IN THE SUPREME COURT OF THE STATE OF GEORGIA

SUPREME COURT OF GEORGIA
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ATLANTA OCULOPLASTIC SURGERY, P.C. D/B/A OCULUS

Appellant,

vs.

BETTY NESTLEHUTT AND BRUCE NESTLEHUTT

Appellees.

CASE NO.: S09A1432

AMICUS CURIAE BRIEF ON BEHALF OF THE GEORGIA HOSPITAL ASSOCIATION AND THE AMERICAN HOSPITAL ASSOCIATION

Donna P. Bergeson
Georgia Bar No. 054315
Angela T. Burnette
Georgia Bar No. 629230

ALSTON & BIRD, LLP
1201 West Peachtree Street
Atlanta, Georgia 30309
Telephone: 404-881-7000
Facsimile: 404-881-4777

Attorneys for Amicus Curiae
Georgia Hospital Association and the
American Hospital Association

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STATE OF GEORGIA

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AMICUS CURIAE BRIEF OF
THE GEORGIA HOSPITAL ASSOCIATION AND
THE AMERICAN HOSPITAL ASSOCIATION

Pursuant to Georgia Supreme Court Rule 23, The Georgia Hospital Association and the American Hospital Association respectfully submit an Amicus Curiae Brief in support of the position urged by Appellants.

I. STATEMENT OF INTEREST

The Georgia Hospital Association ("GHA") is a nonprofit trade association composed of approximately 170 hospitals and health systems throughout the State. GHA thus represents the interests of the very "medical facilities" expressly provided the protections of O.C.G.A. § 51-13-1.

GHA is committed to improving the delivery of care and citizens' access to

quality hospital care, which will be damaged if O.C.G.A § 51-13-1 is not upheld. In the absence of Georgia's cap on non-economic damages, unlimited awards for pain and suffering could limit access to high risk services such as obstetrics, impede a hospital's ability to provide indigent care, and, in a worse case scenario, result in a hospital's closure. From 1995-2008, 22 hospitals in Georgia have closed, and as of May 2009, 48 different Georgia counties have no acute care hospital.[1] Without Georgia's cap on non-economic damages, a large pain and suffering award could shut the doors of additional hospitals in Georgia, leaving even more Georgia citizens without needed health care services in their home communities.

GHA represents its members in legislative matters, as well as in filing amicus curiae briefs on matters of great gravity and importance to both the public and to health care providers serving Georgia citizens. This case presents issues of critical importance to hospitals throughout Georgia. Because of the broad implications of the trial court's decision, GHA has particular interest in assisting the Court with the issues presented.

The American Hospital Association ("AHA") is a national not-for-profit association that represents the interests of nearly 5,000 hospitals, health care

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[1] *See Hospital Closures in Georgia (1980-2008)* and *Georgia Counties with No Acute-Care Hospitals* (Ga. Hosp. Ass'n, Apr. 2008), available at http://www.gha.org/Publications/Factbook.html. For this Court's convenience, these materials are attached as Exhibits A and B, respectively.

systems, networks and other care providers, as well as 37,000 individual members, all of whom are committed to finding innovative and effective ways of improving the health of the communities they serve. The AHA educates its members on health care issues and trends, and it advocates on their behalf in state and federal legislative, regulatory, and judicial fora to ensure that its members' perspectives and needs are understood and taken into account in the formulation of health care policy. Because of their commitment to advancing the health of communities they serve, the AHA and its members have a great interest in the outcome of this case. The AHA has been in the forefront of advocating for meaningful medical liability reform to assure access to health care services for communities across this country.

As evidenced by the parties' briefs, this case involves the hotly debated issue of Georgia's cap on non-economic damages, O.C.G.A. §51-13-1. GHA and AHA wish to bring to the Court's attention three specific points in filing this brief, all of which result in upholding the caps imposed by O.C.G.A. § 51-13-1 and reversing the decision of the trial court.

First, the Georgia Legislature declared and responded appropriately to a health care crisis in Georgia in 2005, which had already resulted in reduced access to essential health care services in parts of the state, hospitals experiencing 200-300% increases in insurance premiums for significantly less coverage, hospitals attempting to obtain bank loans to pay insurance premiums, and hospitals forced to

choose between staying open or going without insurance coverage altogether.[2] The trial court's Order shows its ***disagreement*** with the legislative finding of a healthcare crisis by including quotation marks around the word "crisis" and declaring "Complaints about a 'crisis' in the medical field are far from new." (Order, p. 5). However, the Georgia Legislature engaged in a detailed fact-finding process in 2005 regarding the status of health care in Georgia. The Legislature engaged in lengthy hours of debate and heard testimony from 34 witnesses, including from GHA, who testified how medical liability reform was needed to ensure public access to health care. The Legislature's fact-finding process was further supported by Federal Government reports, which in 2002 had recognized Georgia as a state in a "health care crisis."

Second, the Georgia Legislature is the proper body to determine whether a health care crisis exists, and upon such a determination, craft a remedy to address it. Neither the trial court, nor this Honorable Court, is empowered to substitute its judgment for that of the legislature on policy decisions that have a *rational relationship* to a legitimate objective of government.

Third, Georgia's cap on *non-economic* damages applies equally to all. There is no distinction as relates to race, nationality, gender or any other classification.

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[2] *See GHA: Medical Liability Insurance Crisis,* Jan. 12, 2004 ("GHA White Paper"), which was distributed to Georgia Legislators in 2004 and in 2005. For this Court's convenience, a copy of this White Paper is attached as Exhibit C.

Even plaintiffs of disparate economic status are treated similarly by the statute. The statute not only satisfies equal protection guarantees of our Constitution, but it in fact *promotes* equal protection guarantees.

For these reasons, GHA and AHA respectfully submit that this Court should reverse the trial court and uphold the constitutionality of O.C.G.A. § 51-13-1.

II. STATEMENT OF RELEVANT FACTS

GHA and AHA adopt the Statement of Facts submitted by Appellant.

III. ARGUMENT AND CITATION OF AUTHORITY

A. THE GEORGIA LEGISLATURE ENGAGED IN A DETAILED FACT-FINDING PROCESS AND DETERMINED A HEALTH CARE CRISIS EXISTED.

Rather than relying on "speculation" and "conjecture" as the trial court stated in its Order (p. 19), the Georgia Legislature reviewed empirical data and engaged in over 20 hours of testimony and debate regarding whether a health care crisis existed and possible solutions.[3] One way the crisis evidenced itself was in malpractice insurance rates charged to providers across the State. During the fact-finding process, the Legislature heard about the following: 1) a small hospital in Alma, which included a nursing home, which had to take out a bank loan to cover

[3] Hannah Yi Crockett et al., *Torts and Civil Practice*, 22 Ga. St. U. L. Rev. 221 (2005) (also known as "The Peach Sheets"), n. 11 (referring to Audio Recordings of Senate and House proceedings).

a malpractice insurance premium that had tripled in one year (ten insurance companies had refused to quote the hospital because of the nursing home); 2) a hospital with a nursing home in Bainbridge which had a 600% increase in its policy premium; 3) an Atlanta hospital which was required to take a policy with a $15 million deductible (only one insurance company bid on this hospital's business); 4) a 49-bed hospital in Claxton which decided to go without insurance coverage, due to an insurance premium that more than doubled in one year; and 5) physicians who gave up their obstetrical practices because of high insurance premiums.[4] Georgia legislators debated numerous reasons necessitating tort reform in Georgia, including the need to: improve access to health care for all Georgians, especially poor women; address rising medical malpractice premiums due to large jury awards and settlements; remedy the departure of insurers from the State by creating more predictability in malpractice awards; retain medical facilities and specialist physicians who were leaving the State; and retain a sufficient number of physicians in Georgia to serve her citizens.[5]

