FINAL REPORT

MEDICAL MALPRACTICE LIABILITY STUDY

SUBMITTED TO:
THE LEGISLATIVE COUNCIL
THE STATE OF MAINE

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MEDICAL MALPRACTICE LIABILITY STUDY

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EXECUTIVE SUMMARY

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.

SECTION II: MEDICAL MALPRACTICE INSURANCE PROBLEM IN MAINE

MEDICAL MALPRACTICE INSURANCE IN MAINE

THE PRICE OF MEDICAL MALPRACTICE INSURANCE:

This section will describe, with available information, key dimensions of the malpractice insurance problem in Maine including the price of liability premiums, the frequency and severity of claims, and settlements brought in Maine during the last four years. There are two insurance firms which sell over 90% of the medical malpractice policies in Maine. They are St. Paul Insurance Companies of St. Paul, Minnesota and Medical Mutual Insurance Company of Maine (MMIC). In 1988, Medical Mutual insured over 1172 Maine physicians and one of Maine 36 nongovernmental hospitals. In 1988, St. Paul's insured almost all of the remaining hospitals and 665 physicians. There are approximately 1800 licensed and active physicians in Maine.

Recent physician sponsored efforts to address the medical malpractice liability system are primarily responses to the price of medical liability insurance, particularly price instability, as well as threat of malpractice suits. Both have motivated physician groups to seek tort changes, challenge insurance rate increases, alter their medical practice patterns, increase peer and quality reviews, and develop alternative malpractice dispute resolution systems. As the discussion of medical care access will show, it is price coupled with the fear of being sued that has motivated physicians to reduce or stop obstetrical services.

In nearly every one of the last ten years, the price of medical liability insurance nationwide has outstripped rises in overall inflation as well as inflation in the medical marketplace. For example, nationwide medical malpractice liability premiums were 75% higher in 1986 than 1983 while the Consumer Price Index rose 10.1% during this period and the Medical Care Index rose 21.3% (Rosenbach & Stone, 1988). Yet, in some years the price has actually gone down demonstrating the price volatility of this product.

Medical malpractice liability premiums in Maine have experienced similar increases (and decreases). This has occurred despite the fact that Medical Mutual Insurance Company of Maine, a physician owned insurance company organized in Maine in the latter 1970's, now controls two thirds of the physician market for liability insurance. The average premium for liability insurance in 1984 for MMIC physicians was $6,447. In 1988, the average premium was $13,978--a 117% increase. Some of this increase is due to increased coverage limits, however, much is due to other factors, notably, increased claims, claims severity, reinsurance costs and the cost of conducting business. Data in Table 1 is indicative of the rising and unstable price of this product in Maine during the last ten years.

At the same time, it should be noted that the average price of a claims made insurance policy in Maine (a claims made policy insures a physician only for the year in which it is purchased) is still lower than most urban, large states and many rural

states. As of July, 1988, the price in Maine for a class 4 doctor/mature claims made policy at $1-3 million coverage limits from St. Paul's was $16,968. In California, the price for the same policy was $39,281; in Michigan $29,753; in West Virginia $27,218; in New Jersey $27,179; and, in Arkansas $18,916. Regionally, Vermont's rate ($15,704) was slightly lower than Maine's while Connecticut's ($19,199) was somewhat higher.

TABLE 1
LIABILITY PREMIUM RATE INCREASES

	Medical Mutual of Maine Increase/(Decrease)	St. Paul's Increase/(Decrease)
1979	(20%)	Reduction of 25% for year 1 insured; Increase of 16% for year 5 insured; Increases from 0 to 16% for years 2,3, and 4.
1980	0%	0%
1981	20%	50%
1982	15%	20%
1983	21.3%	Increase in rates, changes in classifications.
1984	14.4%	20%
1985	30%	30%
1986	24.4%	22%
1987	16%	31%
1988	9.2%	11%
1989	No filing yet	(22%)

Data Source: Medical Mutual of Maine & The St. Paul Companies

Price as a function of physician income is perhaps a more equitable way to compare premium rates since both the price of insurance and physician incomes vary widely across specialties, states, and regions. Nationwide, malpractice premiums were 6.2% of physicians' gross practice income in 1986. The percentage was 4.0% in 1983, an increase of 57%. (Rosenbach & Stone, 1988) The survey of Maine physicians conducted as part of this study, indicates that the current (1989) average malpractice premium payment for Maine physicians who paid their own premiums was 11% of their 1988 gross practice income. For Family Physicians as a

specialty, it was 5.7%; for specialists in obstetrics and gynecology, it was 22%; and for Doctors of Osteopathy it was 11%.

CLAIMS, LITIGATION EXPENSES AND THE PRICE OF INSURANCE:

A number of factors affect the price of medical liability insurance coverage, and it is not within the scope of this study to analyze them for Maine. The major factors thought to influence the price of insurance include the frequency and severity of claims, return on investment, the cost of conducting business, insurer loss to premiums ratios, urbanization, access to attorneys, rates of iatronic injuries, and the regulatory system. There is a presumed relationship between the frequency and severity of claims, the price of insurance, and access to medical care.

The product of claims frequency times severity along with incurred losses and expenses (transaction costs) all figure into the price insurance companies charge for their products. Reduction in these are expected to reduce the price of medical malpractice premiums. Insurance rates for Maine are currently calculated primarily using nationwide claims and severity data. However, it is important to compare Maine's rates of claims frequency and severity experience to national data to determine the status of the insurance problem in Maine. TABLE 2 compares these figures.

