December 6, 1988

TO: Access Commission

FROM: Deborah Curtis

Enclosed are several materials for your review prior to the meeting on Tuesday, December 6.

1. Communication from Gordon Smith, Maine Medical Association re malpractice issues.

2. Communication from Jack Dexter, Maine Chamber of Commerce re malpractice issues.

3. Brief summary of November 29, 1988 meeting.

4. Population and Cost Estimates for providing Medicaid-like health care coverage to citizens, to 150% of poverty.

Please keep in mind the following caveats and questions when reviewing these estimates:

a. These are <u>draft</u> estimates, still in the discussion phase.
b. Enrollee cost estimates are based on AFDC costs for children and adults. These may or may not reflect the costs of the enrollee population.
c. Cost projections <u>do not</u> include:
   1. provider fee increases, which would be essential in implementing such a program, or
   2. administrative costs.
d. First year costs have been determined based on two premises:
   1. participation will not exceed 50%
   2. average enrollee participation per year is 9.55 months.
e. The estimates for the population 100-150% of poverty need further attention. Though we continued to use 20% as the estimate of those who are privately insured, other studies seem to indicate that this percentage is much higher.
f. The estimates for children under 100% of poverty still include ages 5 to 8. They will be excluded from a revised estimate.

MAINE MEDICAL ASSOCIATION

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Legal Counsel
Gordon H. Smith

December 1, 1988

Bonnie Post
Chairperson
Joint Select Commission on Access
to Health Care
c/o Deborah Curtis
Bureau of Medical Services
State House Station 11
Augusta, Maine 04333

Dear Bonnie:

Re: Medical Liability Reform

I am writing to follow-up on some of the discussion that took place at your Commission meeting on November 29th. As usual, it was frustrating not to be able to respond directly to the number of misstatements that were made concerning medical liability in Maine. In order that your Commission, before its final report, may have a more balanced view of the medical liability scene, I am enclosing the following material:

1. Current premium rates for Medical Mutual Insurance Company of Maine and St. Paul for doctors insured in the State of Maine.

2. Current rates for the New Hampshire Medical Malpractice JUA.

3. A one-page sheet entitled "Summary of Studies Establishing a Relationship Between Tort Reform and Insurance Premium Relief."

4. Two letters from Medical Mutual sent to the Legislature in the spring of 1988 regarding the relationship between tort reform and insurance rates.

5. A list of states having caps on non-economic damages.

6. Material prepared by the American Tort Reform Association regarding the impact of tort reform, and

7. Information from a malpractice carrier in California stating that consumers saved $789.3 million between 1984

and 1986 with a substantial portion of those savings being directly attributable to the passage in California of the Medical Injury Compensation Reform Act in 1975. The most significant provision in MICRA limits a physician's liability for non-economic damages to $250,000.

I am particularly concerned about remarks that were made regarding doctors in New Hampshire, in some classes paying less than half of what Maine physicians are paying. I have the rates being charged by the New Hampshire Medical Malpractice JUA, effective July 1, 1988, and have examined them class by class against the rates of Medical Mutual and St. Paul. There is no class in which the doctors in New Hampshiare are paying one-half of what Maine physicians are paying. The normal differential is about 20 to 25% which is easily explained by the fact that the Joint Underwriting Association represents a State-initiated pooling concept. Rhode Island, Massachusetts and New Hampshire all have JUAs and, by the testimony of the actuaries employed by these JUAs, their collective underfunded liabilities now exceed $500 million. In New Hampshire, the liabilities exceed $20 million. In other words, it is clear that the doctors in New Hampshire, Massachusetts and Rhode Island have been paying artificially low medical malpractice rates through the years as a result of "political" and unrealistic rate setting. In New Hampshire, the matter was further complicated by the fact that there were two JUAs - one, pre-1983, managed by one company, and a post-1983 JUA, managed by the well-known insurance firm of Johnson and Higgins. The old JUA is still running at a deficit and New Hampshire physicians have to pay an assessment on their current premiums to fund the contingent liabilities of the old JUA. This surcharge, which is called a stabilization reserve fund, is expected to continue until the early 1990s.

The Maine Medical Association and I am sure Medical Mutual Insurance Company of Maine as well would be happy to provide any information that your Commission believes it needs to make firm recommendations in the area of medical liability.

Sincerely yours,

Gordon H. Smith
Legal Counsel

GHS:pp

Enclosures

cc: Robert B. Keller, M.D., President, M.M.A.
Edward David, M.D., Past President, M.M.A.
Patrick A. Dowling, M.D., Chairman, Board of Directors, Medical Mutual Insurance Company of Maine
Ted Briggs, Executive Director, Medical Mutual Insurance Company of Maine
Frank O. Stred, Executive Vice President, M.M.A.

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PROFESSIONAL LIABILITY RATE COMPARISON

In accordance with discussion during the House of Delegates Meeting in September we herewith publish a comparison of the current professional liability insurance premiums for St. Paul and Medical Mutual.

LIMITS: $500,000/$1,500,000

St. Paul (12 Month Rate)		Medical Mutual (12 Month Rate)	
R.C. 1A	$ 4,711		
R.C. 1	5,828	R.C. 1	$ 4,890
R.C. 2	8,624	R.C. 2	8,060
R.C. 3	11,419	R.C. 3	14,951
R.C. 4	14,213	R.C. 4	19,626
R.C. 5A	21,786		
R.C. 5	24,860	R.C. 5	24,301
R.C. 6	34,084	R.C. 6	28,976
R.C. 7	40,232	R.C. 7	35,988
R.C. 8	53,759	R.C. 8	43,000

LIMITS: $1,000,000/$3,000,000

St. Paul (12 Month Rate)		Medical Mutual (12 Month Rate)	
R.C. 1A	$ 5,653		
R.C. 1	6,994	R.C. 1	$ 5,863
R.C. 2	10,349	R.C. 2	9,812
R.C. 3	13,703	R.C. 3	18,226
R.C. 4	17,055	R.C. 4	23,993
R.C. 5A	27,206		
R.C. 5	31,044	R.C. 5	29,759
R.C. 6	42,562	R.C. 6	35,525
R.C. 7	50,240	R.C. 7	44,175
R.C. 8	67,132	R.C. 8	52,825

NEW HAMPSHIRE MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION
SUMMARY OF OCCURRENCE RATES
EFFECTIVE JULY 1, 1988