(1) The Senate's Process Regarding The Damages Cap

Senate Bill 3 ("SB 3"), Georgia's tort reform bill, was first read in the Georgia Senate on January 11, 2005.[6] Testimony and vigorous debate ensued on

[4] *See GHA White Paper,* p. 8 ("Examples From Around Georgia").
[5] *See* 22 Ga. St. U. L. Rev. at nn. 12-13, 133, 134.
[6] *Id.* at n. 21 (referring to State of Georgia Final Composite Status Sheet).

the Senate floor regarding whether a health care crisis existed, whether physicians practiced "defensive medicine," the need to reduce frivolous lawsuits, and whether a cap would lower insurance premiums.[7] Legislators' comments included "focusing on what is best for the patient" and supporting the bill "in an effort to increase overall access to quality health care."[8] After considerable debate, the Senate passed SB 3, which included a cap on non-economic damages.[9]

(2) The House's Process Regarding The Damages Cap

In the Georgia House of Representatives, SB 3 was read on February 3, 2005 and assigned to a Special Committee on Civil Justice Reform.[10] The House considered amendments to SB 3's non-economic damages cap, including a catastrophic injury exception and appropriate cap amounts.[11] Georgia Representatives discussed whether a cap would ensure better access to health care for Georgians and alleviate the negative effect that large and unpredictable jury verdicts were having, including insurance premiums increasing and insurers, medical practitioners, and facilities leaving Georgia.[12] The House Committee also evaluated the appropriate level of a cap, and decided in so doing to raise the

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[7] *Id.* at nn. 92, 95, 96, 99.
[8] *Id.* at nn. 93, 95.
[9] *Id.* at n. 106 (referring to Georgia Senate Voting Record, SB 3 (Feb. 1, 2005)).
[10] *Id.* at nn.107-108 (referring to State of Ga. Final Status Sheet, SB 3, Feb. 3, 2005)).
[11] *See, e.g., id.* at n. 121.
[12] *Id.* at nn. 128, 131-132.

damages cap in the Senate version of the bill to $350,000 for a single medical facility, $700,000 for multiple medical facilities, and a maximum cap of $1,050,000. The House Committee's substitute bill passed in the House.[13]

(3) The Senate reviews House's Amended Substitute

On February 10, 2005, the Senate reviewed the House's substitute to SB 3, including the cap on non-economic damages, and after initially rejecting the House amendments, further debate occurred.[14] Four days later, after additional consideration and debate, the Senate voted to accept the House substitute by a vote of 38-15 because a vote to accept the House substitute was "the best vote for the people."[15] As finally enacted, the caps on non-economic damages are as follows: $350,000 for one or more health care providers, $350,000 for a single medical facility, $700,000 for multiple medical facilities, and a maximum cap of $1,050,000. O.C.G.A. § 51-13-1.

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[13] *Id.* at n. 148 (referring to Audio of House Proceedings).
[14] *Id.* at nn. 149-156.
[15] *Id.* at nn. 169, 170 (referring to Audio of Senate Proceedings).

(4) Georgia Legislators Considered Arguments Opposing the Damages Cap Before Voting to Enact O.C.G.A. § 51-13-1; the Legislature Determined The Cap's Substantiated Benefits Could Be Realized In Georgia.

The Georgia Senate and House considered the evidence, debated the issues and ultimately determined that a cap on non-economic damages was best for the State.[16] The arguments advanced against the cap and debated in the Legislature at that time are basically the same arguments posited now by Appellees and repeated by the trial court. The Georgia Legislature considered but rejected these arguments.

In 2004, various studies estimated that non-economic damages account for 50 percent or more of the amounts paid in settlements and judgments and benefit trial lawyers, who commonly retain at least 50 percent of the awards.[17] While economic damages are objectively proven, damages for pain and suffering are wholly subjective, and a jury may award such damages without considering the impact on the rest of the community.[18] The Georgia Legislature concurred that the State could no longer afford to ignore the connection between unpredictable non-economic damages and the ability of health care providers to continue providing Georgia's citizens with essential health care services. The Legislature thus enacted

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[16] **For the express holdings of the Legislature, *see* Ga. L. 2005, p. 1, §1, a copy of which is attached as Exhibit D.**

[17] *GHA White Paper*, p. 4.

[18] *Id.*

a cap on non-economic damages as a rational solution to the health care crisis in Georgia and in order to safeguard access to care for Georgia citizens.

The issue of tort reform is a topic about which many disagree. However, the fact that there are differing views about the efficacy of Georgia's cap on non-economic damages does not render it unconstitutional. By enacting O.C.G.A. § 51-13-1, the Georgia Legislature exercised and fulfilled its unique responsibility of listening to differing views, deliberating policy issues, and balancing competing interests. The Legislature's findings and the resulting damages cap are thus entitled to deference by this Court. *See, e.g., Nichols v. Gross*, 282 Ga. 811, 653 S.E.2d 747 (2007); *see also Bravo v. United States,* 532 F.3d 1154, 1169 n.9 (11th Cir. 2008), *reh'g en banc denied*, No. 06-13052, 2009 WL 2357016 (11th Cir. Aug. 3, 2009) ($50 million award of non-economic damages in a medical malpractice case; reduced by the trial judge to $30 million and later vacated as excessive by the Eleventh Circuit, which noted a damages cap had been enacted in Florida after the suit's filing).

In 2002, the U.S. Department of Health & Human Services, Office of Disability, Aging and Long-Term Care Policy ("HHS") issued a report entitled *Special Update on Medical Liability Crisis*.[19] In its report, HHS noted rapid

[19] Office of the Assistant Sec'y for Planning and Evaluation, U.S. Dep't of Health and Human Servs., *Special Update on Medical Liability Crisis* (Sept. 25, 2002), available at http://aspe.hhs.gov/daltcp/reports/mlupd1.htm.

increases in the cost of malpractice insurance coverage across the nation from 2000-2002 and concluded such information "further demonstrates that the litigation system is threatening health care quality for all Americans as well as raising the costs of health care for all Americans."[20] In the HHS report, Georgia is listed as a "non-reform state" which had experienced a 40% malpractice premium increase in 2002 and was among 10 non-reform states with the "average highest premium increases" for "three key physician specialties" (internal medicine, general surgery and OB-Gyn).[21] The HHS report expressly recognized Georgia as being one of nine states deemed by the American Medical Association ("AMA") to be in a health care crisis.[22] Another report from the Federal Government predating Georgia's 2005 tort reform also supports the Georgia Legislature's enactment of a cap on non-economic damages. In a 1998 Congressional Budget Office ("CBO") report, the CBO determined that caps on non-economic damages were one of two types of reform that "have been found extremely effective in reducing the amount of claims paid and medical liability premiums" (the other tort reform measure involved collateral source offsetting).[23]

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[20] *Id.* at 1.
[21] *Id.* at 2-3 and at Tables 2 and 3.
[22] *Id.* at 4 and Table 6.
[23] Cong. Budget Office, *Preliminary Cost Estimate, H.R. 4250, Patient Protection Act of 1998*, p. 5, available at http://www.cbo.gov/ftpdocs/7xx/doc701/hr4250.pdf.

The Georgia Legislature concluded that such well substantiated benefits could be realized in Georgia with the enactment of a cap on non-economic damages. The Legislature sought to protect Georgia citizens from the fate of citizens in other states without such caps: physicians closing their practices, retiring early or leaving their state; physicians declining to treat higher-risk patients; physicians declining to take call in hospitals' emergency departments; resident physicians choosing other states in which to train and serve patients; hospitals closing their higher-risk units; and the increasing prevalence of "defensive medicine" (substantially increasing Medicaid and Medicare costs which are ultimately borne by taxpayers).

