# EXECUTIVE SUMMARY

# FINAL REPORT

# MEDICAL MALPRACTICE LIABILITY STUDY

SUBMITTED TO:
THE LEGISLATIVE COUNCIL
THE STATE OF MAINE

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## INTRODUCTION:

The Report of the Commission To Examine Problems of Tort Litigation and Liability Insurance in Maine (delivered to the Maine Legislature in December of 1987) concluded that there was not enough evidence from other State reforms of the 1970's to warrant additional tort reforms aimed at the liability insurance problem in Maine. As a result, while many reforms were offered few were approved by the Legislature and none brought substantial change to the tort system.

Since that report, the price of medical malpractice insurance premiums has continued to rise along with concerns about reduced access to medical care amid reports that physicians were reducing or stopping their services due to high insurance premiums. A renewed effort was undertaken to address this problem with several legislative proposals aimed at changing the tort system, setting up a patient compensation fund, expanding the membership and powers of the Board of Registration in Medicine, and subsidizing the insurance premiums of physicians in rural Maine.

In March of 1989, recognizing the seriousness of both the problem and the intended solutions, the Legislative Council contracted with the Public Health Resource Group of Portland, Maine to conduct an independent study of these issues by the end of May 1989. The aims of this study were to identify the current problems of both medical malpractice liability insurance and access to care in Maine, evaluate selected tort changes enacted

by the Legislature in 1986, and provide an assessment of policy options passed in other states which have demonstrated some measure of success in controlling premiums rates for medical malpractice insurance while assuring access to medical care.

The report that follows addresses each of these areas. In addition to a description of the insurance and access problems in Maine, it focuses on three policy areas that as a whole impact on the medical malpractice liability system: tort changes, insurance regulations, and medical system practices (in particular licensure, standards of care, hospital practice privileges, and Medicaid fee limits).

MALPRACTICE INSURANCE:

Based on the limited information available from the two major medical malpractice liability insurers conducting business in Maine, Medical Mutual Insurance Co.(MMIC) and the St. Paul Companies, premium rates for basic and specialty coverage have been rising to record proportions for Maine physicians over the last ten years. For example, between 1984 and 1988 premium rates for MMIC physicians more than doubled on average. Moreover, premium rates are erratic, going from a substantial decrease in one year to a significant increase the next. They are somewhat lower than the rates for most urban and many rural states. It is noteworthy, however, that premiums as a proportion of gross income are higher in Maine (11%) compared to the nation (6.2%).

Frequency of claims per 100 physicians insured are currently below average for the nation as a whole while claims severity is equal to the national average. Loss ratios for the State are somewhat higher than national averages indicating that premiums collected appear to cover the expected losses. These high loss ratios are due to the targeted and observed loss ratios for MMIC and possibly indicate an unusually conservative approach to reserves. This, combined with the high surpluses generated in recent years, brings into question the practice of computing expected losses and reserves, and their use of reinsurance. Forty percent of the premiums collected by MMIC goes to cover the cost of reinsurance and suggests the current reinsurance system needs review. The proportion of settlements going to legal fees to defend physicians amount to between 40 and 50% of the dollars paid out.

From the data, it is apparent that the frequency, severity, and losses as a percentage of income do not indicate that the liability insurance problem in Maine is out of control. It does suggest that more efficient methods of estimating reserves, reinsuring, and obtaining legal services could reduce the price of premiums for policy holders while continuing to provide high quality coverage. These are areas where policy changes could achieve savings to the insurance industry and ultimately the rate payers.

ACCESS TO MEDICAL CARE:

Based on secondary data and a physician survey conducted as part of this study, Maine has experienced and will continue to experience a decline of approximately 4% per year in physicians who provide obstetrical services. This decline is occurring primarily among Family Physicians and mostly in urban areas of the state. In the future, however, rural areas are expected to experience the same trend. The principal factors reported by physicians as responsible for this decline are the price of medical malpractice insurance and fear of a malpractice suit. Regardless of the size of the pool of physicians practicing obstetrics, the number providing services to Medicaid recipients is not declining any faster than the number providing services to other patients. However, the volume of Medicaid patients being treated by Obstetricians and all other medical doctors except Family Physicians is declining.

While the number of physicians available to provide obstetrical care is declining, the extent to which access to obstetrical services has been adversely affected is not known. While a decline in access in rural areas due to malpractice insurance may have occurred prior to this study and may be observed again if rates continue to climb, it is not apparent from the data available to the study.