CLASSIFICATIONS		LIMITS (IN THOUSANDS): 25/75	100/300	200/600	250/500	250/750	500/1,000	500/1,500	1M/1M	1M/2M	1M/3M
PHYSICIANS											
CLASS I: NO SURGERY (OTHER THAN INCISION OF BOILS, SUTURING OF SKIN).	PREMIUM:	1,399	1,917	2,531	2,665	2,703	3,144	3,221	3,719	3,872	4,046
	SRF CHARGE:	210	288	380	400	405	472	483	558	581	607
	40% DEPOSIT:	559.60	766.80	1,012.40	1,066.00	1,081.20	1,257.60	1,288.40	1,487.60	1,548.80	1,618.40
CLASS II: MINOR SURGERY. ASSISITING IN MINOR SURGERY ON OWN PATIENTS OR OB PROCEDURES - NOT MAJOR SURGERY. NEEDLE BIOPSY. RADIOPAQUE DYE INJECTIONS MYELOGRAPHY. OPHTHALMOLOGISTS.	PREMIUM:	2,520	3,451	4,555	4,796	4,866	5,658	5,797	6,694	6,971	7,281
	SRF CHARGE:	378	518	683	719	730	849	870	1,004	1,046	1,092
	40% DEPOSIT:	1,008.00	1,380.40	1,822.00	1,918.40	1,946.40	2,263.20	2,318.80	2,677.60	2,788.40	2,912.40
SURGEONS											
CLASS III: GENERAL PRACTIONERS ASSISITING IN MAJOR SURGERY ON OTHER THAN OWN PATIENTS, INCL. CATHETERIZATION (NOT INCL. CARDIAC SURGERY). ACUPUNCTURE, RADIATION AND SHOCK THERAPY. ARTERIOGRAPHY.	PREMIUM:	4,226	5,870	8,041	8,160	8,570	9,627	9,862	11,505	12,034	12,679
	SRF CHARGE:	634	881	1,206	1,224	1,286	1,444	1,479	1,726	1,805	1,902
	40% DEPOSIT:	1,690.40	2,348.00	3,216.40	3,264.00	3,428.00	3,850.80	3,944.80	4,602.00	4,813.60	5,071.60
SPECIALISTS											
CLASS IV: UROLOGISTS, E/R PHYSICIANS - NO MAJOR SURGERY.	PREMIUM:	5,637	7,829	10,726	10,882	11,429	12,838	13,152	15,344	16,049	16,909
	SRF CHARGE:	846	1,174	1,609	1,632	1,714	1,926	1,973	2,302	2,407	2,536
	40% DEPOSIT:	2,254.80	3,131.60	4,290.40	4,352.80	4,571.60	5,135.20	5,260.80	6,137.60	6,419.60	6,763.60
CLASS V: SURGERY: LARYNGOLOGY, CARDIAC, GENERAL, OTORHINOLOGY, E/R WITH MAJOR SURGERY. OTOLOGY, OTORHINOLARYNGOLOGY, RHINOLOGY, ABDOMINAL, ANESTHESIOLOGY, GYN (WITHOUT OB).	PREMIUM:	7,045	9,785	13,405	13,601	14,286	16,046	16,437	19,178	20,059	21,134
	SRF CHARGE:	1,057	1,468	2,011	2,040	2,143	2,407	2,466	2,877	3,009	3,170
	40% DEPOSIT:	2,818.00	3,914.00	5,362.00	5,440.40	5,714.40	6,418.40	6,574.80	7,671.20	8,023.60	8,453.60
CLASS VI: SUGERY: OBS & OB/GYN, PLASTIC, HAND & NECK.	PREMIUM:	8,453	11,741	16,085	16,321	17,142	19,256	19,724	23,013	24,069	25,360
	SRF CHARGE:	1,268	1,761	2,413	2,448	2,571	2,888	2,959	3,452	3,610	3,804
	40% DEPOSIT:	3,381.20	4,696.40	6,434.00	6,528.40	6,856.80	7,702.40	7,889.60	9,205.20	9,627.60	10,144.00
CLASS VI[illegible] SURGERY: THORACIC, VASCULA[illegible]THOPAEDIC, NEURO.	PREMIUM:	11,271	15,655	21,449	21,761	22,857	25,675	26,302	30,685	32,093	33,816
	SRF CHARGE:	1,691	2,348	3,217	3,264	3,429	3,851	3,945	4,603	4,8[illegible]	5,072
	40% DEPOSIT:	4,508.40	6,262.00	8,579.60	8,704.40	9,142.80	10,270.00	10,520.80	12,274.00	12,83[illegible]	13,526.40

NEW HAMPSHIRE MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION
SUMMARY OF FIRST YEAR CLAIMS MADE RATES
EFFECTIVE JULY 1. 1988

CLASSIFICATIONS		LIMITS (IN THOUSANDS): 25/75	100/300	200/600	250/500	250/750	500/1.000	500/1.500	1M/1M	1M/2M	1M/3M
PHYSICIANS											
CLASS I: NO SURGERY (OTHER THAN INCISION OF BOILS. SUTURING OF SKIN).	PREMIUM:	700	959	1.266	1.333	1.352	1.572	1.611	1.860	1.936	2.023
	SRF CHARGE:	105	144	190	200	203	236	242	279	290	303
	40% DEPOSIT:	280.00	383.60	506.40	533.20	540.80	628.80	644.40	744.00	774.40	809.20
CLASS II: MINOR SURGERY. ASSISITING IN MINOR SURGERY ON OWN PATIENTS OR OB PROCEDURES - NOT MAJOR SURGERY. NEEDLE BIOPSY. RADIOPAQUE DYE INJECTIONS MYELOGRAPHY. OPHTHALMOLOGISTS.	PREMIUM:	1.260	1.726	2.278	2.398	2.433	2.829	2.899	3.347	3.486	3.641
	SRF CHARGE:	189	259	342	360	365	424	435	502	523	546
	40% DEPOSIT:	504.00	690.40	911.20	959.2	973.20	1.131.60	1.159.60	1.338.80	1.394.40	1.456.40
SURGEONS											
CLASS III: GENERAL PRACTI-ONERS ASSISITING IN MAJOR SURGERY ON OTHER THAN OWN PATIENTS. INCL. CATHETERIZATION (NOT INCL. CARDIAC SURGERY). ACUPUNCTURE. RADIATION AND SHOCK THERAPY. ARTERIOGRAPHY.	PREMIUM:	2.113	2.935	4.021	4.080	4.285	4.814	4.931	5.753	6.017	6.340
	SRF CHARGE:	317	440	603	612	643	722	740	863	903	951
	40% DEPOSIT:	845.20	1.174.00	1.608.40	1.632.00	1.714.00	1.925.60	1.972.40	2.301.20	2.406.80	2.536.00
SPECIALISTS											
CLASS IV: UROLOGISTS. E/R PHYSICIANS - NO MAJOR SURGERY.	PREMIUM:	2.819	3.915	5.363	5.441	5.715	6.419	6.576	7.672	8.025	8.455
	SRF CHARGE:	423	587	804	816	857	963	986	1.151	1.204	1.268
	40% DEPOSIT:	1.127.60	1.566.00	2.145.20	2.176.40	2.286.00	2.567.60	2.630.40	3.068.80	3.210.00	3.382.00
CLASS V: SURGERY: LARYNGOLOGY. CARDIAC. GENERAL. OTORHINOLOGY. E/R WITH MAJOR SURGERY. OTOLOGY. OTORHINO-LARYNGOLOGY. RHINOLOGY. ABDOMINAL. AMESTHESIOLOGY. GYN (WITHOUT OB).	PREMIUM:	3.523	4.893	6.703	6.801	7.143	8.023	8.219	9.589	10.030	10.567
	SRF CHARGE:	528	734	1.005	1.020	1.071	1.203	1.233	1.438	1.505	1.585
	40% DEPOSIT:	1.409.20	1.957.20	2.681.20	2.720.40	2.857.20	3.209.20	3.287.60	3.835.60	4.012.00	4.226.80
CLASS VI: SUGERY: OBS & OB/GYN. PLASTIC. HAND & NECK.	PREMIUM:	4.227	5.871	8.043	8.161	8.571	9.628	9.862	11.507	12.035	12.680
	SRF CHARGE:	634	881	1.206	1.224	1.286	1.444	1.479	1.726	1.805	1.902
	40% DEPOSIT:	1.690.80	2.348.40	3.217.20	3.264.40	3.428.40	3.851.20	3.944.80	4.602.80	4.814.00	5.072.00
CLASS VII: SURGERY: THORACIC. VASCULAR. THOPAEDIC. NEURO.	PREMIUM:	5.636	7.828	10.725	10.881	11.429	12.838	13.151	15.343	16.047	16.908
	SRF CHARGE:	845	1.174	1.609	1.632	1.714	1.926	1.973	2.301	2.407	2.536
	40% DEPOSIT:	2.254.40	3.131.20	4.290.00	4.352.40	4.571.60	5.135.20	5.260.40	6.137.20	6.4	6.763.20

