time the claimant submitted the notice and waiver of rights shall have the right to withdraw the notice of injury and the notice and waiver of rights within 5 business days after the claimant's first meeting with the neutral advisor, which shall occur no later than 10 business days from claimant's notification of the identity of the neutral advisor. In the event the claimant withdraws the notice of injury, the early offer process shall be terminated and both parties shall proceed as if the notice of injury was never filed.

III. No medical care provider or insurer shall extend an early offer prior to the expiration of 15 business days after the claimant receives notification of the appointment of the neutral advisor.

519-C:4 Confidentiality.

I. Proceedings, records, and communications during negotiation of an early offer shall be treated as private and confidential by the claimant and the medical care provider. The outcome and any other writings, evidence, or statements made or offered by a party or a party's representative during negotiation of an early offer and relevant only to the early offer process are not admissible in court or in a screening panel hearing under RSA 519-B, shall not be submitted or used for any purpose in a subsequent trial, and shall not be publicly disclosed.

II. A notice of injury provided pursuant to RSA 519-C:2, III, and subsequent actions taken pursuant to this chapter shall be exempt from the reporting requirements of RSA 329:17 and administrative rules adopted thereunder, unless the parties reach a settlement under this chapter. Settlements reached pursuant to this chapter are not exempt from the reporting requirements of RSA 329:17 and said administrative rules.

519-C:5 Payment of Early Offer.

I. If an early offer is accepted, economic losses previously incurred by the claimant as a result of the medical injury and the reasonable attorney fee shall be paid by the medical care provider to the claimant within 15 days of the claimant accepting an early offer.

II. If an early offer is accepted, the medical care provider shall pay future economic losses incurred by the claimant to the claimant as such losses accrue. If any requested payment is denied, the medical provider shall notify the claimant in writing of the denial and the basis for denial, and inform the claimant that any request for a hearing under RSA 519-C:10 regarding the denial must be made within 30 days of the date of denial.

(a) Payments for medical bills arising after the early offer settlement is reached shall be made within 15 days after the medical care provider receives reasonable proof of the fact and the amount of loss sustained. If reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof shall be paid within 15 days after such proof is received. Any part or all of the remainder of the claim that is later supported by reasonable proof shall be paid within 15 days after such proof is received by the medical care provider. The medical care provider shall pay any and all fees and charges incurred by the claimant resulting from failure to make timely payment of medical bills.

(b) Payment of lost wages shall be made weekly. At a minimum, such payments shall be adjusted annually on July 1 by a factor equal to the percentage change in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) for Boston-Brockton-Nashua, MA-NH-ME-CT for the prior 12 months established by the Federal Bureau of Labor Statistics.

© Payment of any other amounts due under an early offer shall be paid within 30 days of the date that the provider receives notice and proof of the fact and amount that is due.

(d) When necessary for the medical care provider or its insurer to evaluate whether medical expenses are reasonably related to the medical injury, the medical care provider may request in writing that the claimant submit to an independent medical evaluation as provided by RSA 519-C:2, VII.

III. Interest shall accrue at the rate of 1-1/2 percent per month on any amounts due under an early offer that are not paid as prescribed by this section.

IV. In lieu of periodic payments, the claimant and medical care provider may agree upon a lump sum payment for any and all potential future economic losses suffered by the claimant, provided that the lump sum agreement is reviewed and approved by a hearing officer after a hearing.

519-C:6 Compensation for Death. If death results from a medical injury, the amount of an early offer pursuant to this chapter shall include:

I. Any economic loss incurred by the decedent prior to death;

II. The value at the time of death of what would have been the net earnings of the deceased, less living expenses during the period of his or her life expectance, but for the medical injury;

III. The value of replacement services during the period of the decedent's life expectance, but for the medical injury;

IV. The additional payment determined pursuant to RSA 519-C:7; and

V. A reasonable attorney fee.

519-C:7 Additional Payment to the Claimant.

I. In addition to the lost wages, medical expenses, and replacement services, economic loss included in any early offer under this chapter shall include an additional payment to the claimant.

II. The additional payment, as adjusted under paragraph V, that must be included in an early offer shall be:

(a) For a temporary injury involving only emotional harm, without physical injury: $6,600.

(b) For a temporary injury involving insignificant harm: $2,100.

© For a temporary injury involving minor harm: $7,800.

(d) For a temporary injury involving major harm: $31,500.

