

# Mandatory Medical Arbitration: The Wrong Answer to the Rising Cost of Health Care in Utah

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*Few pieces of legislation draw attention from the public, and in the increasingly hurried Utah legislative process legislators themselves have little time to analyze each bill. In 2003, the Utah State Legislature passed Senate Bill 138, which allowed physicians to deny care to patients that refused to sign a mandatory and binding arbitration agreement. In passing the legislation, legislators relied heavily on claims that increasing medical malpractice insurance premiums were due to skyrocketing medical malpractice lawsuits, and inordinate awards from "runaway" juries. In doing so, the true scope and cause of the increasing insurance premiums were overlooked. Just months later Intermountain Health Care adopted mandatory arbitration for more than 170,000 of its patients. The public response to IHC's policy was swift and severe, resulting in the repeal of mandatory arbitration only one year later during the 2004 Legislative Session. While the Legislature should be commended for their quick repeal of mandatory arbitration, given the rushed environment of the Utah legislative process the public can expect such legislative errors to occur in the future*

## INTRODUCTION

Each January, the Utah State Legislature convenes for 45 consecutive days to address the problems facing the residents of Utah. Legislators are overloaded with information as they sort through the hundreds of proposed pieces of legislation. What the exact impact that such legislation will have on citizens is given a superficial treatment at best, as the legislature continues its stampede to the end of the session. Within this atmosphere of law makers struggling to understand the complex issues, the potential for error in law-making is increased. Legislators are forced to rely more and more heavily on information from lobbyists and colleagues, and when the time to vote on a bill arrives, it has become common for a legislator to look to either a member of leadership or the gallery for an indication of how to vote.

Most legislation enacted by the legislature is thought to have little impact on the lives of citizens. The large majority of the public does not pay close attention to the laws that are passed, and displays little public reaction to them. Mandatory medical arbitration, permitted by S.B. 138: Medical Malpractice Amendments, however, proved to be the exact opposite as public reaction was immediately strong and overwhelmingly negative. Only after the public recognized and reacted to the impact of S.B. 138 did the legislature attempt to revise the legislation. The purpose of this essay is to explore

the law making process through the passage and later repeal of S.B. 138. This essay will focus on the inadequate attention given to the issue during the 2003 legislative session, and how health care providers such as IHC implemented an unpopular and controversial mandatory arbitration policy.

## AGENDA SETTING: MANDATORY MEDICAL ARBITRATION

The turmoil started with, and was based almost solely on, what Mark Fotheringham, spokesman for the Utah Medical Association (UMA), called "some indication that with widespread adoption of arbitration there will be a positive effect on premiums" (Collins 2003, A01). The rising costs of health care not only in Utah, but nationwide, have been a concern to many lawmakers. One of the most commonly cited reasons for the rising cost of health care are medical malpractice lawsuits, and "runaway" juries awarding excessive amounts for damages which allegedly led to exorbitant medical malpractice insurance premiums for doctors. Such was the case with Grant Carter, MD. "After making the hardest decision of his life, Grant Carter had to break the bad news to his patients: He was no longer delivering babies." In giving his reason for leaving the practice he commented, "It became economically unfeasible" (Hamilton 2004c, A01).

Virtually all of us have heard about the sudden spikes in

medical malpractice insurance premiums for Utah physicians. Catherine D. Burton, MD in a letter to several legislators claimed, "We, as physicians will eventually be forced out of medicine (as some of our colleagues already have) because of uncontrollable medical malpractice" (C. Burton, 2004). Alarming statistics are often cited. For example, the University of Utah has seen the number of Ob-Gyn resident applications decrease from 175 applicants five years ago to only 126 this year (Hamilton 2004b, A01). This example is valid, as medical malpractice insurance premiums have increased rapidly over the last few years. In fact, "Utah Ob-Gyns saw their insurance premiums jump 94 percent over the past four years, from \$42,000 to \$81,628 per year" (Hamilton 2004b, A01). Other physicians in the state and country have experienced similar increases. This rapid jump threatens the future of our health care system. Some argue that in the near future it will be difficult to find Ob-Gyns and other high specialty doctors. Doctors and the insurance industry contend that there are a skyrocketing number of medical malpractice lawsuits, and that these lawsuits are primarily to blame for the sharp premium increase. The threat of malpractice lawsuits is one that most physicians feel very strongly about. Addressing this threat, Dr. T. Scott Lindley said, "The closest parallel I can think of is having cancer or a chronic, incurable disease" (Collins 2004, A01).