The Georgia Legislature's 2005 fact finding and conclusions were confirmed by a detailed AMA study in 2008. In February 2008, the AMA issued a national report examining medical liability crises and tort reform efforts since the 1970s, including caps on non-economic damages.[24] As reported by the AMA, "[d]irect tort reform, including but not limited to reasonable limits on non-economic damages ... would reduce national health care costs..." and would benefit the citizens of States which have enacted such damages caps.[25]

The AMA reported that the number of physicians in rural counties actually *increases* in states which have caps on non-economic or total damages; Medicare

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[24] http://www.ama-assn.org/ama1/pub/upload/mm/-1/mlrnow.pdf
[25] *Id.* at 8.

spending for hospitals is "five percent lower in states where non-economic damages were capped"; "direct tort reforms increased physician supply by 2.4 percent relative to non-reform states"; and claims can now be settled in California "in one-third less time than in states without caps on non-economic damages," which decreases litigation costs and "also means injured patients receive payment much faster ...."[26]

B. THE GEORGIA LEGISLATURE IS THE PROPER BODY TO ADDRESS WHETHER A HEALTH CARE CRISIS EXISTED IN GEORGIA AND CRAFT A REMEDY.

"It is a fundamental principle that 'the legislature, and not the courts, is empowered by the Constitution to decide public policy, and to implement that policy by enacting laws; and the courts are bound to follow such laws if constitutional.'" *Housing Auth. of Macon v. Ellis,* 288 Ga. App. 834, 836, 655 S.E.2d 621, 623 (2007), citing *Commonwealth Inv. Co. v. Frye*, 219 Ga. 498, 499, 134 S.E.2d 40 (1963). The issue of health policy is "more properly suited to legislative action as the legislature offers a forum wherein all the issues, policy considerations and long range consequences involved .... can be thoroughly and openly debated and ultimately decided." *Atlanta Obstetrics & Gynecology Group v. Abelson,* 260 Ga. 711, 718-19, 398 S.E.2d 557, 563 (1990) (holding the concept of a wrongful birth cause of action is a decision best suited for the legislature). *See*

[26] *Id.* at 11, 12, 15, 30.

also C. W. Matthews Contracting Co. v. Gover, 263 Ga 108, 428 S.E.2d 796 (1993) (upholding the legislatively established public policy that automobile travelers ought to wear seat belts as an exercise of health policy; the court ruled that the legislature had weighed the positive benefits of the policy against the severity of the penalty for non-compliance in a rational and non-discriminatory manner).

The legislature, which includes representatives chosen from all areas of our state and who are accountable to its citizens through the electoral process, is best suited to hear the issues and make the policy decisions. While the judiciary must ensure constitutional protections remain in place during that process, the constitutional inquiry is begun with a presumption of validity. *Smith v. Cobb County-Kennestone Hosp. Auth.*, 262 Ga. 566, 570, 423 S.E.2d 235, 238 (1992). Any doubt by the judiciary is resolved in favor of finding a statute constitutional.

The trial court's personal disagreement with the findings of the Georgia Legislature does not change the legal analysis. A disagreement with the legislature is not enough. "Those challenging the statute bear the responsibility to 'convince the court that the legislative facts on which the classification is apparently based could not reasonably be conceived to be true by the governmental decision maker.'" *Craven v. Lowndes County Hosp. Auth.*, 263 Ga. 657, 659, 437 S.E.2d 308, 310 (1993) (upholding five year statute of repose on medical malpractice

claims as rationally related to legitimate end of government). Most recently, in *Nichols v. Gross*, 282 Ga. 811, 813, 653 S.E.2d 747 (2007), this Court reaffirmed prior holdings that medical malpractice tort claims can be distinguished from other tort claims by the legislature and survive constitutional scrutiny (holding the five year statute of repose governing medical malpractice actions did not violate equal protection). The caps enacted by the Georgia Legislature were thoroughly debated and are reasonably related to the legitimate state interest in assuring health care access to all Georgia citizens.

C. GEORGIA'S CAP ON NON-ECONOMIC DAMAGES PROMOTES EQUAL PROTECTION GUARANTEES TO ALL.

Georgia's cap on pain and suffering awards makes absolutely no distinction based on a person's race, nationality, gender or economic status. In fact, it assures equal protection in an area which is otherwise quite disparate. The amount of such awards was previously left only to the enlightened conscience of a panel of jurors, without further guidance. The Georgia Legislature has now created guidelines that apply to all such injured parties, period. Georgia's cap on non-economic damages does not differentiate based on a plaintiff's wages or economic loss, as does Ohio's cap on non-economic damages. *See* Ohio Rev. Code Ann. §2323.43 (cap is the greater of $250,000 or three times the plaintiff's economic loss up to a maximum of $350,000 per each plaintiff or $500,000 per occurrence, with some exceptions).

Under Georgia's statute, all medical malpractice plaintiffs are treated exactly the same.

If Georgia's cap resulted in lower "total" awards for plaintiffs who earn lower wages than others, as the trial court noted in its Order (p. 19), that result would be caused by an economic difference which *preceded* any injury to a plaintiff; it is not because of O.C.G.A. § 51-13-1. An award of lost wages is not even within the scope of the statute under review. Amici respectfully submit that it is not proper for an award of non-economic damages to equalize lower economic damages incurred by plaintiffs, which is an entirely separate category of damages (and which may not be sought or recovered in all cases). That is neither the intent nor a permissible purpose of a non-economic damages award.

O.C.G.A. § 51-13-1 provides needed certainty to health care providers and insurers in Georgia. It promotes consistency and fairness to plaintiffs and, as explained earlier, safeguards community access to health care for Georgians, especially the poor and women. Just because a properly enacted statute imposes limits in some situations does not render the statute unconstitutional. With the application of laws such as damages caps, statutes of limitation and statutes of repose, there will necessarily be instances in which limits are placed on a plaintiff's potential recovery, even in the face of otherwise compelling or sympathetic facts. *See Kaminer v. Canas*, 282 Ga. 830, 653 S.E.2d 691 (2007)

(patient became infected with HIV as an infant, but was not diagnosed with AIDS until he was a teenager; while recognizing the "harsh" results, this Court held the statute of repose and the statute of limitations barred his malpractice suit), *cert. denied* 128 S. Ct. 2503 (2008); *Nichols v. Gross*, 282 Ga. at 814-815, 653 S.E.2d at 749 (while the patient's estate contended the statute of repose produced "harsh results," this Court held the statute of repose did not violate equal protection).

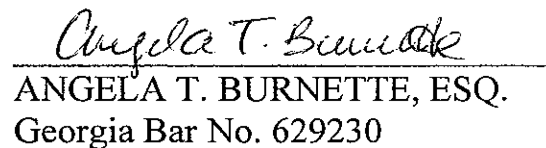
Particular facts of a malpractice suit do not warrant invalidation of a damages cap properly enacted by the Legislature. O.C.G.A. § 51-13-1 was within the Georgia Legislature's power to enact, the Legislature balanced the competing interests and policy issues, and its purpose in so enacting O.C.G.A. § 51-13-1 was a rational exercise of its authority to address the health care crisis in our State. *See Nichols*, 282 Ga. at 815, 653 S.E.2d at 749 (holding statute of repose was "within the General Assembly's legislative power to enact"); *Craven*, 263 Ga. at 659-660, 437 S.E.2d at 310 (noting uncertainty in cases "makes it difficult for [malpractice] insurers to adequately assess premiums based on known risks" and therefore this Court could not say the Georgia Legislature "acted irrationally").

IV. CONCLUSION

O.C.G.A. § 51-13-1 resulted from the Georgia Legislature's detailed fact-finding process, including consideration of issues now advanced by the trial court and Appellees. O.C.G.A. § 51-13-1 is a constitutional and rational solution to Georgia's health care crisis, which was within the Georgia Legislature's authority to enact, and which will improve access to health care in Georgia. GHA and AHA respectfully urge the Court to uphold the constitutionality of O.C.G.A. § 51-13-1 and reverse the trial court's decision.

This 21st day of August, 2009.