Summary of Studies Establishing a Relationship Between Tort Reform and Insurance Premium Relief

P.M. Danzon, The Frequency and Severity of Medical Malpractice Claims. New Evidence, 49 Law and Contemporary Problems 2 (1986) (Danzon states that the average impact of the various statutes to limit all or part of the plaintiff's recovery has been to reduce average claim severity by 23%; abolition of collateral source rule reduced claim frequency by 14% and severity by 11-18%)

U.S. Government Printing Office, Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability (February 1986)

U.S. Government Printing Office, An Update on the Liability Crisis 87 (March 1987)

F.A. Sloan, State Responses to the Malpractice Insurance "Crisis" of the 1970's: An Empirical Assessment, 9 Journal of Health Politics, Policy and Law 4 (1985)

Rand Corporation, P.M. Danzon, The Frequency and Severity of Medical Malpractice Claims (1982)

Danzon, The Frequency and Severity of Medical Malpractice Claims, 27 J. of L. & Econ. 139 (Apr. 1984)

Danzon & Lillard, Settlement Out of Court: The Disposition of Medical Malpractice Claims, 12 J. of Legal Studies 345 (1983)

General Accounting Office, Medical Malpractice, Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms (Dec. 1986) (Demonstrates effect of reforms in California and Indiana)

Cuomo Comm'n Report, Insuring Our Future, (Vol. I, April 1986; Vol. II, July 1986)

Medical Underwriters of California, 1986 California Large Loss Trend Study (copies of study available from Medical Underwriters of California, 6250 Claremont Avenue, Oakland, CA 94618 [Deplte the increase in the number of large awards, a decrease in overall indemnity occurred because of a California Supreme Court decision that allowed strict enforcement of tort reform legislation which, among other things, places a $250,000 limit on noneconomic damages.]

Peat, Marwick, Mitchell & Co., Reports on effect of reforms for Pennsylvania and New York State Medical Societies:

New York:

$100,000 limit on economic damages	Savings 25%
Structured awards	5%
Contingent fees	10%

Pennsylvania:

Collateral Source	2 to 10%
Structured Awards	7 to 14%

MEDICAL MUTUAL

February 26, 1988

Dear Representative:

RE: TORT REFORM

Tort reform legislation to lower the costs of medical malpractice liability will soon come before both Houses of the Legislature for a vote. **We urge you to vote in favor of a bill to (1) cap non-economic damages; (2) eliminate the concept of joint and several liability; and (3) tie pre- and post-judgment interest rates to an interest-sensitive indicator.**

Passage of a meaningful law will have a positive effect on medical malpractice premiums, as well as moderate the upward spiral of rates. There has been a significant amount of erroneous information advanced by opponents of tort reform and a strong attempt to portray tort reform as a case against innocent victims for the benefit of wealthy insurance companies. Nothing could be further from the truth. Tort reform to lower the costs of medical malpractice coverage is an effort to make good medical care available and affordable to all Maine patients. The ever-increasing rates of medical malpractice premiums are forcing physicians either to continuously raise their patient fees or to withdraw from certain high risk procedures, such as obstetrics.

The undersigned are members of the Board of Directors of Medical Mutual Insurance Company of Maine. We are a mutual insurance company established under the laws of the State of Maine and licensed by the Maine Bureau of Insurance on September 1, 1978. We are licensed only in Maine and provide only medical malpractice insurance coverage to Maine physicians. We currently insure approximately two-thirds of the physicians in the state.

MEDICAL
MUTUAL

March 17, 1988

Dear Legislator:

We at Medical Mutual Insurance Company of Maine have been following the legislative debate on tort reform very closely and believe that misinformation about our rates is being advanced by opponents of tort reform.

I would like to correct the idea that Medical Mutual's rates are based entirely on countrywide experience and that Maine's experience is of little value. That is simply not true. Medical Mutual's basic limits pure premium rates are based on State of Maine experience. Increased limits factors are derived from countrywide data for purposes of credibility, and the increased limits factors are applied to the basic limits rates. This is not limited to the medical malpractice line of insurance; virtually all liability lines of insurance utilize countrywide data in developing increased limits factors.

Malpractice premiums are a result of loss frequency and loss severity in Maine. As we pointed out to you in our earlier letter, we are using our best efforts to control frequency and severity of claims. However, meaningful tort reform is needed if we are to be successful in keeping medical malpractice insurance available and affordable, thereby allowing physicians to continue the delivery of quality care to the people of Maine.

Non-economic caps have been successful in those states which have adopted them, and they can't help but affect premiums in Maine as well. Even in Maine there are large claims and jury awards (such as the recent large non-economic award in Penobscot County), which have an adverse impact on the entire claims settlement process.

Once again, we urgently solicit your support in passing a meaningful cap on non-economic damages. Thank you.

Sincerely,

William H. Maxwell, M.D.
President

WHM:cl

MEDICAL MUTUAL INSURANCE COMPANY OF MAINE
43 Baxter Boulevard • P.O. Box 1299 • Portland, Maine 04104 • (207) 775-2791/2792 • 1-800-828-4999

Caps* on Non-economic Damages

State	Amount	Comments
California	$ 250,000	Constitutionality upheld in 1985
Indiana	$ 500,000	Cap is on total damages, not just non-economic. Constitutionality upheld in 1980
Kansas	$ 250,000	Applies to all civil cases; $250,000 cap applies only to pain and suffering, not other non-economic losses
Maryland	$ 350,000	
Minnesota	$ 400,000	Cap on intangible losses, described as embarrassment, emotional distress and loss of consortium, but not pain and suffering
Missouri	$ 350,000	
Nebraska	$1,000,000	Cap is on total damages, found constitutional
New Hampshire	$ 875,000	All personal injury cases
New Mexico	$ 500,000	On total damages exclusive of medical care and related benefits
South Dakota	$1,000,000	Cap is on total damages, replacing a previous cap of $500,000 on non-economic damages
Texas	$ 500,000	Cap is on total award, exclusive of medical, hospital expenses and custodial care
Utah	$ 250,000	
West Virginia	$1,000,000	

Wisconsin	$1,000,000	Subject to cost of living adjustment based on CPI
Michigan	$ 225,000	Contains some exceptions for reproductive system and loss of vital bodily function
Colorado	$ 250,000	All civil actions, but $500,000 can be awarded if court finds "clear and convincing evidence
Alabama	$ 400,000	Includes punitive damages
Idaho	$ 250,000	$400,000 for all cases, sunsets on July 1, 1992
Missouri	$ 350,000	Subject to cost of living increase
Hawaii	$ 375,000	Described as cap on damages for physical pain and suffering
Oregon	$ 500,000	All personal injury actions
Florida	$ 250,000 $ 350,000	If arbitration. If trial. (Earlier $450,000 cap declared unconstitutional in 1987)
Alaska	$500,000	All personal injury cases, excludes physical impairment or disfigurement
Massachusetts	$ 500,000	Contains certain exceptions such as substantial or permanent loss or impairment of bodily function
Georgia	$ 250,000	Cap on punitive damages only
Washington	$ 177,000 - $493,000	Cap set by formula = approximately ½ the average annual wage in state multiplied by life expectancy

Louisiana	$ 500,000	Total damages, status of court challenge unclear
Ohio	$ 200,000	

Statutes establishing caps found unconstitutional in Florida, New Hampshire, Illinois and North Dakota.