For the period, frequency of claims (the number of claims divided by the number of insured in any one year) were higher in Maine compared to countrywide data (the 42 states in which The St. Paul Companies sells medical malpractice insurance). The trend in recent years is lower than the national. Severity of claims (the amount of all past and expected claims settlements including expenses divided by the number of claims) in Maine has been inconsistent compared to countrywide severity data. In earlier years, it was lower; in the last two years, it was higher. Maine's average for the past five years is about equal to the rest of the country. However, it is increasing both for Maine and the country.

These data suggest that frequency is lower in Maine but severity may be increasing at a more rapid pace than the rest of the country. The Maine experience of the two insurers are very different and raise some question about the allocation of reserves to cover expected losses and expenses. This is demonstrated by the loss ratios experience by the two insurers.

A loss ratio is the proportion of the premium dollars that go to pay for claims in any one year. It includes both the amount of money actually paid out in settlements and expenses and the amount set aside for claims yet to be paid. A loss ratio is derived by dividing the sum of total losses (paid and reserved) by the amount of earned premium. Insurance companies gauge their premiums on a target loss ratio so as to produce enough funds, which, in addition to investment income, permit them to cover their losses and expenses in order to earn a profit or surplus.

Table 2

Medical Malpractice Liability Study
Maine/Countrywide Claims Frequency & Severity

Year	Number of Insured	Claims	Claims per 100 Insureds	Incurred Loss & Expense	Severity*
1984	1703	275	16.15	$5,144,585	$18,708
1985	1766	270	15.29	$6,161,693	$22,821
1986	1809	225	12.44	$7,715,217	$34,290
1987	1799	200	11.12	$9,054,750	$45,274
1988	1837	199	10.83	$11,296,318	$56,765
Totals/Ave.	8914	1169	13.11	$39,372,563	$33,681

	Countrywide Frequency	Countrywide Severity
1984	11%	$25,091
1985	11%	$28,962
1986	12%	$34,150
1987	14%	$37,019
1988	12%	$39,298
Total/Ave.	12%	$32,904

Data Source- St. Paul; MedMutual, Exhibit C-1w from St. Paul
* Severity is Total Incurred L;LE/Claims. Loss limit is capped at $200,000 for St. Paul data (Maine and Countrywide)

For example, St.Paul's targeted loss ratio is 75%. For Medical Mutual the target loss ratio is approximately, 105%. Nationwide, the average loss ratio is between 70-80%.

Table 3 presents Maine loss ratio data for the period 1984-88. The overall loss ratio for the period is 93%, above both the target ratio for St. Paul and the national average and below that of Medical Mutual. Table 4 provides the same information only for the St. Paul Companies. Their loss ratio, while fluctuating, has been decreasing over the past four years to where the average is at their targeted amount. The fluctuations in the year-to-year rates express the difficulty of estimating annual premiums rates.

MMIC loss ratios, however, have increased steadily over the past five years from 89.4 in 1984 to 100.14 in 1988 with a five year average of 100.06. It is beyond the scope of this study to examine why the loss ratios of MMIC are that high. We suspect it is due in part to increases in the amount of reserves set aside to pay for claims. In 1985, there were 368 open claims at MMIC (claims made, but not settled). The average reserve set aside for these claims was $40,558. In 1988, there were 233 open claims but the amount of reserves for these claims amounted to $85,088 per claim. Thus, claims are decreasing while reserves are increasing.

One way of looking at the cost of claims to insurance companies is to analyze payments for claims settled in any one year regardless of the incident year. This also can indicate if there is an upward trend in monetary awards from both the courts and insurance company settlements. A table of this data was included in the Draft Report for the three year period 1986-88. This information came from the Maine Bureau of Insurance and indicated there were no trends in the proportion of cases settled with a payment during this period (it was 19% for each of the last three years) nor in the amount of total losses. An upward trend was suggested in the average paid loss and the average paid loss expense (legal fees and expert witness fees). However, following a review of this data with insurers and the Bureau indicated that there were substantial errors with it so it could not be used. Data such as this is needed for an understanding of this problem.

CONCLUSIONS:

This Section has presented information on the growth of insurance premiums and insurance factors that are responsible in part for this growth. The cost of insurance to Maine physicians is less than many other states but accounts for a higher percentage of their income, on average. While the frequency and severity of claims in Maine does not significantly differ from the rest of the country, loss ratios are higher than expected. This is due to the high loss ratios experienced by MMIC and suggests that their reserving practices may be overly conservative. However, it will take further study to resolve this issue. Based on the data presented, the liability insurance problem in Maine does not appear out of control.

TABLE 3

Medical Malpractice Liability Insurance
Loss Ratio (Maine)
(St. Paul; MedMutual Combined)

Year	Earned Premiums	Claims	Incurred Loss & Loss Expense	Loss ratio
1984	$5,373,117	275	$5,144,585	95.75
1985	$6,866,157	270	$6,161,693	89.74
1986	$8,201,852	225	$7,715,217	94.07
1987	$9,806,186	200	$9,054,750	92.34
1988	$11,918,849	199	$11,296,318	94.78
Totals	$42,166,161	1169	$39,372,563	93.37

Data Source- The St. Paul Companies; Med Mutual of Maine

Table 4

Maine Premiums, Losses and Loss Ratio
The St. Paul Companies
(Limited to first $200,000)

Year	Earned Premiums	Claims	Incurred Loss & Loss Expense	Loss Ratio
1983	$1,593,733	83	$1,423,198	89.30
1984	$2,037,816	115	$2,162,484	106.12
1985	$2,831,642	93	$2,608,644	92.12
1986	$3,451,575	77	$3,272,820	94.82
1987	$3,692,896	61	$1,398,976	37.88
1988*	$2,267,045	62	$1,426,317	62.92
Totals	$18,141,752	491	$13,718,756	75.62

Data Source- St. Paul rate filings, Exhibits 2A & 2B

* One-half year of data

SECTION III: ACCESS TO CARE PROBLEM IN MAINE

ACCESS TO CARE PROBLEM IN MAINE

INTRODUCTION:

The problem of access to medical services is complex. Lack of health insurance, transportation, knowledge of services, and availability of providers all affect access to medical care. A primary purpose of state legislative responses to the medical malpractice liability insurance issue has been to ensure consumer access to medical services.