DONNA P. BERGESON, ESQ.
Georgia Bar No. 054315



ANGELA T. BURNETTE, ESQ.
Georgia Bar No. 629230

ALSTON & BIRD LLP
1201 West Peachtree Street
Atlanta, Georgia 30309-3424
(404) 881-7000

Counsel for Amicus Curiae
The Georgia Hospital Association and
the American Hospital Association

EXHIBIT A

4/22/2008 10:16		Hospital Closures in Georgia			
DATE	COUNTY	January 1980-Present / HOSPITAL	TYPE	BEDS	
January-80	Seminole	Seminole Memorial Hospital	G	30	
January-81	Fulton	McLendon Hospital	G	33	
August-82	Taylor	Montgomery Hospital	G	16	
December-83	Paulding	Community Hospital of Paulding County	G	18	
July-87	Clay	Fort Gaines Hospital	G	35	
May-88	Heard	Heard Community Hospital	G	29	
October-88	Turner	Turner County Hospital	G	40	
November-90	Terrell	Terrell Community Hospital	G	34	
July-91	Fulton	Bolton Hospital	G	184	
September-91	Marion	Marion Memorial Hospital	G	30	
June-92	Laurens	Parkside Lodge	P	54	
October-92	Polk	Crest Medical Center/Rockmart-Aragon	G	48	
October-92	Pierce	Pierce County Hospital	G	22	
January-93	Fulton	Fulton County Alcohol and Drug Treatment Center (converted to residential Drug Abuse Treatment Program)	P	90	
July-93	DeKalb	Charter Brook Hospital	P	60	
August-93	Gwinnett	Buford Hospital	S	24	
April-94	Cherokee	Woodstock Hospital	G	21	
October-94	Muscogee	Northridge Hospital	P	51	
January-96	DeKalb	CPC Parkwood Hospital	P	152	
May-97	Chattooga	Chattooga Medical Center	G	31	
April-98	Catoosa	Greenleaf Center-Erlanger	P	90	
June-98	Fulton	Midtown Hospital	S	19	
June-98	DeKalb	Georgia Mental Health Institute	SP	244	
September-98	Rabun	Woodridge Hospital	P	42	
December-98	Ware	Satilla Park Hospital	P	53	
August-99	Rabun	Ridgecrest Hospital	G	49	
November-99	Carroll	Bowdon Area Hospital	G	41	
December-99	Fulton	West Paces Medical Center	G	294	
February-00	Richmond	Charter Augusta Behavioral Health System	P	63	
February-00	Clarke	Charter Winds Behavioral Health System	P	80	
February-00	Bibb	Charter Lake Behavioral Health System	P	118	
April-00	Tattnall	Tattnall Memorial Hospital	G	40	Reopened 10/00
June-01	Dooly	Dooly Medical Center	G	25	
August-01	Hancock	Hancock Memorial Hospital	G	52	
April-02	Douglas	Emory Parkway Medical Center	G	256	
Oct-02	Bibb	Middle Georgia Hospital	G	119	Purchased by MCCG
Dec-04	Fulton	Southwest Hospital and Medical Center	G	125	Reopened 01/06 as Legacy Medical Center
Dec-06	DeKalb	Northlake Medical Center	G	120	
Dec-06	DeKalb	Emory Dunwoody Medical Center	G	168	Replaced by Emory Johns Creek, which opens Feb. 2007
May-07	Fulton	Legacy Medical Center	G	125	
Apr-08	Telfair	Telfair Regional Hospital	G	25	

Excludes mergerss and replacements. Hughes Spalding Medical Center was absorbed by Grady Memorial Hospital in 10/88; it reopened as a separate facility, Hughes Spalding Children's Hospital, in 7/95. Doctors Memorial Hospital and Jesse Parker Williams Hospital were absorbed by Crawford Long Hospital in 12/86 and 1/92, respectively.

Type: G=General; P=Freestanding psychiatric/substance abuse; S=Other freestanding special; SP=State psychiatric/substance abuse

Source: DCH/DHP records as of April 7, 2000 and GHA.

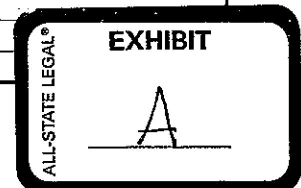
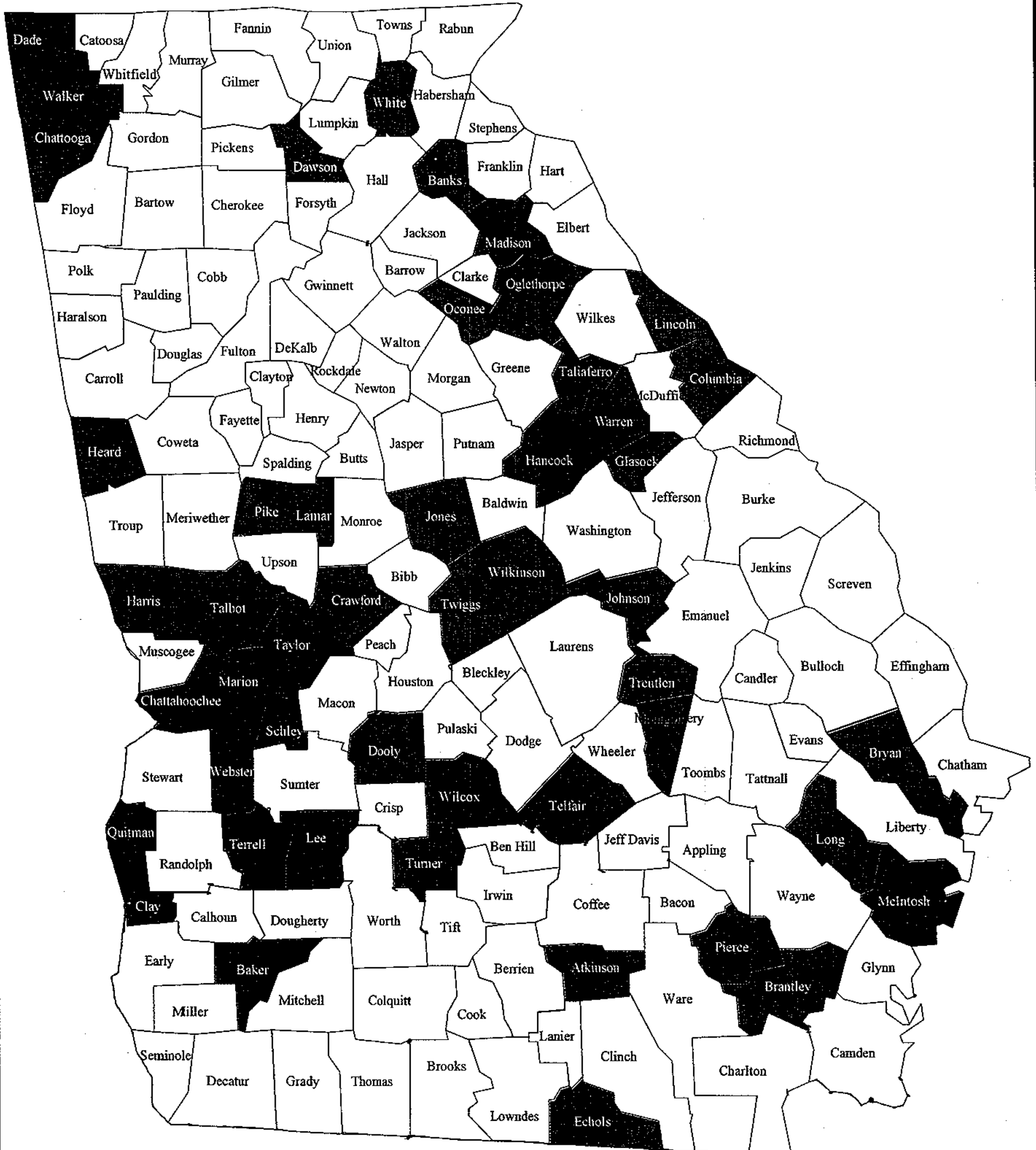


EXHIBIT B

Georgia Counties with No Acute Care Hospitals



Source: Georgia Hospital Association, May 2009

ALL-STATE LEGAL®
EXHIBIT
B

EXHIBIT C

GHA An Association of Hospitals and Health Systems

Medical Liability Insurance Crisis

What are the Issues?