*Unless otherwise noted, the cap applies to medical negligence cases only.

ATRA American Tort Reform Association

1250 Connecticut Avenue, N.W. • 7th Floor • Washington, D.C. 20036 • (202) 637-6490

TORT REFORM'S IMPACT

Findings from Patricia M. Danzon's, Associate Professor of Health Care Systems and Insurance, University of Pennsylvania, The Frequency and Severity of Medical Malpractice Claims: New Evidence, Spring 1986

1. States that have reduced the statute of limitations for adults by one year, have experienced a reduction of total claim frequency of eight percent and frequency of paid claims by six to seven percent.

2. Laws that admit evidence of collateral coverage and laws which mandate offset, reduce claim frequency by an estimated 14%.

3. Because over fifty percent of dollars awarded are paid on five percent of cases, laws which establish caps on awards have been shown to reduce average severity (the average award) by 23%.

4. Laws providing for mandatory collateral source offset and laws permitting offset at the courts's or jury's discretion reduce the amount of awards by between 11 and 18%.

5. States that permit voluntary binding arbitration have an average claim severity about 20% lower than other states.

Findings from the U.S. General Accounting Office's Medical Malpractice Case Study on Indiana, December, 1986

1. Since Indiana passed its Medical Malpractice Act of 1975, which put a $500,000 cap on the amount recoverable, made the statue of limitations two years and set up panels to review all claims before they go to court, the cost of insurance for Indiana physicians and hospitals has been among the lowest in the nation. This is compared to the mid-1970's, when Indiana's premiums were higher than most neighboring states. Also, three new insurance companies have entered the Indiana medical malpractice market since the bill passed.

2. The leading physician medical malpractice insurer had no rate increases from January 1, 1975 until July 1985, when most physician insurers increased their premiums.

3. The physician group, Indiana Bar Association, and Indiana Department of Insurance claim that the panel process, which calls for a panel of health care providers to review the claims before they go to court, has decreased the number of claims that go to trial.

4. According to a large Indiana malpractice insurance company, only two percent of claims filed against the company go to court. The company also reports that their average cost of defending a claim in Indiana is about $2,100 versus about $10,000 in Michigan and Illinois. The company attributes this to the review panel process.

5. The average paid claim, in Indiana, in 1984 was smaller than the average paid in 1980.

More Examples Of The Impact Of Tort Reform

1. A May 1985 California Medical Association-sponsored study attributed savings in malpractice claims costs ranging from 8% to 49% in 1985 to California's malpractice legislation.

   Medical Malpractice Case Study On California, U.S. General Accounting Office

2. Dr. Joseph D. Sabella, president of the Doctor's Company, credits the $789.3 million savings for California doctors from mid-1984 to mid-1986 to the state's tort reform legislation enacted in 1975.

   The Executive Letter of the Insurance Information Institute, June 1, 1987

3. Robert Hunter, president of the National Insurance Consumer Organization, believes that Florida's tort reforms will result in rate reductions of "7% to 12%."

   Journal Of Commerce, December 10, 1986

4. In New Hampshire, insurers providing liquor, day care and municipal liability coverage will drop rates by about 16%, due to the states' tort reforms.

   The Executive Letter of the Insurance Information Institute, October 20, 1986

5. After Washington passed tort reform, Fireman's Fund Insurance Company, SAFECO Insurance Company and Maryland Casualty Company re-entered the insurance market in the state.

   Dick Marquardt, Washington Insurance Commissioner, July 14, 1986

6. Due to Alaska's tort refrom law, Fireman's Fund Insurance Company has decided to provide insurance to small and medium sized cities and school districts in that state.

   The Anchorage Daily News July 11, 1986

7. A Tellinghast study of the potential effect of pending tort reform legislation showed that by changing the collateral source rule, capping attorney fees, and allowing structured payments for settlements and judgements, insurance premiums could be lowered by 27.2%.

Liability Week, March 12, 1987

8. Due to tort reform legislation passed in Colorado, the Travelers Companies, Fireman's Fund Insurance Company, and AEtna Commercial Insurance Division, are increasing insurance availabiity.

Colorado Insurance Legislative Report, Professional Insurance Agents of Colorado, 1986

9. The Tort Policy Working Group found that caps on noneconomic damages could give the tort system substantially more predictability, since only 5.6% of all paid medical malpractice claims for noneconomic compensation exceed $100,000, yet such awards represent, on the average, 80% of the total award.

Report of the Tort Policy Working Group, February 19, 1986

10. Milliman and Robertson, Inc, Consulting Acturies, found that tort reforms like periodic payments, collateral source-offset, limits on non-economic damages ($250,000), and limits on lawyers contigency fees could save between 23% and 33% on state tort costs. The study also found that such reforms could reduce claim severity trends, over the 1986-89 period, by 3% to 6%.

Actuarial Analysis of American Medical Association Tort Reform Proposals, September, 1985

11. Periodic payments for future damages over an injured claiments lifetime, rather than a lump sum payment, could eliminate "windfall" payouts to persons other than the injured person if the patient dies, and could lower liability premiums by an estimated 6%.

Testimony by James E. Davis MD and James S. Todd MD to the Committee on Labor and Human Resources U.S. Senate

12. A sliding scale for attorney's contingent fees could make sure a bulk of the award goes directly to the injured party, while still providing just compensation for the lawyers. Since larger percentages would be at the lower ends of the scale, lawyers would not be discouraged from taking cases with lower anticipated judgments. This reform could save an estimated 9% on liability premiums.

Testimony by James E. Davis MD and James S. Todd MD to the Committee on Labor and Human Resources U.S. Senate

13. A report by the Insurance Services Office, Inc. concluded that although most tort reform changes will have a "relatively narrow and specialized impact on indemnities paid in bodily injury claims", modifications of the rule of joint and several liability and the collateral source rule would have considerable indemnity cost savings.

Claim Evaluation Project April 1987

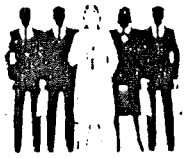
14. Due to North Carolina's childhood vaccine injury compensation program, Lederle says it will eliminate the product liability portion of its price for DTP (diptheria, tetanus, pertussis) vaccine in that state. This will lower the cost of the vaccine from $8.25 to $3.67 per dose.

Washington Drug Letter, May 25, 1987

15. Insurance Commissioner Bill Gunter on the success of Florida's tort reform law, "Even the limited portions of this law that have already been implemented have begun to provide stability and relief to many small businesses and professionals who buy commercial liability insurance."

Liability and Insurance Bulletin, May 4, 1987

NEWS



THE DOCTORS' COMPANY
401 Wilshire Boulevard
Santa Monica Ca 90401

FOR RELEASE: UPON RECEIPT

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TORT REFORM SAVES MILLIONS
FOR MEDICAL CONSUMERS

California health care consumers saved millions of dollars last year because of the passage of the Medical Injury Compensation Reform Act (MICRA) in 1975.

This major benefit to consumers, resulting from the state's tort reform law, was reported here today by Joseph D. Sabella, M.D., president and chairman of the board, The Doctors' Company, the nation's largest, independent, doctor-owned professional liability insurer.