### THE DECISION MAKING PROCESS: INTENSE PRESSURE AND FLAWED ANALYSIS

In the 2003 General Legislative Session, Senator Leonard Blackham (R-Moroni) introduced Senate Bill 138. The bill would amend Utah Code Ann. 78-14-17, that was enacted in 1999, in the following ways:

1. Allowed a physician to refuse care if the patient declined to sign an arbitration agreement.
2. Provided for automatic renewal of the agreement each year unless the agreement is canceled in writing before the renewal date.
3. Allowed the patient to rescind the agreement within 30 days of signing the agreement.
4. Required that one arbiter be chosen by all persons claiming damages, one arbiter be selected by the health care provider, and a third arbiter be selected jointly from a list of individuals approved by the state or federal courts of Utah.

A strong lobbying effort was mounted by well-funded groups such as Intermountain Health Care (IHC), UMA, and the Utah Medical Insurance Association (UMIA). The lobbying effort had begun well before the opening of the legislative session. On December 20, 2002, one month before the 2003 legislative session began, the Utah Trial Lawyers Association's (UTLA) leaders were in attendance at a meeting in the UMA's offices. Douglas G. Mortensen, President of the UTLA Board of Governors, related what happened:

Representatives of the Utah Medical Association, Utah Medical Insurance Association and the Utah Hospital

Association revealed their commitment to amend Utah's arbitration statute in a way which would allow physicians to refuse care to patients declining to sign arbitration agreements.... We were invited to support, or at least not oppose, the legislation. We were warned that if we opposed the legislation, other medical malpractice "reform" measures even less favorable to our clients and to us would be introduced (2004, 4).

The UTLA found itself in a difficult position, and on February 14th 2003, a deal was struck. The UTLA and the Utah Health Care Community issued a joint statement that acknowledged the withdrawal of other bills in return for the UTLA's "withdrawing its opposition to S.B. 138." The deal included the addition of a six-year "sunset" provision to the legislation. In commenting on this deal, Mortensen wrote: "In agreeing to withdraw its opposition to S.B. 138, UTLA did not agree that allowing health care providers to refuse treatment to patients declining to sign pre-dispute arbitration agreements was in the public interest or would likely lead to a decrease in malpractice premiums, nor did it agree that a medical malpractice lawsuit "crisis" existed" (2004).

After the withdrawal of UTLA's opposition, S.B. 138 passed in the Utah State Senate on February 21, 2003, by a vote of 24-3-2, and later in the Utah House of Representatives on March 5, 2003, by a vote of 63-11-1. S.B. 138 passed despite the unanimous opinion of the American Arbitration Association (AAA), American Bar Association (ABA), and the American Medical Association (AMA) published in their July 1998 final report on health care dispute resolution which stated that "The agreement to use arbitration should be knowing and voluntary.... In disputes involving patients, binding forms dispute resolution should be used only where the parties agree to do so after the dispute arises..." (American Arbitration Association [AAA], American Bar Association [ABA], American Medical Association [AMA], 1998). In passing this bill the legislature gave inadequate consideration to the scope of the problem, the causes of the problem, the proposed solution, and the impact of the bill on the public.