In urban areas, the size of the obstetrical physician population is declining, but obstetrical services are available at hospital-based clinics and in family practice residencies. If

insurance rates continue to climb and Medicaid fees remain below market prices, more Family Physicians are likely to drop obstetrics leaving a serious access problem for Medicaid recipients. Family Physicians are the only group of physicians who have increased their volume of Medicaid patients over the past three years.

TORT REFORMS:

Changes in the tort system have been a major focus of efforts to reduce claims frequency, improve claims disposition efficiency, reduce claims processing costs, lower premium rates, and improve access to medical care. It is generally assumed that the price of insurance should decrease with any reduction in claims and that physicians will be more willing to practice with lower insurance premiums. The results of completed evaluations of tort reforms do not demonstrate convincing evidence to confirm these assumptions.

It is not yet clear whether tort reforms actually have succeeded in reducing the price of insurance or the frequency or severity of claims, or whether they will succeed in reducing or stabilizing premiums or claims in the future. It is also not known whether these parameters would have increased more than they have in the absence of the reforms. Moreover, since a significant number of the reforms in other states have been ruled unconstitutional, have not been put into effect, have been repealed, or have been allowed to expire, they may not have been operational long enough to have a clearly measurable effect.

It is difficult to isolate the effect of any single reform. Many other factors, such as the distribution of illness, physicians' capabilities, biotechnology, peer review and risk management programs, litigation strategy, public attitudes towards risk and compensation, and insurance rate-making procedures, all may contribute to the number of claims filed, their outcome, and the price of insurance. It is far easier to estimate the effect of certain reforms on the frequency or severity of claims than on the price of insurance or the willingness of physicians to practice certain high risk specialties. Caps on awards have reasonable potential to limit the dollar volume of high-stakes claims (as well as introduce some consistency into estimates of damages). Limits on contingency fees may increase the proportion of compensation actually retained by injured patients, but may leave patients with meritorious claims for small amounts without representation.

The effect of screening panels is perhaps the most difficult to predict, largely because their effectiveness depends on procedural details such as the permitted use of their decisions in court and the panel's authority to expedite the process. They may help to identify meritorious claims and encourage early settlement, but they may also increase the time and expense of resolving claims and discourage attorneys from accepting meritorious claims which are likely to result in small settlements.

The results of Maine's prelitigation screening panels, operational for over two years, are still uncertain. Information from court officials indicate that the panels have been useful in reducing the number of potential defendants named in a suit. Defendant attorneys like them perhaps because they have been largely successful in cases presented to panels thus far. Plaintiff attorneys would prefer to avoid them and go directly to court. Both agree that it is too soon to make a judgment on the goals stated in the statute that created them. At the same time, defendant attorney costs show they are competitive with similar costs of voluntary settlements and are well below the costs of a trial.

There is little doubt that the tort system can be an inefficient and expensive system of dispute resolution. Other systems have been suggested to replace it entirely, but no state has enacted or implemented such a system to date. The Vermont Legislature is currently considering a version of the American Medical Association's model fault-based administrative system. It will be years before any evidence is available on the impact of this approach.

Any effort to improve the efficiency of the tort system and reduce its cost should be welcome. Virtually all such measures, however, operate by shifting the probability of success somewhat from one party to the other. Efforts to reduce costs by limiting the number of claims that are actionable, the grounds

for liability, or the amount of damages recoverable all increase the probability that some injured persons will go uncompensated. Efforts to increase the mechanisms to better identify meritorious claims may increase the complexity, time, and expense of decision making. Thus, it is necessary to evaluate reforms in light of all the goals they may affect.

Changes in the tort system must also be consistent with constitutional requirements particularly rights of due process and equal protection of the law, access to the judicial system, and trial by jury. Most procedural changes in litigation suggested by the current legislative proposals are likely to be upheld if challenged, based on standards of the Maine Constitution. Placing a maximum limit on recoverable damages is the most constitutionally suspect of all current tort reform proposals.

At the same time, it is clear that changes made specifically for medical malpractice cases are most likely to be successfully challenged for exclusivity since the reasons for their adoption generally apply to other areas of tort law notably product liability. Medical malpractice cases concern only about 15% of all tort actions. Thus, before altering tort law, the Legislature should have good reason to believe that the changes proposed will, in fact, achieve the desired goals and should be careful to avoid drawing unjustifiable distinctions among tort claimants and tort defendants. The right to trial by jury, guaranteed to plaintiffs and defendants in tort cases, is deeply rooted in the

Constitution of Maine, and policies aimed at limiting the right, while probably constitutional, will have broad ramifications.