- Insurance Premiums
- Judicial System
- Patient Safety
- Patient Access & Hospital Financial Health
- The Solution
- Examples From Around Georgia

All of these factors occur in a fragile health care system faced with reduced revenues, skyrocketing cost increases, workforce shortages, an aging population and growing number of uninsureds.

Hospitals are in the midst of a medical liability crisis. Many medical malpractice insurers, unable to make a profit, have either dropped their medical malpractice insurance products, filed for bankruptcy or left the state. Those insurers remaining in Georgia have been forced to dramatically raise premiums to cover higher and higher claims losses.

Hospitals experienced 200% to 300% premium increases between 2000 and 2002, and received significantly less coverage in return. Some hospitals, unable to afford these increases, have chosen to go without insurance coverage. In order to keep the hospital doors open, several hospitals have had to obtain bank loans to pay their premiums. Ultimately, access to health care for thousands of Georgians is at risk due to the unpredictability of medical malpractice verdicts and the impact these verdicts have on future settlement amounts.

Here are the facts:

- Hospitals are finding it difficult, if not impossible, to afford medical malpractice insurance premiums.
- Unavailability of affordable insurance has forced hospitals to become increasingly self-insured and vulnerable to unpredictable claims losses.
- Medical malpractice claims losses in the form of settlements and judgments have dramatically increased in recent years.
- Many Georgia hospitals are struggling to survive and two-thirds, or 113 out of 172 facilities, operating in the red in providing patient care.
- There are no admitted insurers (insurers licensed by the state and subject to rate and other regulations) writing new policies for hospitals. This has forced hospitals to purchase new coverage exclusively from non-admitted (and unregulated) insurers.
- Increased liability premiums will increase the cost of health care paid for by businesses and government through Medicaid, Medicare and the State Health Benefit Plan.
- In 2001 alone, 200 Georgians were awarded damages totaling $100 million against physicians insured by the largest medical malpractice insurer in the state.[1]

ALL-STATE LEGAL® EXHIBIT C

GHA An Association of Hospitals and Health Systems

Issue:
Insurance Premiums

From the early 1990s until 2000, premiums were stable or declining. Based on prior loss history, the insurers believed they were charging enough premiums to cover predicted claims losses. When these losses began to dramatically increase in the late 1990s, the insurers did not have enough money in their reserves to cover them and still make a profit. Many got out of the medical malpractice insurance business altogether, while others were forced into bankruptcy.

The remaining insurers dramatically increased premium rates. They also instituted major changes in policy terms and higher minimum retentions. Therefore, hospitals were forced to pay much higher premiums for significantly less coverage.

Since 1998, eight carriers have gone bankrupt or have withdrawn from the market because they were unable to sustain losses. St. Paul, which was the largest malpractice insurer in the U.S. operating in 45 states, announced in 2001 it would no longer write new policies nor renew existing policies. Representatives from the Insurance Commissioner's office have noted that St. Paul's exit from the medical malpractice market was a statement that medical malpractice was simply uninsurable. Today, there are no admitted (licensed and regulated) insurers writing new hospital business in Georgia. In addition, there is little competition in the non-admitted market, meaning very few insurers are willing to provide medical malpractice insurance to hospitals at any price.

Trial lawyers argue that insurance companies are to blame for this crisis. They argue that insurers are raising premiums, not because of increased claims losses, but due to investment losses. In fact, they deny that there has been any increase in claims losses when you factor in medical inflation. However, these arguments are not supported by the facts. It is true that insurers are required by law to consider investment returns when establishing premium rates and insureds should receive some benefit from the amount insurers make investing premiums. However, state law limits the amount medical malpractice insurers can invest in equities and approximately 80% of their assets are invested in bonds. For this reason there has been little fluctuation in medical malpractice insurers' investment returns over the past several years. While there has been a slight decrease in investment returns (less than 2% over a two year period according to a 2003 report by the U.S. General Accounting Office), no medical malpractice insurer has experienced investment losses. When considering all the factors impacting premium increases (including investment returns), the GAO recently concluded the "primary driver" is increased claims losses.

The bottom line is that insurance carriers have found the medical liability market unprofitable and have chosen to eliminate this line of business. In 2001, for every $1 medical liability insurers took in, $1.54 was paid out for defending claims.[2] Claim payments have increased almost three times the rate of inflation in recent years.[3]

As a result, hospital medical liability premiums have soared. In 2002, one-third of hospitals reported spikes of 200 percent or more with one hospital reporting an increase from $384,000 to $1.3 million.

Premiums increased an average of 5.5 percent in 1999, 34 percent in 2000, 20 percent in 2001 and 74 percent in 2002, which amounts to a $72 million increase from 1999 to 2002.

Another way of looking at the increase is the cost of covering a hospital bed. In 1999, the rate was $3,563. In 2002, this cost averages $9,797, which is an increase of $6,261. Hospitals with nursing homes fared worse, with the cost per bed at $3,386 in 1999 compared to $15,379 in 2002, which amounts to a 354 percent increase in premiums.

While these numbers are staggering, the situation is actually much worse when considering the significantly higher deductibles hospitals must pay. Several years ago, small hospitals carried deductibles of $0 to $5,000. Now those deductibles are $50,000 to $1,000,000. Large hospitals used to carry deductibles of $250,000 to $500,000 and now have deductibles of $1,000,000 to $15,000,000.

Increases in physician premiums have varied widely across states, and some states have experienced increases of 30 to 70 percent. The average increase in physician premiums with states that have enacted non-economic caps of $250,000 is 15 percent. States with caps of $350,000 experienced 12 percent increase. *This compares with a 44 percent increase for those states without caps.* (Georgia is experiencing a 32 percent increase.) [4] Among the states with the highest medical malpractice insurance premiums are Florida, Illinois, Ohio, Nevada, New York, and West Virginia. As a result, Florida, Nevada and West Virginia recently passed a variety of reforms to address the crisis.

Medical Liability Carrier Failures/Withdrawals From Hospital Market

MAG Mutual - January 2001, Withdrawal from hospital market
Reliance National - May 2001, Under Rehabilitation by the Pennsylvania Dept. of Insurance
Frontier - August 2001, Under Rehabilitation by the New York Dept. of Insurance
PHICO – February 2002, Bankruptcy
St. Paul - December 2001, Withdrawal from the market
TVIR - March 2002, B- Best Rating
MIIX - May 2002, Voluntary Rehabilitation
Source: Health Care Insurance Resources, Inc.

Issue: Judicial System

The judicial system in the United States is costly and renders unpredictable results in medical liability cases. Inefficiencies in the system result in the delay of awards to meritorious claimants, often delays as long as five years.[5] Americans spend proportionately far more per person on the costs of litigation than any other country.[6] The American civil justice system cost $179 billion in 2000, up from $130 billion in 1990.[7]

Despite the magnitude of spending, our tort system functions very poorly in meeting its compensation objective. Fifty-seven percent of medical liability premiums go toward attorneys' fees for both sides rather than to the plaintiffs.[8] Sixty-one percent of the cases are dropped or dismissed. Of the 7 percent of cases that go to trial, 5.7 percent are verdicts in favor of the defense and 1.3 percent are in favor of the plaintiff.[9] And the median cost of defending such a case – where the jury rules the defendant not guilty – was $66,767 in 2001.[10] According to the Government Accounting Office, 43% of insurance defense costs are spent on claims that have no merit.