### THE SCOPE OF THE PROBLEM

A 1999 report regarding "medical errors" by the Institute of Medicine (IOM) demonstrates that far too many Americans face serious possibility of injury, or even death, due to medical mistakes in hospitals. Using the IOM's low estimate of 44,000 deaths per year, medical errors are the eighth leading cause of death in the United States; ahead of both breast cancer and AIDS. The IOM's high-range estimate of 98,000 deaths a year would make medical error related deaths the fifth leading cause of death, more than all other accidental deaths combined (Institute of Medicine, 1999).

## THE CAUSES OF THE PROBLEM

Are medical malpractice lawsuits and “runaway juries” awarding excessive amounts for damages to blame for the high costs of health care? Each side has numbers and statistics to support their claim. The many conflicting charts and graphs can easily lead to confusion. As one article reported, “The arguments pro and con are full of data – and honest differences of opinion about how to interpret them. Sorting out the truth is as frustrating as trying to scoop water with a pillowcase” (Collins 2004, A01). Utah is not the only state struggling to sort out the mounds of data. An article in Florida’s Sun Sentinel stated:

During the 13 hours of grilling, senators watched a gaggle of state officials, lobbyists, doctors, and insurance executives eat their previously quoted words – or wish they could. “We have been working on the issue for one year, but we got more information in two days when we were able to extract the truth under oath,” observes Sen. Durrell Peaden Jr., a Republican. In other words, when witnesses who lie could face charges of perjury, the Judiciary Committee stopped getting “weasel words” and “doublespeak,” says Sen. Tom Lee, another Republican. In sworn testimony, senators learned that doctors are not fleeing the state, applications to practice medicine here have increased, emergency rooms and trauma centers are not closing doors because of rising medical malpractice premiums, frivolous malpractice lawsuits are not a problem, and malpractice lawsuits [awards] have not skyrocketed (Goldstein 2003, A01).

Is this the case in Utah? Is there really no crisis at all? Several statistics cannot be ignored. As a percent of their total income, doctors pay about the percentage of income for medical malpractice insurance as they have historically paid. For surgeons, that figure is about 6 percent, for Ob-Gyns about 8.5 percent, and for all physicians in general it is about 5 percent (Newhall, 2004a). Over the last ten years malpractice payouts have grown an average of 6.2 percent between 1990 and 2001. That is almost exactly the rate of medical inflation; an average of 6.7 percent between 1990 and 2001 (Woellert 2003). And, if caps on damages are the answer as many claim, then why do 11 of the 25 identified medical malpractice crisis states already have caps in place? (Newhall 2004a). Currently nineteen states including Utah have implemented caps on non-compensatory economic damages. For example, the most that a person can be awarded in non-economic damages in Utah is \$400,000. The Weiss Report shows that while caps on awards did reduce the burden on insurers, most insurers continued to increase premiums at a rapid pace. This has been the case in Utah. Further, the report states that “there are other, far more important factors driving the rise in medical malpractice premiums than caps or medical malpractice payouts” (Weiss 2003).

According to Doug Mortensen, President of UTLA’s Board of Governors, there is also much evidence that, “so-called measures of ‘tort reform’ having the effect of restricting the rights of injured patients, have never brought about their proponents’ promised decrease in malpractice premiums”

(2004). In testimony given before the Subcommittee on Health of the U.S. House Committee on Energy and Commerce regarding medical malpractice insurance rates, Travis Plunkett, Legislative Director of the Consumer Federation of America (CFA), stated that “Medical Malpractice rates are not rising in a vacuum. Commercial insurance rates are rising overall” (2002). Regarding the claims that medical malpractice premiums are the cause of the increase in the cost of health care, Clark Newhall, MD, JD, points out:

Medical malpractice insurance premiums have nothing to do with increases in health care costs. It is true that the most current figures show that out of the 1.55 trillion dollars in health care costs only \$8.8 billion are medical malpractice insurance premiums. That works out to 57 cents in malpractice premium for every 100 dollars in health care costs (2004b).