"Between mid-1984 and mid-1986, physicians' fees increased 13.1 percent nationwide. In that same period, California physicians saw an increase of only 9.2 percent. If physicians' fees had increased in California at the same rate, an estimated additional $789.3 million would have been spent by patients for doctors' services in this state," Sabella reported.

According to Sabella, a substantial portion of these savings is directly attributable to MICRA. They reflect the moderation of physicians' professional liability insurance premiums, and have a direct impact on health care costs to consumers.

"An intensive analysis of premium rates nationwide has revealed that there is a substantial difference between those of California

and other states without tort reform. Average premium in current dollars in California doubled from $9,743 in 1976 to $19,597 in 1987. However, in constant 1976 dollars, adjusted for the Consumer Price Index (CPI), it actually fell slightly to $9,690," he stated.

"Anesthesiologists, for example, were paying $15,389 in premiums in 1976. In 1987, those specialists are now paying $8,010 in dollars deflated by the CPI," Sabella explained.

"Obstetrician/gynecologists in the state of New York, where there has been no successful tort reform, are, in some cases, paying as much as $85,000, while their counterparts in California are paying almost 50 percent less. In 1976, premiums were almost the same in both states," Sabella pointed out.

According to Sabella, there have been numerous public criticisms by special-interest groups of individuals and organizations who supported the joint and several liability initiative, Proposition 51, alleging that there has been no tangible reduction in premiums.

"It is premature to expect premiums to drop in the first months since that law was enacted. And it is specious to suggest otherwise. However, we've seen the positive effects of MICRA, and they are indisputable. Tort reform does reduce costs," Sabella stated.

"California has the finest, most effective tort reform law in the United States. MICRA has been subjected to four constitutional challenges before the state supreme court. In each case, its provisions were ruled constitutional.

"Our state's tort reform law is used as a model in proposed

legislation throughout the country, and the value of its benefits to the California medical consumer and the state's physicians is beyond question," Sabella concluded.

# # #

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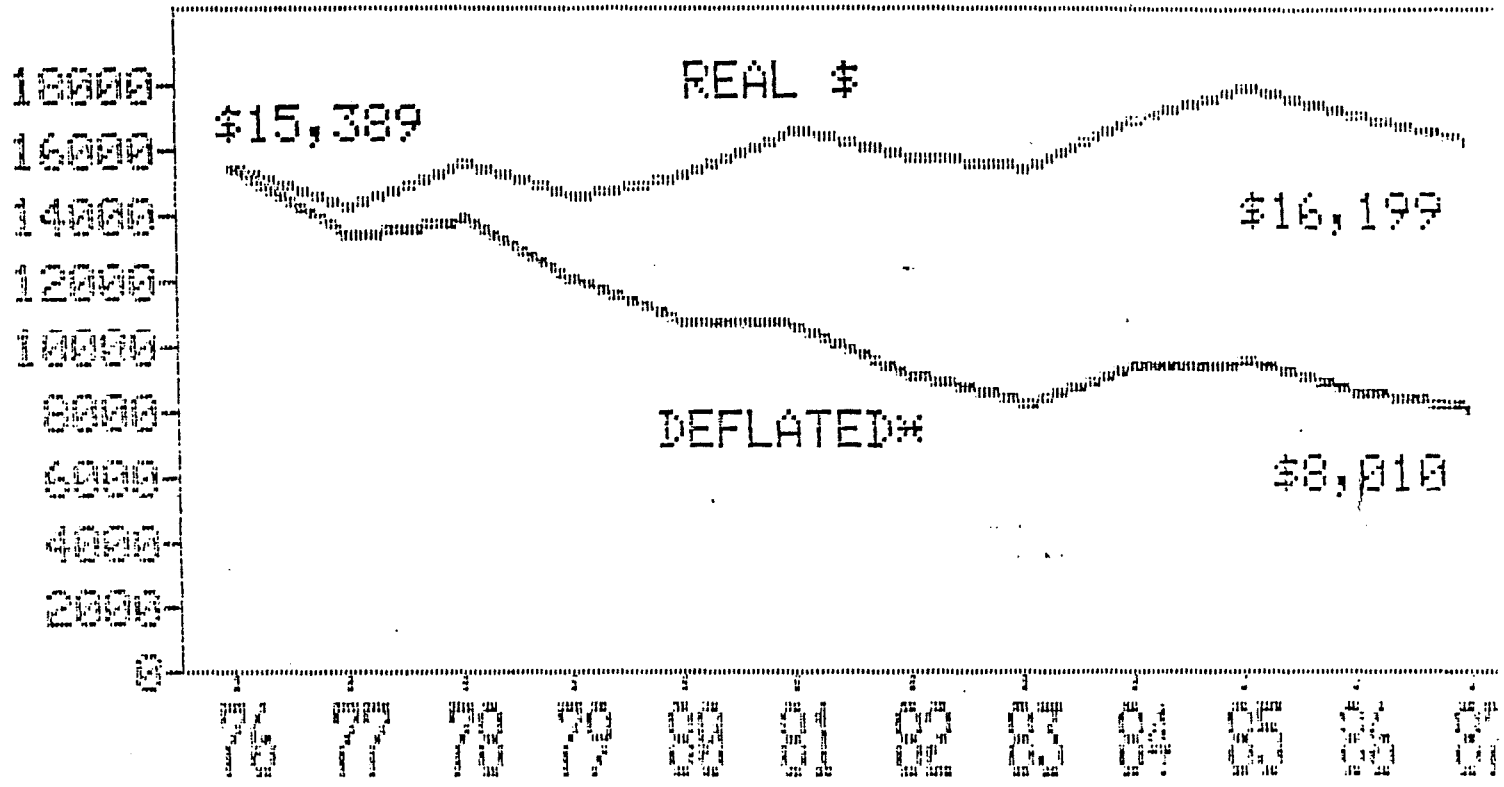
ANESTHESIOLOGY PREMIUMS: 1976-1987