Legislators are concerned that if insurance rates for providers continue to rise, the number of providers available to all or certain classes of patients will decline, thus intensifying the present access problem that has resulted in part by the erosion of health insurance in the 1980's. The medical malpractice liability crisis of the 1970's was primarily a crisis in availability of liability insurance- at least in Maine. The present "crisis" is one of insurance affordability. The effect on access is the same. If medical practitioners cannot afford to buy malpractice coverage for all or part of the services they provide, fewer practitioners will be available to provide those services, and access will decline.

This is of particular concern in rural areas where there are fewer providers per capita. In the published literature, in testimony before governmental bodies, and in press reports, it has been consistently argued that the price malpractice insurance is having a profound effect on the availability of medical care, particularly obstetrical care, and particularly in rural areas. However, while there is some evidence of reduced availability, there is no clear evidence of its effect on access or medical outcomes.

Physician participation rates in the Medicaid Program have been declining in this country in both urban and rural settings. A study published in 1984 designed to determine the factors responsible for low participation rates found that states with higher Medicaid fees and less administrative requirements red tape had higher participation rates (Mitchell and Schurman, 1984). For obstetrical services, however, the professional liability problem may be a more perverse and difficult problem than Medicaid fees in reducing participation. In Maine and the nation, obstetricians have the highest average annual incidence of claims, (Adams and Zuckerman, 1984; MMIC, St. Paul Companies data, 1989). Since Medicaid women tend to be at higher risk for a poor birth outcome, higher fees alone may have little affect on participation rates for this specialty.

There is evidence both from Maine and other states that high risk women do not have equal access to prenatal care specialists (PNC) (Onion and Mockapetris, 1988; Rosenblatt and Detering, 1988; USM,

1984). In a recent study of Maine hospital discharge data for the 1982-84 period, Onion and Mockapetris found that women at high risk for a poor birth outcome were less likely to have access to an Obstetrician or board certified Family Physician. Moreover this occurred more often in urban than rural areas of Maine.

In testimony before the U.S. House Subcommittee on Human Resources and Intergovernmental Relations, Assistant DHHS Secretary Robert Helms stated that high risk women are less likely to obtain early prenatal care despite substantial Federal and state funding (Helms; 1987). The incidence of both late prenatal care and no prenatal care has actually increased over the past few years. A sample survey of Maine women who delivered live infants from February 1 to August 1, 1983 found that Medicaid mothers were less likely to receive adequate PNC than privately insured women. From these and other data, it appears that women most in need of high quality prenatal care and those who have most to gain from the services of specialists have more difficulty gaining access to these services.

In addition to health insurance, there are a number of patient and medical care system barriers which limit access to prenatal care (ANA; 1987). Two major barriers are rural location and poverty. Rural areas are more likely to lack adequate care systems, (social and income support services, providers, and transportation systems). Moreover, transportation is the most significant barrier to women seeking PNC in Maine (USM, 1984), and this factor is almost three times greater among Medicaid women.

A 1988 study of physicians in Washington state found that changes in the practice of obstetrical care has been most evident among Family Physicians the most. Half of those surveyed either discontinued or reduced the volume of their obstetrical practices (Rosenblatt and Detering, 1988). Malpractice concerns were the principal reasons given for those changes with increased premiums and fear of suit the most prominent. These same factors were most likely to influence changes in obstetrical care among Family Physicians nationally, based on a recent study by Kruse et al. (1989).

At the same time, reductions in availability of obstetrical care providers need not result in care being delivered by less qualified physicians. For example, the Washington state study found that those Family Physicians who continued to practice obstetrics were more likely to be young, residency trained, board certified, and working in a more rural county than Family Physicians who left obstetrics (Rosenblatt and Detering, 1988).

PHYSICIAN AVAILABILITY IN MAINE:

Has Maine has also experienced a decline in family physicians who practice obstetrics? Data from surveys conducted in 1984 and in 1986 by the Maine Chapter of the American Academy of Family Physicians suggest there has been a 23% reduction in the proportion of Family Physicians delivering babies, from 62.5% in

1984 to 48% in 1986.

In order to obtain more complete information in Maine on the availability of medical care providers and other potential access problems that may result from rising medical malpractice liability insurance premiums, a scientific survey of physicians was conducted as part of this study. The primary purpose of the survey was to determine the extent to which physicians were reducing or stopping the practice of medicine and whether malpractice liability insurance premiums and/or fear of malpractice suits were factors in these decisions. There were, however, other reasons this survey was conducted. The Legislature wanted to know how Medicaid recipients, as a class of patients, were being affected by the liability insurance problem. They also wanted information about physician involvement in malpractice suits and trends in the price of liability insurance compared to physician income.

The scope of the survey was restricted to the availability of obstetrical services in Maine. This decision was based on many considerations. Obstetrics is considered a marker for availability of other medical services. Reductions in obstetrical providers may lead to reductions in prenatal care for pregnant women which has clear implications for the incidence of poor prenatal outcomes. Furthermore, national and state-level research conducted elsewhere suggests that the medical malpractice crisis has most significantly affected obstetrical services.