The maximum potential savings that could be attained if all forms of legal redress for injured patients were eliminated would be under 60 cents on a \$100 medical bill. This figure is not a significant enough percentage to justify the constant allegation that medical malpractice insurance costs are to blame for the high cost of health care. Furthermore, medical malpractice premiums as a percent of health care costs have been steadily declining over the past decade from .95 percent in 1988 to an estimated .57 percent in 2003 (A.M. Best’s and Company, 2001). So what is the cause of the drastic increase in medical malpractice premiums? The facts point to the natural “insurance cycle” of “hard” and “soft” markets.

In his testimony, Travis Plunkett of the CFA gave many answers to the cause of increasing premiums. “Insurers are pointing fingers,” Plunkett said, “when they should be looking in the mirror.” Further he stated that it is the “hard insurance market and the insurance industry’s own business practices that are largely to blame for the rate shock that physicians have experienced in recent months” (Plunkett 2002). Ironically, his opinion was even recognized by IHC. In an internal memo, IHC stated that “A number of observers believe that the cycle of insurance company investments, and their subsequent hard and soft markets, correlate better with the pattern of changes in malpractice premium rates than do jury awards – either numbers of awards or dollars” (McConkie 2004).

Insurance is a cyclical business. According to the National Association of Insurance Commissioners:

underwriting cycles may be caused by some or all of the following factors: 1. Adverse loss shocks...unusually large loss of shock may lead to supra-competitive prices. 2. Changes in interest rates... 3. Under pricing in soft markets (National Association of Insurance Commissioners [NAIC] 1991).

Prior to September 11, 2001, the insurance industry had been in a soft market since the late 1980s. The usual six to ten year economic cycle had been expanded by the amazing stock market of the 1990s. No matter how much insurance compa-

nies cut their rates, they wound up having a great year when investing the “float” on the premium in this amazing market (the float occurs during the time between when premiums are paid to the insurer and losses paid out by the insurer—for example there is about a 15 month lag in auto insurance). Further, interest rates were relatively high in recent years as the Federal Reserve focused on inflation. But, from the year 2000 to 2002, the market turned with a vengeance and the Fed cut interest rates again and again. Item two above had occurred well before September 11. Item three above, the low rates, were also apparent. Insurance companies’ operating profit as a percentage of premium dropped from 13 percent of premium in 1997 to about 3.5 percent of premium in 2000 (A.M. Best Company 2001). Well before September 11 the cycle had turned, rates were rising, and a hard market was developing. As Plunkett states, “An anticipated price jump of 10 to 15 percent in 2001 was predicted by the CFA and confirmed by the Insurance Information Institute” (2002).

Item number one, the shock loss, was all that was missing. The attacks of September 11 provided that in an aching-painful way. While the increases were mostly due to the cycle turn, they were sped up by the attack, collapsing two years of anticipated increases into a few months. The practices of the insurance industry itself are largely to blame. Plunkett noted that “Each time the cycle turns from a soft market to a hard market the response by insurers is predictable: they shift from inadequate under-pricing to unconscionable over-pricing, cut back on coverage, and blame large jury verdicts for the problem” (2002).

This turn in cycle had a particularly strong effect on Utah’s largest medical malpractice insurer. The physician run UMIA is a relatively small company and so it finds it harder to keep rates low in an era when the larger insurers are competing for the business of Utah physicians. When the market turned down, many of the larger insurers got out of the medical malpractice insurance business. However, smaller insurers like the UMIA, who have no other choice, remained in the medical malpractice insurance business and watched as their profits plummeted. Physicians became outraged when they suddenly had to raise rates to make up for the previous years of less expensive coverage.