PREMIUMS - REAL $
PREMIUMS - DEFLATED $

*DEFLATED BY CPI, LA/LB

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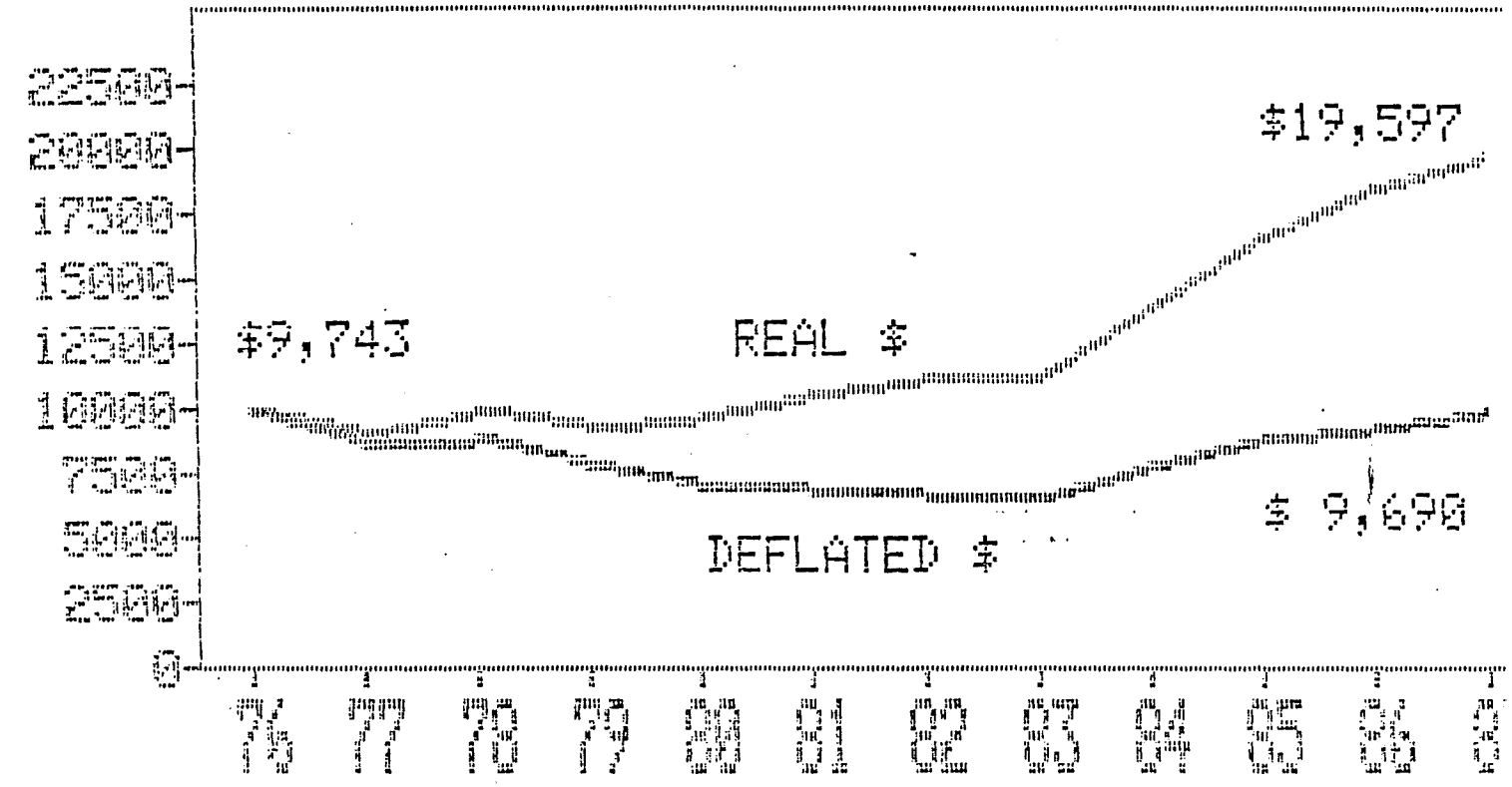
AVERAGE PREMIUMS: 1976-1987



PREMIUMS - REAL $
PREMIUMS - DEFLATED $

*DEFLATED BY CPI-LA/LB

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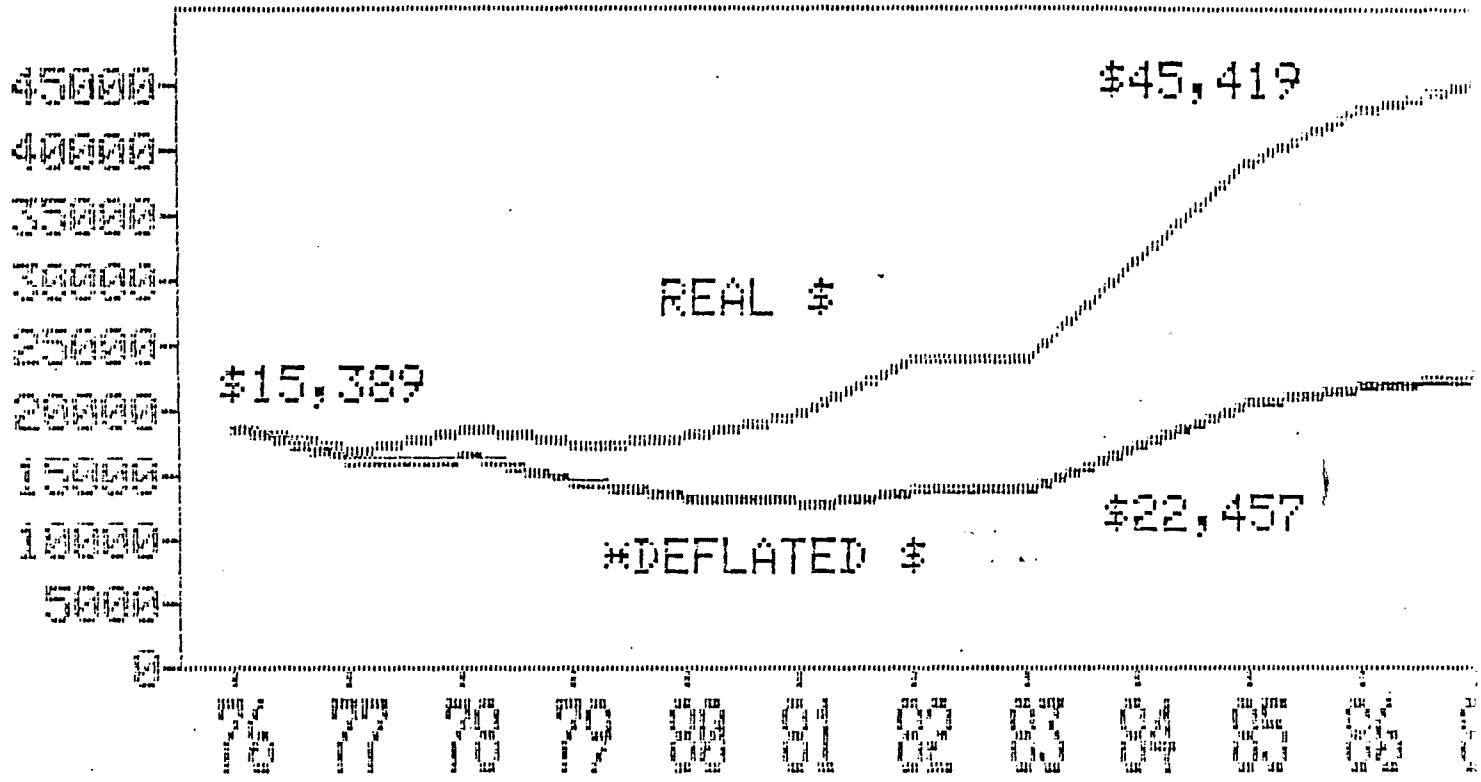
OB/GYN PREMIUMS: 1976-1987



PREMIUMS - REAL $

PREMIUMS - DEFLATED $

*DEFLATED BY CPI-LA/LB

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Maine's Business Advocate

126 Sewall Street ▪ Augusta, Maine 04330 ▪ (207) 623-4568

November 30, 1988

Ms. Bonnie Post
Maine Ambulatory Care Coalition
P. O. Box 2508
Augusta, Maine 04330

Dear Bonnie:

I have been pondering the Joint Select Commission on Access to Health Care discussion on tort liability and medical malpractice insurance since you finished with the subject on the 29th. Two things in particular bothered me. I know you don't need more preaching to you, but I feel I need to get these thoughts off my chest.

First, the Commission worked really hard to find a way to solve the problem for its constituency without solving it for the rest of us. It is disappointing that there isn't more of an attempt to deal with the total problem when the opportunity arises. I would have loved to hear a discussion on the option used in Indiana that Gordon Smith outlined at the Roundtable meeting. It might solve the whole problem without a state subsidy!