This expensive judicial system benefits only a few at the expense of the many. For example, in 2001, 200 Georgians were awarded damages totaling $100 million against physicians insured by the largest medical malpractice insurer in the state. It's important to note that this cost *only* includes payouts from physician insurers and *does not* include payouts from hospitals and other provider insurers. While 200 persons may benefit from the current system, the remaining eight million Georgians suffer the consequences of less access to health care services as a result of this system.

Medical liability claim payments increased by almost three times the rate of inflation from 1987 to 1999. Excessive judgments in a small proportion of cases (52 percent of all awards exceeded $1 million from 1999 to 2000) play a large part in this crisis.[11] The median medical liability award in 1999 was $800,000 and increased to $1,000,000 in 2000. Million dollar verdicts increased 45 percent for the years 1998-1999.[12] From 1994 to 2000, jury awards for medical malpractice claims jumped 176 percent, according to Jury Verdict Research.

Georgia hospitals support a patient's right to be fully compensated for economic losses, such as past and future medical expenses and lost wages, resulting from medical negligence. However, a significant percentage of the jury awards in medical malpractice cases are for non-economic damages (pain and suffering). Various studies have estimated non-economic damages account for 50 percent or more of the amounts paid in settlements and judgments in such cases. These awards benefit trial lawyers, who commonly retain at least 50 percent of the awards.[13]

Unlike economic damages, which can be proven objectively, damages for pain and suffering are entirely subjective. Juries often attempt to punish individual defendants through huge non-economic damage awards with little consideration of the impact these awards will have on the rest of the community.

We can no longer afford to ignore the connection between excessive jury awards and the ability of health care providers to continue providing Georgia's citizens with essential health care services.

Without a limit on how much a jury can award a plaintiff for non-economic damages and other civil justice reforms, Georgia insurance carriers will have no ability to accurately predict future costs and to price coverage accordingly. Limiting awards for non-economic damages could also reduce health care costs by five to nine percent, saving $60-108 billion each year. [13]

Issue: Patient Safety

Safe care of patients has always been a top priority for hospitals. Modern health care depends upon a myriad of complicated technologies, a variety of powerful drugs and teams of caregivers. While new technologies and drugs permit caregivers to perform life-saving interventions that could not have been performed before, they also increase the risks inherent in the delivery of health care.

Trial lawyers often claim that higher jury awards and the cost of insurance premiums are due to poor care. However, the National Practitioner Data Bank and other studies indicate that the frequency, or number of paid claims, has remained fairly constant, thereby countering the argument that there has been an explosion in medical errors.[14] The problem is increasing amounts paid for claims.

Unfortunately, poor outcomes do occur. However, a poor outcome does not necessarily mean poor care. The common initial reaction is to blame someone for a poor outcome. However, unanticipated outcomes are due most often to the convergence of multiple contributing factors. Punishing an individual provider through excessive jury awards will not change these factors. Improving safety for patients requires a systematic approach to identify and address the underlying factors that contribute to errors.

The Georgia Partnership for Health and Accountability (PHA) was founded in January 2000 in response to heightened attention to medical errors and patient safety, increased demand for hospital specific reports, and growing interest in healthy communities. Created upon the vision that collaboration is the key to success, PHA includes representation from multiple stakeholders, including hospitals, physicians, state health officials, legislators, businesses and patients. Its mission is to improve quality of care, reduce medical errors and improve outcomes.

Patient safety is improved through the sharing of information and the reporting of medical errors. Every hospital in Georgia participates in the PHA patient safety initiative, which provides a learning environment within hospitals and emphasizes a blame-free medical reporting system. Since its inception, the PHA has garnered national attention for its innovation and success improving patient safety in hospitals.

Efforts such as PHA will improve patient safety. Unpredictable jury awards will not. Patient injuries rarely result from the type of intentional conduct that could be deterred by high jury verdicts. In fact, instead of improving patient safety by deterring wrongdoers, unlimited jury awards decrease the resources available to hospitals for patient safety initiatives and investments in new technologies.

Issue:

Patient Access & Hospital Financial Health

Examples of Rising Hospital Costs

- Severe workforce shortages. Georgia hospitals are presently experiencing a shortage of approximately 2,700 nurses and 1,400 allied health professionals. In some counties across the state, hospitals report a vacancy rate as high as 19 percent. Hospitals have been forced to increase spending to recruit staff or to hire costly temporary staff.
- Uninsured. 1.3 million Georgians have no health insurance coverage. Georgia hospitals – by their own mission and under federal law – serve as Georgia's health care safety net and provided over $800 million of uncompensated care in 2001 alone.
- Disaster readiness. As front-line responders, hospitals must be ready to provide services in cases of nuclear, biological and chemical disasters.
- Quality improvement. Scientific development, including the introduction of new patient safety technologies and infection controls, requires a substantial investment of resources.
- New federal regulatory mandates. Hospitals are one of the most highly regulated industries and must report to dozens of federal and state agencies. Regulations, such as HIPAA, impose additional administrative and cost burdens on hospitals.
- Rising drug costs. Prescription drug costs paid by hospitals have more than doubled since 1990, surpassing other health care spending.[23]

Hospitals, which provide essential health care services 24 hours a day, seven days a week, are experiencing cost increases and payment cuts that threaten their ability to continue providing such services. Sixty-six percent of Georgia's hospitals have been financially distressed due to budget cuts in Medicaid and Medicare, slow payments and nonpayments by insurers and the growing number of the uninsured.[15] Additional stresses are created by increased financial demands due to regulations, work force shortages and disaster preparation.

Insurance premiums have added to this stress. Hospitals are adjusting to these demands by limiting or reducing services, laying off employees and raising the price of health services. Some hospitals have chosen to forgo insurance coverage. All of these decisions impact access to care.

In the past 12 years, 28 Georgia hospitals have closed.[16] At the same time, Georgia gained 1.7 million people, a 26% increase.[17] More people and less access. Of the remaining hospitals, almost two-thirds (or 113 hospitals) are paid less than cost of the services they provide.[18]

Citizens' access to care is threatened by the inability of many physicians, particularly those in high-risk specialties, to obtain affordable malpractice insurance. As a result, many physicians will retire early, relocate, stop performing high-risk services or they may choose to practice without insurance. In addition to threatening access to care, the costs of health care will continue to rise if nothing is done to bring unpredictable jury

verdicts under control. The costs of premiums will continue to rise. The cost of health care will also increase as providers continue the practice of defensive medicine (ordering tests and diagnostic procedures for no other reason than to protect themselves from a potential lawsuit). As a result, limited health care dollars are siphoned away from important initiatives, such as those designed to increase medical innovation and improve patient safety.

Issue:

The Solution

The following common sense provisions must be included in legislation in order to stabilize the insurance premium market and control costs:

- ✓ **Joint and Several Liability**. Abolishing joint and several liability so that a defendant is liable only for the amount of damages in proportion to his/her degree of fault.
- ✓ **Comparative Negligence**. Providing that where a plaintiff is found 50% or more responsible for his/her own injury, the plaintiff may not recover any damages.
- ✓ **Expert Witness**. Establishing expert witness qualifications by requiring anyone who testifies as an expert to be licensed to practice and to actively practice or teach in the same specialty or area as the defendant for at least three of the last five years. Under current law, an eye, ear, nose and throat specialist could testify against a cardiologist. The expert witness provision would apply to all licensed professionals within the state, i.e. architects, engineers, and attorneys, as well as medical practitioners.
- ✓ **ER Immunity**. Eliminating the recovery of non-economic damages when a patient comes to a dedicated emergency department (as defined by EMTALA) seeking treatment for a medical condition, based on any alleged negligence occurring within the first 24 hours. This immunity would not be available in cases of willful or wanton misconduct or gross negligence.
- ✓ **Periodic Payments**. Allowing defendants to make periodic payments for future damages to the plaintiff over a reasonable length of time rather than a lump sum payment up front.
- ✓ **Increase the Discount Rate**. Reducing the overall cost of the award by discounting the inflation factor for future damages from the current five percent requirement to 10 percent.
- ✓ **Arbitration**. Authorizing pre-dispute voluntary binding arbitration agreements for medical malpractice claims.
- ✓ **Civil Case Final Disposition Form**. Requiring that a prevailing party in a civil action file with the clerk a final disposition form that includes information such as the type of action, the type of disposition and the amount of the award.
- ✓ **Insurance Commissioner Access to Information**. Allowing the Insurance Commissioner access to the data from the disposition forms in order to analyze such data and to use the data to determine, among other things, the appropriateness of premium rate increases (the information would be confidential).
- ✓ **Offer of settlement**. Requiring the party that refused to accept an offer of settlement to pay the other party's costs and attorney's fees from the time the offer was made if the final award is less than what was offered.