(e) For a permanent injury involving minor harm: $35,500.

(f) For a permanent injury involving significant harm: $81,500.

(g) For a permanent injury involving major harm: $127,500.

(h) For a permanent injury involving grave harm, or an injury resulting in death: $140,000.

III. Classification of injuries under paragraph II shall be determined using the National Practitioner Data Bank severity scale.

IV. Either party may request a hearing pursuant to RSA 519-C:10 to resolve a dispute regarding classification of injury severity under this section.

V. The additional payment amounts in paragraph II shall be adjusted annually on July 1 beginning in 2013 by a factor equal to the percentage change in the CPI-U index for medical care for the Northeast Region for the prior 12 months established by the Federal Bureau of Labor Statistics.

519-C:8 Assignments; Certain Claims of Creditors.

I. Payments for economic loss under this chapter shall not be assignable.

II. Claims for child support, spousal support, or combination child and spousal support payments, pursuant to RSA 458-B, may be enforced against economic loss

settlements.

519-C:9 Multiple Parties Alleged to Have Contributed to Causing Medical Injury.

I. Every early offer to settle a claim under this chapter shall include all of the economic loss, plus a reasonable attorney fee as set forth herein, and shall not be reduced or apportioned based on comparative fault of multiple providers. Any medical care provider, or combination of providers alleged to have contributed to causing an injury may extend an early offer as provided in this chapter, and acceptance of that offer by the claimant shall bar any further lawsuit or other claims for compensation by the claimant against all medical care providers arising as a result of the same medical injury. However, any medical care provider that extends an early offer to a claimant may seek contribution in a separate action against any medical care provider or other party that contributed to causing the medical injury. The injured individual shall not be a party to any action for contribution between medical care providers; however, the injured individual shall reasonably cooperate with the proceedings and provide such reasonable information and testimony as may be necessary to resolve the contribution claim. The parties to the action shall pay the injured individual all reasonable costs associated with such reasonable cooperation and testimony, including travel expenses and reasonable loss of earnings or a witness fee of $100 per day, whichever is greater.

II. Nothing in this section shall be regarded as exempting contribution claims from any applicable provisions of RSA 519-B.

III. Nothing in this section shall limit claims by the claimant against any party other than medical care providers who participated in providing medical care which gave rise to the medical injury.

519-C:10 Dispute Resolution.

I. Upon the request of either party, a qualified hearing officer shall be chosen as provided in RSA 519-C:1, V to resolve a dispute regarding an early offer made under this chapter.

II. Dispute resolution under this chapter shall be limited to the following issues:

(a) Whether an early offer includes all of the economic loss related to the injury that is required by this chapter;

(b) Whether economic loss of any kind, past or future, asserted by the claimant, is reasonably related to an injury that is the subject of an early offer;

© Which severity level, pursuant to RSA 519-C:7, most closely describes the injury that is the subject of an early offer; or

(d) What the net present value of an early offer is, for the purposes of calculating the appropriate payment for reasonable attorney fees.

III. No other disputes arising under this chapter may be the subject of, or resolved through, a hearing under this section.

IV. Any request for a hearing pursuant to this section shall contain a reasonably complete statement of the issue or issues to be resolved in the hearing and shall fully identify all parties to the dispute. Any issue not listed in paragraph II shall not be considered. Hearings concerning economic loss that arises after a settlement under this chapter shall be requested within 30 days of the date payment for such economic loss is denied under RSA 519-C:5, II.

V. The medical care provider or, if applicable, the medical care provider's insurer shall pay all reasonable costs associated with a hearing under this section.

VI. Hearings conducted under this chapter shall be governed exclusively by this section and by rules adopted pursuant to RSA 519-C:15.

VII. Any hearing conducted under this chapter shall be conducted within 45 days of the request and a decision shall be issued within 10 days of completion of the hearing. Hearings may be conducted in person or telephonically.

VIII. On a motion from any party, or on his or her own motion, a hearing officer may summarily determine any issue in dispute without a hearing if it appears from the record that there are no material issues of fact in dispute. By agreement of the parties, any dispute may be determined by the hearing officer on the written record without a hearing.

IX. Hearings conducted pursuant to this chapter shall be limited to a reasonable amount of time as determined by the hearing officer, shall not require the presence or testimony of expert witnesses, and shall be recorded by an accurate audio or stenographic recording of all testimony, available to both parties at the non-prevailing parties' expense.