A sample of 621 physicians was selected to receive the survey, a copy of which can be found as ATTACHMENT A. Physicians in the sample included all providers who, in the 1988 DHS Physician Manpower Resource Inventory, listed their primary specialty as Obstetrics/Gynecology; Family Practice; or who indicated their secondary specialty as obstetrics regardless of their primary specialty; or were Doctors of Osteopathy. Although it is known from other data that there were approximately 225 physicians who delivered babies in Maine last year, the sample included all physicians who were trained to provide obstetrical services or who claimed they were providing them in 1988. This was done to find out who left the practice and why.

The survey was developed using a number of questions from similar national and state surveys and a number of questions developed specifically for this project. Leaders of each provider group surveyed (Obstetricians, Family Physicians and Osteopathic Physicians) provided us with constructive comments on the contents and wording of survey questions. These same leaders endorsed the survey and requested completion of the survey in the letter that accompanied its mailing.

Of the 621 surveys sent out, as of May 24, 1989, 386 have been returned as valid surveys, while another 37 have been returned by the post office as undeliverable or returned with notification that the person has retired from the practice of medicine or is deceased. Thus the response rate as of that date

was 66%. (An additional 40 responses have been received since.) An analysis of respondents and nonrespondents was conducted on the first 279 responses. This analysis is found in the appended as ATTACHMENT B. The results indicate very slight differences between respondents and nonrespondents on age, sex, urban/rural residence, specialty and other factors.

DECLINE IN OBSTETRICAL PROVIDERS:

Overall fourteen percent of those surveyed indicated that they had stopped practicing obstetrics. Between 1987 and 1989 physicians have left the practice of obstetrics at the rate of approximately 4% per year. Those who have stopped practicing obstetrics in this time period are overwhelmingly Family Physicians and located primarily in urban, rather than rural areas of Maine. Those physicians who have reduced or stopped practicing obstetrics have done so primarily as a result of rising malpractice insurance premiums and the fear of malpractice suits.

Overall, 42% of those physicians surveyed indicated they were practicing obstetrics in 1987. In 1988, this declined to 39% and in 1989 to 34%. This represents a 19% decrease over the 3 year period. The rate of decline among Family Physicians as a specialty for this period was 31% Family Physicians represents 82% of all physicians who stopped practicing obstetrics during this period. See Table 1.

The physicians who stopped practicing obstetrics between 1987 and 1988 are young (average age 39) and averaged 30 deliveries a year. The average age of physicians who continued practicing obstetrics in 1988 was 43 and they averaged 72 deliveries a year. The average age and annual deliveries for Family Physicians who continued obstetrics in 1988 was 39 and 35 respectively.

There was a 26% decline during this period among physicians who had been practicing obstetrics in one of Maine's three Standard Metropolitan Statistical Areas (SMSA), Portland, Lewiston-Auburn, and Bangor. Rural non-SMSA's saw a 17% decline during this period. At the same time the proportion of physicians practicing obstetrics in rural areas of Maine was higher than those practicing in an SMSA.

Can Maine expect to experience a continued decline in the number of physicians providing obstetrical services. Based on the response to a question as to whether physicians planned to drop obstetrics in 1990 and 1991, the decline will continue but at a slower rate (3% in 1990 and 1% in 1991). Unlike the current trend, most of those who plan to drop obstetrics in 1990 are rural-based physicians rather than urban-based. However, a large proportion (27%) of those currently providing obstetrical services are not sure yet about their plans for continuing these services.

TABLE 1

MEDICAL MALPRACTICE LIABILITY STUDY

Survey of Maine Physicians - 1989

QUESTION 3 (a,b,c)	Type of Practice								Total	
	Family Practice		OB/GYN		Other MD		DO			
Births - 1987										
None	102	55%	15	27%	39	80%	50	78%	206	58%
1 - 49	60	32%			9	18%	8	13%	77	22%
50 - 149	25	13%	16	29%			6	9%	47	13%
150 or more			24	44%	1	2%			25	7%
Total	187	100%	55	100%	49	100%	64	100%	355	100%
Births - 1988										
None	116	62%	12	22%	39	80%	50	78%	217	61%
1 - 49	58	31%	1	2%	9	18%	10	16%	78	22%
50 - 149	14	7%	18	33%	1	2%	3	5%	36	10%
150 or more			24	44%			1	2%	25	7%
Total	188	100%	55	100%	49	100%	64	100%	356	100%
Births - 1989										
None	130	69%	13	24%	41	84%	52	81%	236	66%
1 - 49	44	23%	2	4%	7	14%	8	13%	61	17%
50 - 149	13	7%	14	25%	1	2%	2	3%	30	8%
150 or more	1	1%	26	47%			2	3%	29	8%
Total	188	100%	55	100%	49	100%	64	100%	356	100%

Question 3: Please estimate how many deliveries you personally attended in : 1987 1988 Estimated total for 1989.

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CHANGES IN OBSTETRICAL SERVICES:

Physicians were also asked if they had made any changes in their obstetrical practices since January of 1987. Among those who had changed, the two biggest changes were reducing or stopping obstetrical services care to Medicaid patients (34%) and high risk patients (32%). This was followed by reducing or stopping care for the uninsured (27%), and limiting the number of obstetrical patients accepted (19%). Among the specialties, Obstetricians were more likely to have reduced their care to Medicaid patients (66%) followed by Doctors of Osteopathy (50%), and Family Physicians (25%). In urban areas 41% of the physicians reported reducing or stopping services compared to 29% of the rural physicians.

Those who had reduced or stopped their obstetrical practice were then asked to indicate the most important reasons why. Of those who responded (N=178) 68 or 38% indicated the most important reason was the cost of malpractice insurance, 42 or 24% listed the most important reason as concern over a malpractice suit and 26 or 15% listed the inconvenience of obstetrics. It is noteworthy that only 17 or 10% listed Medicaid fee limits as the most important reason for reducing or stopping obstetrical care. These results did not vary substantially by specialty or rural/urban location.