- ✓ **Venue Shopping**. Requiring that the case against remaining defendants be transferred to another county and court in the event that all defendants that reside in the county in which the action is pending are released from liability.
- ✓ **Apparent Agency Relationship**. Eliminating a hospitals vicarious liability for the acts or omissions of a healthcare provider that is an independent contractor rather than a hospital employee.
- ✓ **A $250,000 Non-Economic (pain and suffering) Damage Cap**. Placing a $250,000 limit on non-economic (pain and suffering) damages in a medical malpractice action while placing no limits on economic damages such as lost wages and medical expenses.
- ✓ **Plaintiff's Right To Minimum Compensation**. Increasing the percentage of an award the plaintiff is entitled to keep by limiting plaintiff attorney fees in medical malpractice actions to 30% of the first $500,000, 20% of any amount between $500,000 and $1,000,000 and 10% of any amount over $1,000,000.

Examples From Around Georgia

- In Alma, a 50-bed hospital with an 88-bed nursing home was forced to take out a bank loan in 2001 to cover a medical malpractice insurance premium that more than tripled in one year (rising from $118,000 to $385,000). Additionally, the hospital had to lay off a dozen employees and the top executives took a pay cut in excess of five percent. The hospital instituted a 10 percent rate increase for its services across the board. In 2002, the liability premium was quoted at $723,000. (The entire health system operates on a budget of $12 million a year.) Ten insurance companies refused to quote the hospital because of the nursing home.

- In Bainbridge, an 80-bed hospital with a 107-bed nursing home was faced with a staggering 600 percent increase on its existing policy (increasing from $140,000 to $970,000).

- In northeast Georgia, a health system of three hospitals and two nursing homes received a bill by fax this summer with just 24 hours to make a decision. The premium jumped from $553,000 to $3.15 million.

- In Atlanta, a 900-bed hospital purchased a new policy in 2002 with a $15 million deductible per claim with a $50 million cap, up from a $2.5 million deductible with a $13 million cap in 2001. Only one insurance company bid on their business.

- In Claxton, a 49-bed hospital decided to go without coverage due to a premium increase from $216,000 in 2001 to $581,000 for $1 million in coverage with a $50,000 deductible in 2002.

- An OB/GYN physician in Thomasville said her medical malpractice insurance increased 30 percent just this year. She is considering giving up delivering babies. She should not be forced to make this choice and her patients will suffer if they lose her expertise and experience in this area.[20]

- In Fitzgerald, a family practitioner decided to discontinue the OB portion of his medical practice when his insurance premium more than doubled.[21] His liability insurance expired in April and it took him six weeks to get a new policy.

- Another Fitzgerald family practitioner has had to give up performing Caesarean sections. His premiums quadrupled to $80,000 this year and would have been $110,000 had he continued the surgical delivery procedure, which insurance companies consider "high risk."[22]

GHA An Association of Hospitals and Health Systems

California MICRA Experience

California enacted significant liability reform in 1975 by enacting the Medical Injury Compensation Reform Act (MICRA). It provides limits on non-economic damages to $250,000; allows for introduction into evidence of collateral source payments; allows for period payments of judgments in excess of $50,000; allows patients and physicians to contract for binding arbitration; and, allows limits on trial lawyers' contingent fees according to a sliding scale.

As a result, California premiums are much lower than national average. The National Association of Insurance Commissioners (NAIC) reports that California increases were only 168 percent (1976-99), where the rest of the states' increases were 420 percent.

Medical liability lawsuits in California settle in an average of two years with the same lawsuits in states without limits on non-economic damages settle in an average of 2.6 years (or 23 percent longer). The reason claims settle faster is that the lottery aspect of non-economic damages has been controlled. And, the average lawsuit in California settles for $15,387 compared to $32,714 nationally.

California patients that have been injured take home a higher percentage of their awards due to the limits on contingency fees so that an attorney winning a $1 million claim must be satisfied with a legal fee of $221,000, not $500,000 plus as in many contracts with clients. Currently, 23 states restrict contingency fees that may be charged by trial lawyers.

California's premiums for physicians have *decreased* by 40 percent in constant dollars, despite the fact that there is not limit on actual damages awarded. In 1976, an actual premium of $7,614 would be $23,698 adjusted to 2001 dollars. Yet, the average physician premium in California in 2001 was $14,107. (See chart below for medical liability insurance premiums for $1,000,000/$3,000,000 coverage, AM Best Source)

Premiums	1976		1986		2002	
	GA	CA	GA	CA	GA	CA
OB/GYN	$5,192	$10,580	$37,799	$28,220	$48,973	$37,801
Neurosurgeon	$6,894	$10,580	$47,491	$30,112	$63,532	$48,396

[1] MAG Mutual, 2002
[2] Bests Aggregates and Averages.
[3] American Tort Reform Association.
[4] HHS "Confronting the New Health Care Crisis", July 24, 2002
[5] Florida Hospital Association.
[6] U.S. Dept. of Health & Human Services, "Confronting the New Health Care Crisis," July 24, 2002.
[7] U.S. Tort Costs 2000: Trends and Findings on the Costs of the U.S. Tort System, Tillinghast-Towers-Perrin
[8] Ignani, Karen, "The Malpractice Mess," The Charlotte Observer, January 21, 2002.
[10] Physician Insurers Association of America
[10] Ignani, Karen, "The Malpractice Mess," The Charlotte Observer, January 21, 2002.
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[12] Current Award Trend in Personal Injury, Jury Verdict Research Series, LRP Publications 2000 edition
[13] U.S. Dept. of Health & Human Services, "Confronting the New Health Care Crisis," July 24, 2002..
[14] Florida Hospital Association
[15] 2001 Georgia Department of Community Health Division of Health Planning Survey.
[16] Georgia Department of Community Health.
[17] 2000 census data.
[18] 2001 Georgia Department of Community Health Division of Health Planning Survey.
[20] Chambliss, Saxby, statement in the Congressional Record, September 26, 2002.
[21] Chambliss, Saxby, statement in the Congressional Record, September 26, 2002.
[22] Chambliss, Saxby, statement in the Congressional Record, September 26, 2002.
[23] Mays, Glenn P., Hurley, Robert E., Grossman, Joy M., "Consumers Face Higher Drug Costs As Plans Seek to Control Drug Spending," Center for Studying Health System Change, Issue Brief No. 45, November 2001.

EXHIBIT D

CHAPTER 13

RECOVERY IN MEDICAL MALPRACTICE ACTIONS

Sec.
51-13-1. Definitions; maximum liability; allowance for periodic payments.

Effective date. — This chapter became effective February 16, 2005.