X. Parties to a hearing under this section shall exchange exhibits and witness lists at least 10 days prior to the hearing. No exhibit may be introduced or witness called in a hearing unless exchanged with the opposing party pursuant to this paragraph.

XI. The hearing officer shall issue a written decision resolving the issues in dispute. If the hearing officer finds against the medical provider on any issue, the decision shall modify the terms of the early offer. The early offer, as modified by the decision of the hearing officer, shall be binding on the parties.

XII. In a hearing conducted pursuant to subparagraph II(b) of this section, if the

hearing officer determines the claimant's position to be frivolous, the claimant shall reimburse the medical care provider for its costs related to presenting the dispute to the hearing officer, up to a maximum of $1,000.

XIII. In a hearing conducted pursuant to subparagraph II(b) of this section, if the hearing officer determines the medical care provider's position to be frivolous, the medical care provider shall reimburse the claimant for its costs related to presenting the dispute to the hearing officer, up to a maximum of $1,000, or if the claimant is unrepresented, pay the claimant double the amount that was frivolously disputed or denied.

519-C:11 Limitations of Claims.

I. Except for claims on behalf of deceased individuals, claims for medical injury to a competent adult under this chapter shall be subject to the limitation set forth in RSA 508:4.

II. Except for claims on behalf of deceased individuals, claims for medical injury to a minor or incompetent under this chapter shall be subject to the limitation set forth in RSA 508:8.

III. Claims for medical injuries on behalf of deceased individuals shall be subject to the limitations set forth in RSA 556:7.

IV. Providing a notice of injury to a medical care provider as provided in this chapter shall operate to toll the applicable statute of limitation with respect to that injury from the time such notice is provided to a medical care provider until the expiration of time for a medical care provider to extend an early offer, or if an early offer is extended, until the acceptance or rejection of an early offer by the claimant, whichever occurs later.

519-C:12 Subrogation. Any insurer or third party who has paid or reimbursed economic losses to or for the benefit of the claimant, shall have the right of subrogation against the medical provider entering into an early offer of settlement under this chapter.

519-C:13 Notice and Waiver of Rights.

I. Claimants electing to pursue resolution of a medical injury under this chapter shall execute a notice and waiver of rights which contains the following wording:

WAIVER OF RIGHTS

By agreeing to submit a notice of injury to the medical care provider, I understand that my rights to seek legal remedies and a jury trial for my injuries guaranteed by Part I, Articles 14 and 20 of the New Hampshire Constitution may be affected.

I understand that I have the right to consult and retain an attorney to represent me regarding this matter, and that if an early offer settlement is reached, my attorney will be paid pursuant to RSA 519-C:5, I by the health care provider, in addition to any amount that is paid for my economic loss.

If I do not have an attorney when I sign this waiver form, the medical provider will appoint a neutral advisor to assist me in the early offer process and to explain, among other things, the differences between proceeding under this chapter or as provided in RSA 507-E and RSA 519-B. I HAVE THE RIGHT TO WITHDRAW THIS WAIVER AND THE NOTICE OF INJURY ANY TIME PRIOR TO MIDNIGHT OF THE FIFTH BUSINESS DAY AFTER MY FIRST MEETING WITH THE ADVISOR, WHICH MUST OCCUR NO LATER THAN 10 BUSINESS DAYS FROM MY NOTIFICATION OF THE IDENTITY OF THE NEUTRAL ADVISOR.

If after submitting a notice of injury, the medical care provider does NOT extend an early offer (RSA 519-C:1, III), I am free to pursue my legal remedies as defined in New Hampshire law without restriction.

If after submitting a notice of injury, the medical care provider does extend an early offer (RSA 519-C:1, III), I may either:

(1) Accept the early offer;

(2) Request a hearing before a hearing officer to determine whether the early offer includes all of the economic loss I am entitled to under the statute, and if necessary, the hearing officer may order the medical care provider to increase the early offer to meet the requirements of the early offer law; or

(3) Reject the early offer and seek legal remedies.

I understand that if I reject an early offer and am later awarded economic damages equal to or less than 125 percent of the amount of the early offer, I will be responsible for paying the medical care provider's reasonable attorney's fees and costs incurred in proceedings under this chapter.

I understand that if an early offer is made by the medical care provider and I accept that offer, disputes regarding the early offer can be resolved only in accordance with RSA 519-C:10 by a hearing officer listed with the judicial branch office of mediation and arbitration, at my request or the request of the medical care provider. If either party believes that the decision of the hearing officer is unlawful, that party may seek discretionary review in the New Hampshire court system; however, there is no assurance that the courts will undertake such review.