### POLICY IMPLEMENTATION: IHC’S ARBITRATION AGREEMENT

Soon after the adoption of S.B. 138, IHC implemented mandatory arbitration for many of its customers. In a radio interview Senator Parley Hellewell (R-Orem) admitted, “When we passed the bill last year, we had no idea what kinds of things that IHC would put in their contract that would make it so one-sided and so lopsided” (2004). An analysis of common provisions of IHC’s and other arbitration agreement follows:

**1. High cost of Arbitration:** Article 3 (C) of IHC’s arbitration agreement stated that: “Patient(s) and

Provider(s) will each pay the fees and expenses of the arbitrator they appointed. Each side shall also pay one-half of the fees and expenses of the Presiding Arbitrator and the other expenses of the arbitration panel.” (McConkie 2004). Patients pay thousands of dollars per day to arbitrate. Most cases occupy more than one day and a complicated case could occupy many more. For example, a ten day case would cost \$40,000, of which the patient is required to pay half, win or lose. Compared to a court filing fee of about \$200, and arbitration is clearly the more expensive option. In court, the the process is at no cost to either the defendant or the plaintiff.

- 2. Forfeiture of past or future claims.** Upon signing the agreement, patients must give up their right to sue IHC for any past or future claims, and pursue those claims through arbitration. For example, patients with medical injuries that occurred prior to the signing of the agreement, and for which an action may be currently pending, can be forced to start those claims from the beginning, this time through arbitration.
- 3. Patients forfeit their right to sue any person or company who contracts with IHC:** The arbitration agreement covers “any person or entity in any way employed by, contracting with, or working for IHC” (McConkie 2004). Parties not even employed by IHC and others who are not actual signatories to the document are thereby released from any civil legal action for malpractice. For example, if IHC contracts with a company that supplies a faulty pacemaker, the patient cannot sue that company.
- 4. IHC retains the right to sue patients:** Patients give up their right to go to trial against IHC. However, IHC reserves the right to go to trial and pursue legal action by any means against a patient.
- 5. Patients have no right of appeal:** “Arbitration is your sole and exclusive remedy. That means that you waive your right to...seek any other legal remedy” (McConkie 2004). Arbitration is final and binding, meaning that the patient is bound by the decision of the arbitration panel. Patients waive their right to seek any other legal remedy. The ability to appeal influences both parties to reach a fair and just decision. Without the right to appeal, this important check on the legal system is lost.
- 6. Patients sign away more than just their rights:** Patients sign away the rights of their spouse, heirs, children, and unborn children: IHC maintains that parents can forfeit the legal right to sue of their minor and unborn children and that one spouse can forfeit the rights of another, even when they are separated, without mutual consent and knowledge.
- 7. Secrecy of arbitration proceedings:** The outcome of arbitration proceeding is private and confidential. While IHC maintained that it was an important pro-

tection of a patient's right to privacy, this provision of the arbitration agreement prevents the public from ever learning the identities of IHC physicians who potentially practice bad medicine in that they have been repeatedly accused or convicted of malpractice. However, IHC will be able to closely track the outcome of arbitration proceedings. The information gathered could be used by IHC to improve its defense strategies while patients will be denied access to information to prepare for their own cases. For example, if an arbiter on the approved list leans in IHC's direction repeatedly when deciding a case, the patient will not have access to this information while IHC will.

**8. Arbitration agreement automatically renews itself:**

The IHC contract automatically renews each year unless the patient cancels the agreement before the renewal date. Once IHC receives a signature for treatment, the agreement does not end. IHC makes renewal automatic each year. The only way to get out of the agreement is for the patient to contact IHC and follow their procedures to cancel the agreement. Upon termination of the agreement the patient is asked to go elsewhere for medical help.

**9. Patients are coerced into signing IHC arbitration agreements:**

In most cases, patients are part of employee/employer health plans. This means that they are less able to change their health plan unless their employer switches all employees over to a new health plan. In rural areas and in other high specialty areas many times there are no other alternatives. It is more than likely that a patient who refuses to sign the agreement must choose no treatment at all. Without other options available to the patient, his or her ability to choose is severely limited.