INSURANCE CHANGES:

Significant savings are possible in medical malpractice insurance even without reducing the number of claims brought or causing financial injury to insurers. Obtaining these savings will require more vigorous public (regulatory) oversight of the medical malpractice insurance industry in Maine. Specifically, a data base of Maine's claims, settlements, and insurance practices is essential if the insurance Superintendent is to have the data necessary to carry out oversight functions and if the Legislature and general public are to have the information necessary to evaluate both the Superintendent's and the industry's actions.

A principal role of the government in a regulated industry such as insurance is to get insurers to manage their business as efficiently as possible and provide a quality product to consumers at a reasonable price and with a fair return on investment. Inefficiency in malpractice insurance comes from a number of sources. To guard against the insurance industry's practice of understating investment income, the Superintendent of Insurance should be authorized and directed to promulgate an investment income model. Insurers have little incentive to control their expenses as long as rate increases can be passed on to policy holders. Expenses incurred by the leading two medical malpractice insurers make up a significant proportion of premiums. To ensure efficiency, the Legislature might require

that the Superintendent of Insurance mandate that insurers demonstrate an effective cost control program.

To minimize disruption in the marketplace due to unstable fluctuations in the price of insurance, the Legislature could authorize the Insurance Superintendent to spread the effect of substantial rate changes over a three-year period. To spread the risk of claims payments and resulting increases in premiums to those policy holders responsible, the Legislature might consider implementing a merit rating system, a system of deductibles, or both.

Finally, the heavy reliance by MMIC on reinsurance promotes inefficiencies because reinsurance is a costly product and reinsurers are not subject to effective State regulation. Significant savings could be achieved if the Superintendent of Insurance were directed by the Legislature to set standards for reinsurance limits which, to the extent feasible, reduce dependency on outside reinsurance. Secondly, the Legislature should consider a patient compensation fund such as that suggested in L. D. 762.

The insurance industry, like the medical care system, is based on trust that consumers give to providers. The integrity of the system demands that the income of policy holders be fully accountable and used as efficiently as possible. Actions to assure this outcome will have as much impact on the malpractice

problem as reduced rates.

MEDICAL SERVICES:

Patricia Danzon has conducted extensive research on effects of the 1976 tort reforms on frequency and severity of claims and other outcomes. When claims began to decline in the late 1970's following the medical malpractice "crisis" of that period, it was her opinion and that of other experts that the reforms passed by many states had less to do with the decline than the response by the medical profession to improving peer review and other efforts aimed at preventing the number of malpractice incidents.

Activities in several areas have been taking place in Maine and the Nation which show promise of improving quality of health care and reducing incidents of malpractice. There are others the Maine Legislature might consider. One 1986 reform charged the Board of Registration in Medicine with investigating any physician who had three or more malpractice claims over a ten-year period which resulted in a monetary settlement. This policy led to investigation of only seven physicians over a ten-year period. The Legislature could create an ombudsman capability within the Board which would serve to defuse potential complaints prior to their being elevated to a claim. Additional investigatory capability for the Board could be initiated, as called for in L.D. 1407, to follow up on complaints that come through an ombudsman office. Requiring the Board to collect additional information on the voluntary or involuntary loss of hospital privileges in or outside of Maine is also warranted before

licensing physicians or before hospitals grant privileges.

In addition to improved licensure standards, care standards have been proposed by JCAHO, selected hospitals in Maine, and MMIC as a means of improving quality and reducing the likelihood of malpractice suits. While physicians on both sides of this issue argue the merits of supposed "cook-book" medicine, this approach continues to develop as a potentially viable method of accomplishing these ends. The Legislature might consider endorsement of this approach as well as educational activities promulgated by the Maine Medical Assessment Program.

CONCLUSIONS:

There are many approaches to controlling rising and unstable medical malpractice liability insurance premiums in Maine and their effect on access to care. These include changes in the tort system, the insurance regulatory system, and the medical care delivery system. To target one while ignoring the others will create disequilibrium and lead to policies likely to fall far short of the mark. Each has some merit and some drawbacks. Each needs to be addressed with a realistic understanding of what will be gained and what will be lost. It was no surprise to many experts that the St. Paul Companies decided to lower their premiums due in part to a reduction in expected reserve demand for outstanding claims. Considering past history, however, the medical malpractice issue is likely to revisit Maine in a very few years. The severity of the problem at that time will depend on how comprehensive an approach the Legislature takes now.