Date _____ Signature _____

II. A properly executed waiver form by a claimant who is competent at the time the waiver is executed shall be conclusively presumed to be a sufficient, knowing, and voluntary waiver if the waiver form complies with this section.

519-C:14 Other Action for Injury. Except as set forth in RSA 519-C:2, IX, a claimant may only pursue an action for medical injury as provided in RSA 507-E and RSA 519-B when:

I. The claimant elects not to submit a notice of injury pursuant to this chapter;

II. The medical care provider elects not to extend an early offer pursuant to this chapter in response to the notice of injury; or

III. The claimant withdraws the notice of injury and the notice and waiver of rights pursuant to RSA 519-C:3.

519-C:15 Rulemaking. The commissioner of the New Hampshire insurance department shall adopt rules necessary to administer the hearings process under this chapter.

519-C:16 Reports.

I. The insurance commissioner shall report to the general court annually, on or before November 1, on the effects of the early offer process established in this chapter. Such reports shall include, but not be limited to, statistics of each time the early offer process was initiated, including the number of claimants requesting early offers, the number of claimants receiving early offers, a record of the amount of each demand for economic loss, the corresponding early offer from the medical provider and the ultimate amount received by the claimant, if any, the severity of injuries, the time from initial notice to final resolution of claims, and the amount paid on claims.

II. The insurance commissioner may adopt rules under RSA 541-A to collect the data from insurers or any self-insured entity necessary to prepare the report required by this section. To the extent the commissioner collects information from insurers regarding individual claims, loss adjustment and other expenses, reserves, indemnity payments, or other financial information that is not otherwise reported to the commissioner and available to the public, such information shall be treated as examination materials, kept confidential, and not be subject to RSA 91-A.

III. SIMILARITIES BETWEEN THE OHIO "MICS" SYSTEM AND THE NEW HAMPSHIRE "EARLY OFFER" SYSTEM

While it can be argued that the Ohio system is much more radical than the New Hampshire legislation, the justifications being used by both proponents in Ohio as well as those in New Hampshire are striking. More specifically, the following is the findings and purpose section from the New Hampshire Bill:

288:1 Findings and Purpose.

I. The general court finds that the legal system for resolving claims for medical injury requires reform to encourage the fast and efficient payment of meritorious claims. Under the current system individuals with meritorious claims are either unable to litigate their claims or wait for an uncertain recovery while medical providers are often deprived of a fair and reasonable opportunity to address and resolve claims in a timely manner. In addition, the general public is adversely affected because significant resources are spent on litigation costs and defensive medicine or on coverage for those unable to litigate claims. The result is a system that has higher than necessary health care costs, higher liability insurance premiums, and higher health insurance premiums.

II. These overarching conclusions are based upon the following factual findings:

(a) Inconsistent results: Recent data presented to the general court by the New Hampshire insurance department pursuant to RSA 519-B:14, II shows that the current medical injury liability system produces inconsistent results with average indemnity payments on similar claims varying substantially from year to year.

(b) Long waits for the parties: The testimony before the general court demonstrates that medical injury cases are highly complex, requiring specialized medical evidence and testimony. This complex medical evidence and testimony requires additional discovery and case preparation that results in a particularly lengthy process for resolving cases.

© Costly litigation: Recent data presented to the general court by the New Hampshire insurance department pursuant to RSA 519-B:14, II shows that the aggregate administrative and litigation costs for all claims for medical injury nearly exceed the amount that claimants receive for their injuries.

(d) Defensive medicine: Data from the American Medical Association, Gallup, Harvard School of Public Health, Health Affairs Magazine, and other reliable sources estimate that defensive medicine, practiced in response to the current medical injury system, increases the annual health care expenditures in the United States by billions of dollars. These organizations consider defensive medicine to be diagnostic tests or treatments that have little or no expected benefit to the patient, ordered primarily as a means to guard against claims of liability.

III. The legislature further finds that the slow, inconsistent, and costly nature of the existing medical injury litigation system has a detrimental impact upon injured claimants, whose medical and economic needs require rapid resolution of their claims with less uncertainty, risk, and costs, as well as upon medical providers whose provision of patient care is disrupted by lengthy and costly litigation of medical injury claims.