The other frustration I felt was that Commission members don't seem to understand that, unless they are concerned about and aggressive in solving the cost problems in the whole system, the pool of people without access will only grow. This is another reason whey they should want to deal with the whole tort reform problem, not just a little piece.

I know you understand these issues, but I'm not sure others do. As I said, I needed to get them off my chest.

Sincerely,

John S. Dexter, Jr.
President

JSD:sjp

December 6, 1988

SPECIAL SELECT COMMISSION ON ACCESS TO HEALTH CARE

Notes From November 29, 1988 Meeting

I. State-Funded Health Care Coverage for Population to 150% of Poverty

Population and Cost Estimates distributed. Methodology for projections will be provided to Commission members. Small group to meet before next meeting to discuss projections.

Estimates and methodology are enclosed.

Projected participation rates, and potential first year "adverse selection" discussed.

Suggestion: to contact Commonwealth Fund in New York and the state of Michigan, which recently implemented an RWJ health care program for general assistance population, for more information.

II. Discussion of Service-Contingent Health Professions Program

Commission supports notion of loan repayment program for health professionals. Debbie will draft recommendation.

Issue of whether or not health professionals are limited to primary care, or inclusive of all practitioners was discussed. It was agreed that more information and data on the need for various health professionals, by service and by geographic area is necessary. Criteria for funding also needs to be developed.

Information will be requested from:

Office of Health Planning
Maine Hospital Association
Katahdin Area Health Education Center
Consortium for Health Professions Education

III. Rural Networks for Physicians

Explanation as to mechanics of this program will be requested from Lewin.

IV. Malpractice Reforms

Lengthy discussion as to role Commission can take in recommending and/or developing proposals. Again, more data is needed. Ron Deprez will draft a general recommendation on tort reform for the Commission.

V. Private Insurance Options

Marcus Barresi presented a proposal for a state administered insurance pool for employers with less than 20 employees. State would set eligibility and benefit package, and fund reinsurance through stop-loss coverage.

Any insurer complying with benefits and eligibility could negotiate with state to provide third party coverage.

Employer eligibility: could be limited to those designated as high risk, and thus not covered by commercial insurers or open to all employers, both profit and nonprofit, with less than 20 employees.

Marcus and Beth Kilbreth will provide a written recommendation for this proposal.

*Question of coordination and relationship between employer-based insurance and "Medicaid buy-in" coverage.

Could employers offer alternative of Medicaid buy-in coverage to employees, without contradicting anti-discrimination provisions of Section 89? Legal opinion is needed.

Preliminary information from Janice Hird, of UNUM:

If employee is a) seasonably employed (6 mos. or less)
b) under 21, working 20 hours or less
c) non-resident alien
Employer is not required to offer coverage.

If employer opts to cover, then employees included in provisions of Section 89, and must be included in discrimination test. Coverage to employees must be comparable.

If employer does not cover employees in employer plan, he/she <u>will not</u> get credit for cash contribution for employee buy-in to Medicaid-like program. Further, cash to individuals for buy-in would be taxed.

Information on Section 89 and its application to insurance proposals has been requested from Lewin.

Ron Deprez advocated a program of tax incentives to employers who provide health insurance. He will prepare written material on this recommendation.

Some of the unanswered questions include:

1. Can health insurance be a required benefit in a flexible benefits plan? (Most employers with flex plans have over 100 employees)

2. Financing of tax credits?

3. What about nonprofit employers?

4. Experience of state of Oregon - which has implemented tax credit program?

5. How to incorporate the self-employed?

SPECIAL SELECT COMMISSION ON ACCESS TO HEALTH CARE

Notes of October 24, 1988 Meeting

The meeting consisted of a page by page review, clarification, and discussion of the Lewin plan. Comments were accepted from the audience only after Commission members completed their discussion of each section.

1. Criteria for Designing Plan

   Criteria still acceptable; no additions.

2. Population Groups Who Have Access Problems (clarification of lists)

   a. Insured With Access Barriers (Delete Low-Income)

      °Medicaid recipients
      °Medicare beneficiaries
      °Underinsured for Primary Care
      °Individuals in areas with lack of services
      °Low-income individuals with high copay/deductibles
      °Medically high-risk individuals

   b. Easier-to-Reach Uninsured

      °Employed and Dependents
         full time
         part time
         seasonal
         self-employed
         "self-proclaimed immortals"

      °Children
      °High Risk Individuals
      °Non-dependent students

   c. Difficult-to-Reach Uninsured
      °Adult non-workers
      °Isolated rural persons
      °Homeless
      °Migrant and seasonal workers

3. Discussion Of Strategies To Reach Insured With Access Barriers

   °Clarification: In Commission discussion, the term "health care" is inclusive of medical, mental, and dental health, and substance abuse care.

INSURED WITH ACCESS BARRIERS

°Medicaid Improvements

- Raise provider fees for some or all providers
- Adopt all-inclusive fee (clinic-reimbursement option)
- Reduce provider administrative burden
- Malpractice reforms (e.g., limits, subsidy)

°Service Delivery Expansion

- Community service delivery grants to provide primary care, outreach, referral, and/or transportation
- Rural networks for physicians
- Service contingent health professions program

(Add) - Clearinghouse to disseminate information on available services, and/or insurance options

(Add) °Insurance

- Employer tax credits for providing preventive and primary care benefits
- Expansion of existing high-risk insurance organization

EASIER-TO-REACH UNINSURED POOR

°Medicaid Expansion

- Coverage for children ages 5-8 in families with incomes below poverty level
- Medicaid buy-in
- Enhance enrollment efforts

°Private Insurance Expansion

- Statewide pool of small employers
- Subsidized insurance product <u>currently</u> available to small groups and individuals

(Add) - <u>Create</u> subsidized product for small groups and individuals

°Service Delivery Expansion

- Community service grants

- Clearinghouse

(Add) - Rural networks for physicians

(Add) - Service contingent health professions program

(Add) °High Risk Insurance Pool Expansion

In this section there was considerable discussion about how incentives can be offered to employers to cover all employees. One does not want to set up a system which encourages employers to reduce employee hours so that they become part-time workers, exempt from coverage. There was particular interest in what mechanisms might allow or encourage coverage. There is a need for a system which provides a subsidy to the low-income individual and/or a subsidy to the employer so that the insurance is an affordable product. The importance of creating equity amount employees was emphasized.

Ron Deprez brought up the question of how to address the "demand" side of the equation. Can we improve access by reducing or redirecting the utilization of some services?

Should we build in mechanisms to improve the utilization of appropriate services, such as support of health centers in lieu of hospital utilization? Marcus Barresi noted that case management is being used increasingly by private insurance carriers.

DIFFICULT-TO-REACH UNINSURED POOR

°Private Insurance Expansion

- Subsidized individual product

(Add) - Medicaid Expansion, including buy-in

(Add) - High Risk Insurance Pool Expansion

°Service Delivery Expansion

- Community service grants

- Service contingent program

- Outreach

- Transportation

- Linkages to social and other services

COMMUNITY SERVICE DELIVERY GRANTS

°Local community grants to provide:

- Primary and preventive services
- Referral to specialty and inpatient care
- Prescription drugs
- Ancillary services
- Case-finding outreach
- Health education

°Grants may be awarded to primary care centers, physician groups, or hospital outpatient departments.