SERVICES TO MEDICAID PATIENTS:

The number of physicians who practice obstetrics in Maine has declined over the last few years based on these data. However, women on Medicaid and in need of obstetrical services do not appear to have been affected to a greater extent than women with or without private insurance. The proportion of physicians who continue to treat Medicaid obstetrical patients has remained somewhat constant declining by only three percentage points over the last three years-from 74% in 1987 to 71% in 1989. This reduction is principally due to Obstetricians and Osteopathic Physicians stopping services to Medicaid patients. Among the Family Physicians who continue to provide obstetrical services, there has been an increase in participation in the Medicaid Program.

There has been some decline in the volume of Medicaid patients which make up a physicians obstetrical practice. This has occurred among Obstetricians and Osteopathic physicians but not among Family Physicians or other physicians surveyed although the number of these physicians answering this question was small. See Table 2. When asked about practice policy regarding the limitation of care to Medicaid obstetrical patients, 16% of the Family Physicians limit the number of Medicaid patients in their practice. Seventy-one percent of the Obstetricians and all of the Doctors of Osteopathy who treat Medicaid patients have a limit on the number of these patients in their practice.

TABLE 2

MEDICAL MALPRACTICE LIABILITY STUDY

Survey of Maine Physicians - 1989

QUESTION 6 (a,b,c)	Speciality								Total	
	Family Practice		OB/GYN		Other MD		DO			
% Medicaid Babies 1987										
Zero	14	22%	11	27%	3	38%	5	33%	33	26%
1 to 25	15	24%	21	51%	2	25%	7	47%	45	35%
26 to 50	23	37%	8	20%	1	13%	3	20%	35	28%
51 plus	11	17%	1	2%	2	25%			14	11%
Total	63	100%	41	100%	8	100%	15	100%	127	100%
% Medicaid babies 1988										
Zero	14	22%	11	27%	3	38%	6	40%	34	27%
1 to 25	16	25%	25	61%	2	25%	5	33%	48	38%
26 to 50	22	35%	4	10%	1	13%	4	27%	31	24%
51 plus	11	17%	1	2%	2	25%			14	11%
Total	63	100%	41	100%	8	100%	15	100%	127	100%
Expected % Medicaid Babies 1989										
Zero	15	24%	13	32%	3	43%	6	40%	37	29%
1 to 25	14	22%	23	56%	1	14%	7	47%	45	36%
26 to 50	23	37%	4	10%	1	14%	2	13%	30	24%
51 plus	11	17%	1	2%	2	29%			14	11%
Total	63	100%	41	100%	7	100%	15	100%	126	100%

Question 6: Medicaid patients make up what percentage of your obstetrics practice during 1987, 1988 and estimated 1989: (Please exclude those you were called on for delivery only.)

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Inadequate reimbursement is the most important reason mentioned for limiting the number of Medicaid patients in their practice or providing only care back-up services. Forty two percent of those responding to this question cited this as the most important reason, while 25% cited the lack of patient compliance as the most important reason. Only 10% listed fear of a malpractice suit as the most important reason why they limit obstetrical services to Medicaid patients. There was very little difference in these factors by location or specialty.

CONCLUSIONS:

Based on the information from the physician survey Maine has experienced and will continue to experience a decline in physicians who provide obstetrical services. This decline is occurring primarily among Family Physicians and mostly in urban areas of the state. However, in the future the rural areas will experience the same trend. The principal factors cited for this decline are the cost of malpractice insurance and the fear of a suit. While the size of the pool of physicians practicing obstetrics is declining, the proportion of those continuing to provide services to the Medicaid patients has declined only slightly. Nevertheless, the volume of Medicaid patients who make up the practice of these physicians is declining at a higher rate. However, Family Physicians are an exception to this trend.

This information suggests that obstetrical patients in urban areas may have to look harder to find medical care. Given the increased availability of care generally in urban areas, they are likely to find it although for poorer patients it may be at the specialty clinics in the larger hospitals. In rural areas, the data does not suggest a problem of reduced medical care availability. However, a serious decline in physicians available to treat obstetrical patients in rural areas may still come if insurance premium rates continue to climb. In urban areas, increased insurance rates coupled with Medicaid reimbursements are likely to create an access problem among the Medicaid population if more Family Physicians drop obstetrics. They are the only group of the physicians who have increased their volume of Medicaid patients.

Based on this information it cannot be demonstrated that Maine faces a medical care "crisis" in availability and access to medical care due to rising medical malpractice insurance premiums. It can be demonstrated that Medicaid patients have increasingly limited options for their obstetrical care and this is due in part to the inadequacy of reimbursement fees for these services.

REFERENCES

Adams, E.K., and Zuckerman, S. Variation in the Growth and Incidence of Medical Malpractice Claims. Journal of Health Politics and Law, Fall 1984, 9(3).

Curry, M.A. Access to Prenatal Care, Key to Preventing Low Birthweight. Kansas City, Missouri: American Nurses' Association. March 1987.

Helms, R.B. Access of Poor Women to Prenatal Care. Paper presented to the Human Resources and Intergovernmental Relations Subcommittee of the Committee on Government Operations, September 29, 1987, Washington, D.C.

Human Services Development Institute. A Study of Prenatal Care Utilization in Maine. Center for Research and Advanced Study, University of Southern Maine, June 1984.

Kruse, J.; Phillips, D.; Wesley, R.M; Factors Infuencing Changes in Obstetric Care Provided by Family Physicians: A National Study. The Journal of Family Practice, 28(5), 597-602, 1989.

Mitchell, J.B., and Schurman, R. Access to Private Obstetrics/Gynecology Services Under Medicaid. Medical Care, November 1984, 22(11), 1026-1037.