IV. Therefore, the important governmental objective of this act is to supplement the existing medical injury compensation system with an alternative system that will provide fast and certain results for those who use it, while preserving access to the court system and medical injury screening panels for parties that choose to resolve claims under the current system. The general court further finds that the early offer process set forth in RSA 519-C

as inserted by this act to resolve medical injury claims is substantially related to this important governmental objective.

V. The general court further finds that medical injury claimants will benefit from the early offer process set forth in RSA 519-C as inserted by this act as it provides the option of a simple, clear process defined in statute that provides prompt and sure recovery of all economic losses associated with meritorious claims settled pursuant to RSA 519-C. The early offer process, if elected, would be more efficient and cost effective in many cases than the high risk, high cost traditional litigation process.

VI. In exchange for the benefits of the early offer process established in this act, the claimant agrees to participate fully in the process, which may affect the damages the claimant can recover, the fees the claimant's attorney may receive, and other important rights or claims that may exist under the existing system.

VII. The general court finds that the benefits to the public and to the parties to medical injury claims from the process established in this act far exceed the burdens imposed on the general public and medical injury claimants.

Most of the above mentioned language is also being touted by the supporters of the MICS System as flaws in our current system that necessitate change.

It can be argued that the flaws in the current system as highlighted in the New Hampshire Bill and those used by supporters of the Ohio MICS System are accurate. However, the means they offer to get there are a radical shift from hundreds of years of constitutional law, common law and statutory law.

IV. IOWA'S CANDOR BILL

On April 14, 2015, Iowa Governor Terry Branstab signed into law Iowa Senate File 426. That act passed into law is informally labeled the "Candor" Bill that is properly titled as "an act relating to privileged communications between healthcare provider or health facility and a patient following an adverse healthcare incident." The Bill essentially covers the following:

RELATING TO PRIVILEGED COMMUNICATIONS BETWEEN A HEALTH CARE PROVIDER OR HEALTH FACILITY AND A PATIENT FOLLOWING AN ADVERSE HEALTH CARE INCIDENT.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. NEW SECTION. **135P.1 Definitions.**

For the purposes of this chapter, unless the context otherwise requires:

1. *"Adverse health care incident"* means an objective and definable outcome arising from or related to patient care that results in the death or serious physical injury of a patient.

2. *"Health care provider"* means a physician licensed under chapter 148, a physician assistant licensed under chapter 148C, a podiatrist licensed under chapter 149, or an advanced registered nurse practitioner licensed pursuant to chapter 152 or 152E.

3. *"Health facility"* means an institutional health facility as defined in section 135.61, hospice licensed under chapter 135J, home health agency as defined in section 144D.1, assisted living program certified under chapter 231C, clinic, or community health center, and includes any corporation, professional corporation, partnership, limited liability company, limited liability partnership, or other entity comprised of such health facilities.

4. *"Open discussion"* means all communications that are made under section 135P.3, and includes all memoranda, work products, documents, and other materials that are prepared for or submitted in the course of or in connection with communications under section 135P.3.

5. *"Patient"* means a person who receives medical care from a health care provider, or if the person is a minor, deceased, or incapacitated, the person's legal representative.

Sec. 2. NEW SECTION. **135P.2 Confidentiality of open discussions.**

1. Open discussion communications and offers of compensation made under section 135P.3:

a. Do not constitute an admission of liability.

b. Are privileged, confidential, and shall not be disclosed.

c. Are not admissible as evidence in any subsequent judicial, administrative, or arbitration proceeding and are not subject to discovery, subpoena, or other means of legal compulsion for release and shall not be disclosed by any party in any subsequent judicial, administrative, or arbitration proceeding.

2. Communications, memoranda, work products, documents, and other materials, otherwise subject to discovery, that were not prepared specifically for use in a discussion under section 135P.3, are not confidential.

3. The limitation on disclosure imposed by this section includes disclosure during any discovery conducted as part of a subsequent adjudicatory proceeding, and a court or other adjudicatory body shall not compel any person who engages in an open discussion under this chapter to disclose confidential communications or agreements made under section 135P.3.