°To qualify for a grant, entity must demonstrate:

- Arrangement for services 24 hours a day, 7 days a week
- Arrangements to refer patients
- Provision of follow-up care
- Access to ancillary services
- Linkages to other social services
- Acceptance of Medicaid
- Publicized sliding fee scale
- Managed care capacity

*Full hospital privileges was deleted as a criteria. It was not seen as practical in many instances.

°Grants are for three years with annual performance reviews

°Grants are administered by Health Department

°Additional targeted assistance may be provided to communities that lack primary care capacity:

- Small grants to coordinate linkages among health providers
- Grants to expand existing capacity

(Add) °Additional targeted assistance to provide prevention/health education
This type of funding might be separate from the grants described above; not contingent on the same criteria.

Discussion of community service delivery grants included the following points:

- °Are grants for the provision of comprehensive services, or for specific services?
- °Can providers be service-specific or must they be capable of providing the full range of services?
- °The fragmentation of services, particularly in rural areas supports the notion of promoting comprehensive service delivery.

Medicaid Expansion

Considerable interest and support for a Medicaid "Buy-In program:

- °Coverage of individuals up to 100% of poverty, at full subsidy
- °Coverage of individuals up to 150% of poverty, with sliding scale premium
- °Full Medicaid benefits

°Medicaid provider fees: support an increase and review DHS proposal for physician fee change in 1989.

REQUESTS FOR INFORMATION/DATA FOR NEXT MEETING:

- °Cost of Medicaid buy-in program for economically eligible individuals, to 150% of poverty
- °Experience of Washington, Wisconsin and any other states - which have implemented a Medicaid buy-in program.
- °Costs and calculations for expansion of High Risk Insurance Organization
- °Cost of small group (1,000) insurance product
- °Means of providing employer incentives to provide health insurance; and maintain incentives for those already offering coverage.

NEXT MEETING: November 29, 1988, 9:30 a.m.- 4:00 p.m.

DRAFT POPULATION AND COST ESTIMATES, FIRST YEAR IMPLEMENTATION
December 6, 1988

I. Population 5-21 years old between 75 and 100% poverty (under 75% presently categorically eligible for Medicaid kids under 5 eligible to 100% under SOBRA)

STEP A — July 1, 1987 total Maine population From U.S. Census estimate

(5-14)	164,000
(15-20)	115,200
(5-20)	279,000

STEP B — 1979 Maine persons below poverty 13% (from U.S. Census data)

	140,996
	1,087,369

Ages 5-17 below poverty - 15%

	36,015
	237,740

Ages 18-66 below poverty - 10.7%

	69,581
	640,676

STEP C — 1985 Maine persons below poverty - 11.9% (from estimate by Institute on Research & Poverty. V. Wise) 1985 estimated poverty rate for sub-group of children 5-17 from ratio of 1979 total rate to child rate:

1979 total poverty - 13% x 15 — 1979 child rate
1985 total poverty - 11.9% x X — 1985 child rate

X = 13.7% poverty rate estimated for ages 5-17, 1985

STEP D — 1987 children 5-20 (see Step A) X child poverty rate 1985

279,000
x .137
38,250 estimated children 5-20 under poverty, 1987

STEP E — Rate of children under 21 under 75% of poverty - 1979 Maine census data

	Kids < 75%	Total Kids
6-13	14,803	141,171
14-17	6,178	81,604
	20,981	222,775 = 9.4% estimate of kids under 75% poverty

STEP F Estimated current rates of kids under 21 under 75% poverty.

1979 total poverty rate 13 x 9.4 1979 kids under 75%
1985 total poverty rate 11.9 x X 1985 kids under 75%

X = 8.6% Estimated current rate of kids < 75%

Estimated number of kids < 75% in 1985 =
279,200 x 8.6 = 24,011 kids

STEP G
38,250 1987 Maine kids 5-20 < 100% poverty
-24,011 1987 Maine kids 5-20 < 75% poverty
14,239 1987 Maine kids 5-20 between 75% and 100% poverty

STEP H
14,239
x .50 Participation rate (CDF)
7,120

STEP I Annual Unit cost per child $586, (from AFDC costs, 1988)
assume mean length of enrollment is 9.55 months
Unit Cost Multiplier =

$\frac{\$586}{12} \times \frac{X}{9.55}$ $12X = 5596$ $X = \$466$

STEP J Total Potential Costs

1. 14,239 kids, ages 5 to 20, between 75% and 100% poverty
x $586 annual cost
$8,344,054 total costs, full participation

2. 7120 participation, first year
$466 average cost per enrollee
$3,317,920 total costs, first year of implementation

II. Population, ages 21 to 64, 72 - 100% poverty

A. Total Maine 1987, ages 21 - 64 from census tables

	76,800
	201,000
	169,000
	111,000
	109,000
Total Maine, ages 21 - 65	686,800

B. Maine adult poverty rate for 1985
Ratio of total rate to adult rate, 1979

Maine poverty rate 1979	13%		10.7%	18-65, 1979
Maine poverty rate 1985	11.9%	x	X	

(from U.S. Census estimates)
X = 9.8% estimated poverty rate, 1985, ages 18-65

C. 9.8% x 686,800 = 67,306 ages 21 - 65, below poverty, 1987

D.
67,306 adults, 21 - 65, below 100% poverty
-1,400 SOBRA adult women eligible
65,906

E. 1. SSI Disabled

15,719 receiving Medicaid (DHS, 1988)
-2,099 no Medicaid
17,818

2. Less SSI children - 1985 Disability Determination Services Date

Total Disabled	13,713	-	100
Disabled Children	1,081		X

13,713 X = 108,100
Children = 7.8% of total disabled

17,818 Total SSI disabled, 1988
x .078 Children SSI disabled
1,390 " " "

17,818
- 1,390
16,428 SSI Disabled adults, 1988

F. 65,906 (from Step D)
-16,428 Disabled adults
49,478

G. 49,478
-23,750 AFDC eligible adults, assuming 80% participation rate
25,728 Population, 72% to 100% poverty, ages 21 to 64

H. 25,728
x .50 Estimated participation rate
12,864 .Potential enrollees, first year

I. Annual Unit cost per adult $1,298
Mean length of enrollment is 9.55 months

$$\frac{1298}{12} \times \frac{X}{9.55}$$

X=1033, ave cost per enrollee

J. Total Potential Costs

1. 25,728 Total adult population, ages 21 to 64, 72-100% poverty
x 1,298
$33,394.944 Total costs, full participation

2. Potential Costs, first year

12,864 Potential enrollees
x1,033 Average cost per enrollee
$13,288,512 Potential Costs

PERSONS BETWEEN 100 - 150% of POVERTY

III. A. US 1986 Rate: All persons < poverty / All persons < 150% poverty x Maine 1985 Rate: All persons < poverty / All persons < 150% poverty

$$\frac{13.6}{22.9} \times \frac{11.9}{x}$$

x = 20% Maine, all persons < 150% poverty

B. 20% x total Maine population (1,187,000) - 237,400

C.
237,400
-141,253 less population < 100% poverty
96,147
- 2,000 less women and infants (covered by "SOBRA")
94,147
-7,000 less nursing home elderly (covered by Medicaid)
87,147

D.
87,147 Total eligibles
-17,429 Less 20% privately uninsured (estimate)
69,718

E.
69,718
x $846 Annual cost per enrollee (based on blended rate, AFDC costs)
$58,981,428 Total Potential Costs
x .50 Reduced Participation Rate, first year
$29,490,714
x .50 (?) Less Enrollee Contribution, sliding fee
$14,745,357 Potential First Year Costs