Onion, D.K., and Mockapetris, M. Specialty Bias in Obstetrical Care for High Risk Socioeconomic Groups in Maine. Journal of Family and Community Medicine, 1988.

Rosenbach, Margo L., and Stone, Ashley G., Impact of Malpractice Insurance Costs on Physiciahn Practice, 1983-1986. Chicago, IL, May 1988.

Rosenblatt, R.A., and Detering, B. Changing Patterns of Obstetric Practice in Washington State: the Impact of Tort Reform. Family Medicine, March/April 1988, 20(2), 101-107.

SECTION IV: TORT REFORMS

A. Evaluating The Effect of Tort Reform Legislation

B. Constitutionality In Maine

EVALUATING THE EFFECT OF TORT REFORM LEGISLATION:

INTRODUCTION:

In this section data on malpractice tort reforms passed by states in the past 10 years has been evaluated for evidence of their effect on insurance premium rates and access to care. We have relied on secondary information from recent initiatives in other states. For this evaluation, it had been planned to use information that was to be available from the first-round of effectiveness studies funded by the Robert Wood Johnson Foundation; However,the planned release of this information was postponed from April to October of this year. For the evaluation of the tort changes in Maine passed in 1986, primary data generated from the courts, insurance companies, and attorney interviews have been used.

Like most other states, the State of Maine enacted changes in the medical malpractice and liability insurance system in 1986 (P.L. 1986, C. 804) to achieve four general goals: (1) to improve the efficiency of the tort system in compensating medical injuries caused by provider negligence and deterring avoidable injuries; (2) to reduce medical errors and resulting injury to patients; (3) to make medical malpractice insurance more available and affordable to health care providers; and (4) to ensure the availability of essential health care services to the residents of Maine.

It is generally believed that mechanisms intended to reduce the number of medical malpractice claims brought against health care providers or to identify meritorious claims for expeditious resolution reduce the costs of defending such claims (transaction costs). Since both claims frequency and transaction costs figure into the price insurance companies charge for their products, reductions in these areas are expected to reduce the price of medical malpractice premiums. With stable or reduced insurance premiums, health care providers could afford to continue in practice and provide essential care to the people of Maine.

While the 1986 Maine reform measures have not been in effect long enough to assess their long-term success in achieving the four goals, evaluations of the effects of similar reforms in other states may suggest their probability of effectiveness. In evaluating the effect of tort reform, it is useful to remember that no single reform is likely to achieve all of the possible goals that may exist for the health care system, dispute resolution system, and financing systems. To adequately evaluate one reform, therefore, it is necessary to identify clearly not only the goal intended to accomplish, but also the effects it may have, either directly or indirectly, on other areas. It is also useful to distinguish between the goals of a particular reform measure and the goals of tort law itself, for the two may conflict. For example, one goal of the tort system is compensating persons injured by the negligence of others. If one goal of tort reform is to reduce the cost of compensating patients, this might be accomplished simply by reducing the type

or amount of compensation payable in tort actions. Thus, success in reducing the costs of tort litigation may undermine the tort law goal of compensating injured persons.

Reforms intended to reduce the costs of the medical malpractice system should also be evaluated in relation to the savings they may produce, including prevention of injuries. Danzon has suggested that "From a public policy perspective, the problem is one of designing liability rules and insurance mechanisms that minimize the total costs of injuries, including the utility costs of injuries, the resource costs of prevention, and the overhead costs of effecting compensation."1

The reforms enacted across the country in the wake of the 1985-1986 malpractice crisis were directed primarily at improving the operation of the tort system, rather than reducing the incidence of medical error or improving the availability of affordable insurance.2 Most states enacting such reforms did so in the belief that a tighter, more efficient tort system would lead insurers to moderate the price of insurance and make it available to physicians needed to deliver essential care in the state. Several states enacted new requirements for reporting insurance data and information about malpractice claims against physicians. Nonetheless, the bulk of reforms were tort reforms reminiscent of those enacted in the mid-1970's.

The immediate purpose of these tort reforms was to reduce either the frequency (number) of malpractice claims or the amount (severity) of any settlement or judgment on claims made. These measures can be classified into four categories: 3

1. Measures intended to limit the number of claims eligible to enter the tort system :

   Shortened statutes of limitation.

   Requirements that plaintiffs pay legal fees and costs for bringing nonmeritorious claims.

   Limitations on contingency fees payable to plaintiffs' lawyers.

2. Measures intended to increase the plaintiff's burden of proving a claim:

   Limitations on the use of res ipsa loquitur (which infers negligence in certain circumstances).

   Narrowing the applicable standard of care to more local standards.

   Speciality qualification requirements for expert witnesses.

3. Measures intended to expedite or replace the process of claims resolution:

   Requirements for disclosing expert witnesses.

   Pretrial screening mechanisms.

   Encouragement of arbitration as an alternative to litigation.

4. Measures intended to reduce the amount of awards:

   Elimination of ad damnum clauses (requesting large damages in the initial complaint).

   Requirements for structured or periodic (in lieu of lump sum) payment of awards.

   Collateral source rule modifications.

   Limitations or caps on the amount of awards (either the total amount recoverable or the amount recoverable for non-economic damages or pain and suffering).

In spite of the attention to medical malpractice in recent years, empirical evaluations of the effects of tort reform remain limited, both in number and in generalizability. Studies reported to date focus mostly on the legal effects of specific reforms, the frequency of claims or the amount of awards paid. Few have been designed to assess the effect of reforms on the price of insurance or the willingness of physicians to continue to provide specific kinds of care. So while they can tell us the effect of reform on frequency and severity of claim, their effect on reducing or stabilizing insurance premiums or increasing access to care remains in doubt.