4. This section does not affect any other law, regulation, or requirement with respect to confidentiality.

Sec. 3. NEW SECTION. **135P.3 Engaging in an open discussion.**

1. If an adverse health care incident occurs in a health facility, the health care provider, or the health care provider jointly with the health facility, may provide the patient with written notice of the desire of the health care provider, or of the health care provider jointly with the health facility, to enter into an open discussion under this chapter. If the health care provider or health facility provides such notice, such notice must be sent within one hundred eighty days after the date on which the health care provider knew, or through the use of diligence should have known, of the adverse health care incident. The notice must include all of the following:

a. Notice of the desire of the health care provider, or of the health care provider jointly with the health facility, to proceed with an open discussion under this chapter.

b. Notice of the patient's right to receive a copy of the medical records related to the adverse health care incident and of the patient's right to authorize the release of the patient's medical records related to the adverse health care incident to any third party.

c. Notice of the patient's right to seek legal counsel.

d. A copy of section 614.1, subsection 9, and notice that the time for a patient to bring a lawsuit is limited under section 614.1, subsection 9, and will not be extended by engaging in an open discussion under this chapter unless all parties agree to an extension in writing.

e. Notice that if the patient chooses to engage in an open discussion with the health care provider or health facility, that all communications made in the course of such a discussion under this chapter, including communications regarding the initiation of an open discussion, are privileged and confidential, are not subject to discovery, subpoena, or other means of legal compulsion for release, and are not admissible in evidence in a judicial, administrative, or arbitration proceeding.

2. If the patient agrees in writing to engage in an open discussion, the patient, health care provider, or health facility engaged in an open discussion under this chapter may include other persons in the open discussion. All additional parties shall also be advised in writing prior to the discussion that discussions are privileged and confidential, are not subject to discovery, subpoena, or other means of legal compulsion for release, and are not admissible in evidence in a judicial, administrative, or arbitration proceeding. The advice in writing must indicate that communications, memoranda, work products, documents, and other materials, otherwise subject to discovery, that were not prepared specifically for use in a discussion under this section, are not confidential.

3. The health care provider or health facility that agrees to engage in an open discussion may do all of the following:

a. Investigate how the adverse health care incident occurred and gather information regarding the medical care or treatment provided.

b. Disclose the results of the investigation to the patient.

c. Openly communicate to the patient the steps the health care provider or health facility will take to prevent future occurrences of the adverse health care incident.

d. Determine either of the following:

(1) That no offer of compensation for the adverse health care incident is warranted and orally communicates that determination to the patient.

(2) That an offer of compensation for the adverse health care incident is warranted and extends such an offer in writing to the patient.

4. If a health care provider or health facility makes an offer of compensation under subsection 3 and the patient is not represented by legal counsel, the health care provider or health facility shall advise the patient of the patient's right to seek legal counsel regarding the offer of compensation.

5. Except for offers of compensation under subsection 3, discussions between the health care provider or health facility and the patient about the compensation offered under subsection 3 shall remain oral.

Sec. 4. NEW SECTION. **135P.4 Payment and resolution.**

1. A payment made to a patient pursuant to section 135P.3 is not a payment resulting from any of the following:

a. A written claim or demand for payment.

b. A claim for purposes of section 272C.9.

c. A claim for purposes of section 505.27.

2. A health care provider or health facility may require the patient, as a condition of an offer of compensation under section 135P.3, to execute all documents and obtain any necessary court approval to resolve an adverse health care incident. The parties shall negotiate the form of such documents or obtain court approval as necessary.

It can be said that the Iowa Candor Bill addresses the same supposed purposes highlighted in the introduction to the Ohio MICS System and the New Hampshire "Early Offer" Bill. The Candor Bill is being touted as a mechanism to provide open communication, potential early offers without the expense of litigation on both sides and is meant to reduce the number of lawsuits being filed in the courts. Empirical data exists both at the University of Michigan, which has followed an internal early offer system for years that has resulted in a dramatic decrease in the number of lawsuits filed against the University's Medical Center and it has in turn decreased the cost of litigation and money spent on paying medical negligence claims.

CONCLUSION

What I've attempted to highlight during this presentation is the obvious migration of State legislatures towards systems that either (1) completely eradicate the jury system, (2) penalize a plaintiff from pursuing litigation or (3) a system to try to engage early enough to avoid both litigation and jury.

While the New Hampshire system is too new to study any empirical evidence of its efficacy, it has certainly laid down a precedent that other states may follow in their future. While in past decades the battle has been almost exclusively over the constitutionality of tort reform efforts, we have now seen, I believe, clear evidence of a shift away from that battle to a much more aggressive agenda attempting to remove medical negligence litigation from our courts and from determinations by unbiased jurors. Beware.