Editor's notes. — Ga. L. 2005, p. 1, § 1, not codified by the General Assembly, provides that: "The General Assembly finds that there presently exists a crisis affecting the provision and quality of health care services in this state. Hospitals and other health care providers in this state are having increasing difficulty in locating liability insurance and, when such hospitals and providers are able to locate such insurance, the insurance is extremely costly. The result of this crisis is the potential for a diminution of the availability of access to health care services and a resulting adverse impact on the health and well-being of the citizens of this state. The General Assembly further finds that certain civil justice and health care regulatory reforms as provided in this Act will promote predictability and improvement in the provision of quality health care services and the resolution of health care liability claims and will thereby assist in promoting the provision of health care liability insurance by insurance providers. The General Assembly further finds that certain needed reforms affect not only health care liability claims but also other civil actions and accordingly provides such general reforms in this Act."

Ga. L. 2005, p. 1, § 15(b), not codified by the General Assembly, provides that this chapter shall apply only with respect to causes of action arising on or after February 16, 2005, and any prior causes of action shall continue to be governed by prior law.

51-13-1. Definitions; maximum liability; allowance for periodic payments.

(a) As used in this Code section, the term:

(1) "Claimant" means a person, including a decedent's estate, who seeks or has sought recovery of damages in a medical malpractice action. All persons claiming to have sustained damages as the result of the bodily injury or death of a single person are considered a single claimant.

(2) "Health care provider" means any person licensed under Chapter 9, 10A, 11, 11A, 26, 28, 30, 33, 34, 35, 39, or 44 of Title 43. The term shall also include any corporation, professional corporation, partnership, limited liability company, limited liability partnership, authority, or other entity comprised of such health care providers.

(3) "Medical facility" means any institution or medical facility licensed under Chapter 7 of Title 31 or any combination thereof under common ownership, operation, or control.

(4) "Noneconomic damages" means damages for physical and emotional pain, discomfort, anxiety, hardship, distress, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium,

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injury to reputation, and all other nonpecuniary losses of any kind or nature. This term does not include past or future:

(A) Medical expenses, including rehabilitation and therapy;

(B) Wages or earnings capacity;

(C) Income;

(D) Funeral and burial expenses;

(E) The value of services performed by the injured in the absence of the injury or death including those domestic and other necessary services performed without compensation; or

(F) Other monetary expenses.

(b) In any verdict returned or judgment entered in a medical malpractice action, including an action for wrongful death, against one or more health care providers, the total amount recoverable by a claimant for noneconomic damages in such action shall be limited to an amount not to exceed $350,000.00, regardless of the number of defendant health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based.

(c) In any verdict returned or judgment entered in a medical malpractice action, including an action for wrongful death, against a single medical facility, inclusive of all persons and entities for which vicarious liability theories may apply, the total amount recoverable by a claimant for noneconomic damages in such action shall be limited to an amount not to exceed $350,000.00, regardless of the number of separate causes of action on which the claim is based.

(d) In any verdict returned or judgment entered in a medical malpractice action, including an action for wrongful death, against more than one medical facility, inclusive of all persons and entities for which vicarious liability theories may apply, the total amount recoverable by a claimant for noneconomic damages in such action shall be limited to an amount not to exceed $350,000.00 from any single medical facility and $700,000.00 from all medical facilities, regardless of the number of defendant medical facilities against whom the claim is asserted or the number of separate causes of action on which the claim is based.

(e) In applying subsections (b), (c), and (d) of this Code section, the aggregate amount of noneconomic damages recoverable under such subsections shall in no event exceed $1,050,000.00.

(f) In any medical malpractice action, if an award of future damages equaling or exceeding $350,000.00 is made against any party in the action, the trial court shall, upon the request of any party, issue an order providing that such damages be paid by periodic payments. Such periodic payments

shall be funded through an annuity policy with the premium for such annuity equal to the amount of the award for future damages. (Code 1981, § 51-13-1, enacted by Ga. L. 2005, p. 1, § 13/SB 3.)

Editor's notes. — Ga. L. 2005 p. 1, § 14, not codified by the General Assembly, provides for severability.

Law reviews. — For article on 2005 enactment of this section, see 22 Ga. St. U.L. Rev. 221 (2005). For annual survey of trial practice and procedure, see 57 Mercer L. Rev. 381 (2005). For article, "Of Frivolous Litigation and Runaway Juries: A View from the Bench," see 41 Ga. L. Rev. 431 (2007).

CHAPTER 14

ASBESTOS AND SILICA CLAIMS

Sec.	
51-14-1.	Legislative findings and purpose.
51-14-2.	Applicability.
51-14-3.	Definitions.
51-14-4.	Prima-facie evidence of physical impairment a prerequisite of asbestos or silica claims.
51-14-5.	When limitations period begins to run.
51-14-6.	Dismissal for failure to establish prima-facie evidence of physical impairment with respect to an asbestos claim or silica claim; procedure; evidentiary requirements.
51-14-7.	Sworn information form providing required information; failure to state a claim; class actions barred.
51-14-8.	Limitations on discovery; satisfaction of medical criteria necessary to establish prima-facie evidence of medical impairment; admissibility of expert reports.
51-14-9.	Who may bring a claim; claims in multiple jurisdictions.
51-14-10.	Venue.
51-14-11.	Consolidation of claims.
51-14-12.	Application of chapter dependent upon date claim accrues.
51-14-13.	Severability.

Effective date. — This chapter became effective May 1, 2007.

Editor's notes. — Ga. L. 2007, p. 4, § 1, effective May 1, 2007, repealed the Code sections at this chapter and enacted the current chapter. The former chapter consisted of Code Sections 51-14-1 through 51-14-10, relating to asbestos claims and silica claims, and was based on Ga. L. 2005, p. 145, § 1/HB 416 and Ga. L. 2006, p. 72, § 51/SB 465.

Ga. L. 2007, p. 4, § 3, not codified by the General Assembly, provides for additional severability.

Ga. L. 2007, p. 4, § 4, not codified by the General Assembly, provides that this chapter shall apply to certain accrued or future accruing asbestos claims or silica claims in which trial has not commenced as of May 1, 2007, in accordance with its terms.

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Asbestosis, 45 POF2d 1.

IN THE SUPREME COURT OF THE STATE OF GEORGIA

ATLANTA OCULOPLASTIC SURGERY, P.C. D/B/A OCULUS	)	
Appellant,	)	**CASE NO.: S09A1432**
vs.	)	
BETTY NESTLEHUTT AND BRUCE NESTLEHUTT	)	
Appellees.	)	

CERTIFICATE OF SERVICE

I do hereby certify that I have served a true and correct copy of the within and foregoing **AMICUS CURIAE BRIEF ON BEHALF OF THE GEORGIA HOSPITAL ASSOCIATION AND AMERICAN HOSPITAL ASSOCIATION** by First Class United States Mail, postage prepaid, properly addressed as follows:

Adam Malone
Law Office of Tommy Malone
Two Ravinia Drive, Suite 300
Atlanta, Georgia 30346

Michael B. Terry
Bondurant, Mixson & Elmore
1201 W. Peachtree Street, NW
Suite 3900
Atlanta, Georgia 30309

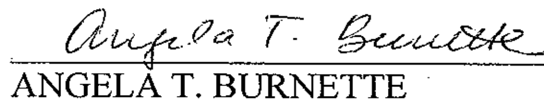
Darren Summerville
Bird Law Group
2170 Defoor Hills Rd.
Atlanta, Georgia 30318

Frank Ilardi
Houck, Ilardi and Regas
Two Ravinia Drive, Suite 800
Atlanta, Georgia 30346

Jonathan C. Peters
Melissa B. Johnson
Jeffrey S. Bazinet
Peters & Monyak
One Atlanta Plaza, Suite 2275
950 East Paces Ferry Road, NE
Atlanta, Georgia 30326

Thomas S. Carlock
Eric J. Frisch
Carlock, Copeland & Stair LLP
2600 Marquis Two Tower
285 Peachtree Center Avenue
Atlanta, Georgia 30303

This 21st day of August, 2009.



ANGELA T. BURNETTE