### POLICY IMPACT

While the passage of S.B. 138 drew little public attention, IHC's implementation of their mandatory arbitration agreement did. Whether the public understood the fine points of the legislation is doubtful. However, the one-sided nature of the bill soon became evident. In late November of 2003, IHC mailed out over 170,000 letters to Utah citizens in Bountiful and Salt Lake City announcing that patients would be required to sign the arbitration agreement before receiving medical care. They were told that if they refused to sign the agreement they would have to go elsewhere for medical care. Certainly, the way in which IHC presented arbitration, and the details of their agreement, were thought unethical by many, even by those within the health care community. Scott Barton, an Ob-Gyn at Old Farm Obstetrics and Gynecology in Salt Lake City, said, "It's unfortunate that IHC made this come to a head. I don't know if IHC took enough time to explain it [arbitration] to their patients" (Hamilton 2004a,

B01). Even R. Chet Loftis, UMA General Counsel, in an e-mail to legislators wrote, "We believe that it is unfortunate that IHC chose to introduce arbitration to its patients in the way that it did" (2004).

Thousands of consumers were surprised and even outraged when they learned the details of the agreement. As a KSL editorial noted, "Last year, you'll recall, lawmakers passed a bill to allow mandatory medical arbitration. To say the public didn't buy it is an understatement. The outcry was loud and determined" ("Medical Arbitration" 2004). In a poll conducted January 18, 2004, by the *Salt Lake Tribune*, the subjects were asked: "Should health care providers be allowed to require arbitration of disputes over possible medical malpractice and prohibit lawsuits as a condition of treatment?" 56.3 percent responded "No," 34.8 percent responded "Yes," and 8.9 percent responded "Don't know" ("Should Health Care" 2004). In addition, a Dan Jones and Associates poll conducted Dec 27-Jan 3 2003-2004, asked: "In general, do you favor or oppose patients signing binding arbitration agreements before being treated by a doctor or hospital?" Similar results were found, as 22 percent responded that they were strongly in favor, 17 percent responded that they were somewhat in favor, and 38 percent indicated strong opposition to arbitration agreements (Collins 2004, A01).

### POLICY EVALUATION: A LEGISLATIVE CORRECTION

In the weeks leading up to the 2004 legislative session the debate heated up. Sides were formed, including groups such as Patients Against Mandatory Medical Arbitration (PAMMA) and the Utah's Citizen's Alliance (UCA), both fighting to repeal S.B. 138, while arbitration supporters included IHC, the Arbitration Alliance, and hundreds of Utah physicians. Each organization had well funded agendas and convincing lobbyists to sway the views of not only the lawmakers, but the public as a whole. As the *Deseret Morning News* reported on December 24, 2003:

Members of a group called PAMMA, Patients Against Mandatory Medical Arbitration, picketed outside the Salt Lake Clinic...handing out information packets and waving signs with messages like 'IHC refuses to treat sick babies! Sign or Suffer' (Collins 2003a, B01).

On the first day of the 2004 Utah General Legislative Session lawmakers were greeted in the capitol with a rally of more than 30 protesters urging the repeal of S.B. 138. They were joined by legislators such as Representative Mike Thompson (R-Orem), and Senator Parley Hellewell.

Two pieces of legislation were proposed to repeal S.B. 138: S.B. 117 sponsored by Senator Parley Hellewell, and S.B. 245 sponsored by Senator Leonard Blackham. At the beginning of the session, the differences in the pieces of legislation were few. They both repealed the right of a physician to refuse care to a patient who declined to sign an arbitration agreement, however S.B. 117 called for a sole arbiter in the case

that a patient voluntarily opted for arbitration; while S.B. 245 called for a panel of three. At first IHC opposed both pieces of legislation, but as a local newspaper reported:

IHC had only tested the policy for three months before bowing to pressure from legislators, patients' advocacy groups, and trial lawyers. Now, the 400 IHC-employed physicians in Salt Lake County and Bountiful will no longer demand patients to sign agreements or be refused care.... IHC reversed its hard-line support of forced arbitration and agreed to back a bill proposed by Sen. Leonard Blackham, R-Moroni (Hamilton 2004c, A01).