In reviewing the empirical findings of these studies, two caveats are in order. Most studies use statistical regression models with data from many states to identify the degree to which generic reforms explain increases or decreases in claim frequency or severity or premium rates. Since the reforms enacted in different states varied significantly in their details and these details cannot be captured in a single quantifiable measure, the results may contain unavoidable errors.[4] In addition, the majority of studies published to date were conducted shortly after reforms were enacted and offer only short-term conclusions which may overestimate or underestimate the effect of the reforms. Long-term effects remain under study. In short, at this time one cannot really tell what the effect of tort reforms will be.

In its December 1986 report on claims and insurance costs in six states, the GAO "identified no studies conducted in the six states to measure the effect of any specific tort reforms."[5] The GAO itself did not attempt to isolate the effect of particular reforms. Instead, it interviewed groups of officials and other

interested organizations in each of the six states. None of the groups interviewed believed that the tort reforms enacted had any major effect on any aspect of the malpractice problem in Arkansas, New York, or North Carolina, or Florida.

Some Florida officials thought it too early to assess the 1985 and 1986 reforms. Four of six interest groups in Indiana believed their 1975 reform legislation (especially its $500,000 cap on total awards and the pretrial screening panels procedure) was a significant factor in stabilizing malpractice insurance premiums. Groups surveyed in California believed its reforms helped stabilize the size of awards and the price of insurance, although both have increased since 1980.

The GAO study may be evidence of the need to allow reform measures several years to produce any effect. As shown in TABLE 1, the frequency of claims continued to rise in the six states studied between 1980 and 1984 (although the increase for hospitals was less) even though reforms initiated in the mid-1970's had been in effect for many years. Moreover, the price of premiums rose even more dramatically during the same period. See Table 2. The experience of these states contrasts with that of Minnesota, North Dakota, and South Dakota. A study by the Minnesota Insurance Commissioner of virtually all closed claims in those three states from 1982 to 1987 found that premiums for physicians more than tripled (from $23 million to $71 million per year) despite unchanging claim frequency (about 11.6 claims per 100 insureds, quite similar to the national average for St. Paul's insured physicians) and declining loss payments and loss expense.6 These studies suggest that reforms may not yet have had much effect on the frequency of claims and have not had any effect in lowering insurance premiums.

Indiana University School of Law is currently conducting a study of the impact of tort reform in Indiana on the availability of obstetrical services. A preliminary comparison of the number of obstetricians per 1,000 live births in several states between 1970 and 1985 indicates that Indiana's experience does not differ significantly from that of several midwestern states or the nation as a whole.7 Final results of the study are not expected until late summer 1989.

STATUTES OF LIMITATIONS

Changes in state statutes of limitations to reduce the time within which a claim must be filed or forfeited have been found to reduce both claim frequency and claim severity. Using multiple regression analysis, Danzon's 1986 Rand Corporation sponsored study of claims closed nationwide from 1975 through 1984, found that claims frequency decreased by eight percent.8 The number of paid claims decreased between 6% and 7% in states

TABLE 1

Frequency, Severity and Costs of Claims in Selected States

	St. Paul US	AR	CA	FL	IN	NY	NC
Claims Per 100 Physicians:							
1980	10.6	6.6	20.4	20.8	5.3	27.1	7.5 (1987
1984	16.5	8.6	26.0	26.1	10.2	35.7	8.9
Claims per 100 occupied hosp. beds:							
1980		1.2	8.6	2.1	2.2	7.5	1.5
1984		1.2	10.1	2.4	2.4	8.7	1.9
Average paid claim for physicians:							
1980		$31,619	$32,963	$80,556		$46,789	$36,064
1984		$51,685	$61,774	$140,594	↓18%	$104,810	$62,043*
Average paid claim for hospitals:							
1980		$12,00	$13,025		$7,146	$90,577	$7,098
1984		$18,345	$24,874		$11,244	$88,917	$20,091
Insurers average cost of defending claims against physicians:							
1980		$2,714	$2,284				$2,216
1984		$5,269	$9,358		18%	163%	$4,772
--against hospitals:							
1980		$2,263	$3,422				$3,083
1984		$4,120	$5,608		19%	18%	$5,704

*Reflects a $6.5 million award in 1985; until 1982, largest NC award was $200,000.

Source: U.S. General Accounting Office. Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms (1986).

TABLE 2

Percent Increase in Malpractice Insurance Rates for Selected Specialties Between January 1, 1980 and January 1, 1986

	AR	CA[c]	FL[d]	IN[e]	NY[f]	NC
General practice (minor surgery) ('80-'86)	58	173	199	93	335	239
Internal medicine (minor surgery) ('80-'86)	58	61	199	93	326	239
General surgery ('80-'86)	80	88	256	56	175	306
Anesthesiology ('80-'86)	61	35	217	56	96	262
Obstetrics/gynecology ('80-'86)	147	140	395	116	345	547
Orthopedic surgery ('80-'86)	50	88	198	83	216	241
Neurosurgery ('80-'86)	136	113	370	96	273	438

[a]Computation based on rates obtained from the state's leading insurer of physicians for the predominately purchased coverage limits and policy form for the rating territory in which there was the greatest total number of physicians insured.

[b]In Florida, percentage increases between March 1, 1980, and January 1, 1986.

[c]Computation based on rates applicable to Southern California.

[d]Computation based on rates applicable to the entire state, except for Dade and Broward Counties.

[e]Computation based on rates that include surcharge to participate in the Patient's Compensation Fund. On January 1, 1980, the surcharge rate was 10 percent of the provider's premium for basic insurance coverage. On January 1, 1986, the surcharge rate was 75 percent.