Even Elliott J. Williams, a prominent former advocate for S.B. 138, when speaking in a Utah House Minority Caucus meeting stated, "We all agree that compulsory arbitration was not a good idea.... [A]rbitration as an option if chosen voluntarily is a good one" (2004). The complete reversal of opinion was almost immediate as IHC struggled to maintain its reputation.

The issue soon turned into not whether or not a physician could require arbitration agreements, but whether a one or three member panel should be used when a patient had voluntarily chosen arbitration. Strong opinions were voiced from each side. Senator Parley Hellewell said, "With three arbitrators, it guarantees that IHC wins every single time" (Spangler 2004), while Elliott Williams, the self-proclaimed Utah arbitration expert, said that "Most Utah arbiters are reluctant or refuse to take cases where they are the sole decision maker." The advocates of a single arbiter cited lower costs to consumers, while the advocates of a three member panel cited the "small universe of people qualified to be a sole arbiter" as the basis for their argument (Williams 2004).

The issue continued to be debated until the final hours of the legislative session. It was finally resolved in a quick hall huddle in the final few hours of the legislative session. "That was one of the quickest conference committees I've been to.... Fast and furious" remarked Senator Blackham (Bryson 2004b). The result of the conference committee was a widely accepted compromise, and the final bill:

1. Prohibited a health care provider from denying health care to a patient in the sole basis that the patient refused to sign an arbitration agreement.
2. Allowed the patient to rescind a signed arbitration agreement within 10 days of signing it.
3. Established a three member arbitration panel unless both sides agree to a single arbiter.

S.B. 245 passed the Utah State Senate on March 3, 2004 by a unanimous vote of 26 to 0 with three absent, and later passed the Utah House of Representatives on the same day by a vote of 64 to 6 with 5 absent. "We hope this will be resolved once and for all," said Senate President Al Mansell (R-Sandy) (Bryson 2004a). Senator Blackham, the sponsor of S.B. 245, commented, "I believe this is a well balanced approach that is fair and reasonable" (Bryson 2004b). However, not all were

pleased with the outcome. Cheryll Willey, office manager at Wasatch Internal Medicine, said, "We were getting a five percent discount from UMIA, which is peanuts, but every little bit helps because the malpractice rates are so expensive" (Hamilton 2004, A01). While a five percent discount on medical malpractice premiums may help some struggling doctors, the Legislature agreed that mandatory medical arbitration was too high a price to pay.

## CONCLUSION

The repeal of S.B. 138 was a victory for the citizens of Utah. It shows, to a certain extent, that the opinions of Utahns can have a significant effect on decisions of the Utah State Legislature. Mandatory arbitration was enacted due to a lack of information and foresight. The overwhelming majority of legislators accepted the claims by the UMA and UMIA that health care costs were rising due to large medical malpractice payouts. Few legislators understood the complexity and scope of the problem. Once properly informed, the Legislature acted to right the wrong it had created only one year prior. In this case the Utah State Legislature should be commended for its quick response and urged to give a more thorough and critical analysis of the hundreds of bills proposed each year.

Many of us unrealistically expect and assume that our elected officials make decisions only after being properly informed. The passage and later repeal of S.B. 138 shows that there are serious faults in the way that our legislators receive their information. In many instances important decisions are made without the proper time for debate and analysis. As not only the sheer quantity of legislation increases, but more complicated issues come before the Utah State Legislature, more and more legislators turn to lobbyists, colleagues, and other special interests for direction. In this setting of rushed analysis and speculation, it becomes easy for a legislator to accept the facts and figures presented by interest groups as reality. In an intense and compact legislative session, it is ever more unrealistic to expect any issue to receive adequate attention, and the possibility of "legislative errors" is enhanced.

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