[f]Computation based on rates applicable to the entire state except Nassau, Suffolk, Bronx, Kings, Queens, Richmond, Rockland, Sullivan, New York, Orange, Ulster, and Westchester Counties.

Source: U.S. Congress, General Accounting Office. Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Rise Despite Reforms 15 (1986).

that reduced the limitations period by one (1) year. Since most claims are filed within 3 years of injury, the reduction is more effective with respect to statutes of limitation that are less than 5 years. Most states already have special statutes of limitation requiring medical malpractice claims for injury to adults to be brought within 2 or 3 years of injury, while other personal injury claims may be brought typically within 6 years.

JOINT AND SEVERAL LIABILITY:

The doctrine of joint and several liability means that a plaintiff who is successful in a malpractice suit may recover all damages from any defendant found at all liable for the injury. This is intended to provide the plaintiff with a mechanism to collect damages regardless of the distribution of fault. While this eases the collection process for injured patients, it may occasionally place a disproportionate burden on a defendant who is only minimally at fault. Ordinarily, such a defendant who has paid a judgment is entitled to recover from his co-defendants who were also at fault. But, if they are insolvent or immune from suit, the right is meaningless. Insolvency and immunity from suit are probably rare in the professional malpractice context.

No reported study could be found in which abolition of the doctrine of joint and several liability affected either the frequency or severity of claims or the price of insurance. Since the doctrine is essentially a means of allocating risk in satisfying judgments, abolishing it simply shifts the risk of non-recovery from a negligent defendant to the injured plaintiff. As long as liability is based on fault, the fairness of requiring one defendant to pay more in damages than he/she is personally responsible for causing must be questioned. At the same time, abolition of the doctrine does not appear to have substantial potential for reducing the amount paid on claims unless more than a handful of health care providers had no insurance or were significantly underinsured and were otherwise judgment proof. This is unlikely in Maine, although it has been reported that some hospitals are currently underinsured.

LAWYERS CONTINGENCY FEES:

Arguments for and against contingency fees are well-known. Proponents claim that they provide access to the legal system and effective representation for plaintiffs who could not otherwise afford to pursue a claim, and that they deter frivolous suits by placing the plaintiff's lawyer at financial risk. Interestingly, some citizens groups in England are advocating a similar payment system in order to obtain representation for injured persons.[9] Critics argue that they encourage and prolong litigation and drive up the cost, leaving less for the injured patient.

There is little empirical evidence specifically assessing these positions. A study conducted for the Secretary's Commission on

Medical Malpractice in the early 1970's found that plaintiffs' lawyers accepted only one out of eight cases presented to them for representation.10 It has been suggested that, today, lawyers are likely to reject cases in which anticipated damages are less than $50,000.11 Based on these studies and interviews conducted with Maine attorneys as part of this study, it is difficult to assess the extent to which the rejection of potential cases is attributable to the merits of the claim or to the financial cost and recovery expected.
Danzon's studies of legislative reform focused on the effect of regulating contingency fees on the rate of claims made and payments received. Her 1983 study, using 1974 and 1976 closed claims data, tentatively found that contingency fee limits reduced the amount of settlements (severity) by 9%, reduced the percentage of cases litigated to verdict by 1.5%, and increased the percentage of cases dropped by five percent.12 However, Danzon's later 1986 study using data for the 10 years before 1985 found no systematic effect on either the number of claims filed or the size of awards.13

In addition, Danzon also found that there was no association between the number of attorneys in a state and the frequency of claims there. Instead, the single most important factor contributing to the rate of claims was urbanization, which increased the number of claims filed, but paradoxically decreased the number of claims paid.

COLLATERAL SOURCE PAYMENTS:

This doctrine permits plaintiffs to receive compensation for injury expenses from several sources such as health and disability insurance in addition to that awarded from a settlement. The collateral source rule prohibits introducing into evidence at trial any information about such collateral sources of compensation or reducing any award made against the defendant from other sources. In many cases, patients who receive tort awards are required to repay their health insurance for amounts expended in their behalf, but enforcement of such requirements is uncertain. Danzon's 1986 study found that states that permit or require offsetting damage awards by collateral benefits received reduced the average amount of paid claims by 11% to 18% and the frequency of claims by fourteen percent.14

CAPS ON PAYMENT AMOUNTS:

Limitations or caps on the maximum amount payable to a successful claimant probably have the most direct effect in reducing the dollar amount paid as a result of a court decision or private settlement. Many states have enacted statutory caps on either the amount payable for non-economic damages (pain, suffering, and disfigurement) or the total amount of the award (including past and future medical expenses, lost wages, and other actual monetary losses). Danzon's 1986 study found that the average

payment was reduced by 23% in states that enacted caps on all or part of awards payable.15 At the same time, there is no clear evidence that caps have reduce liability insurance premiums.

Caps appear to affect a small number of cases--those with the largest awards. Danzon found that 5% of the claims closed with payment between 1979 and 1985 accounted for 50% of the total dollars paid. Thus, caps do effectively limit the total amount paid by insurers. They may also contribute greater predictability to future liability estimates by setting an outside limit on some or all of the damages payable. However, because they serve to reduce only those awards that would exceed the cap, they may have little effect in states where awards already rarely exceed the cap.
A preliminary report of on ongoing study of tort reform in Indiana, where total damages are limited to $500,000, noted that the median payment per closed claim was $446,000.16 Since the maximum of $500,000 was paid in one-third of the claims, the report expressed concern that "some large claims may be inadequately compensated." In cases where medical expenses and lost wages approached $500,000, there would be little left to pay general damages after deducting attorneys fees.

Some states have placed limitations on non-economic damages rather than caps on total awards because the former does not prevent recovery of out-of-pocket expenses and lost earnings. Moreover, it has been reported that non-economic damages account for a substantial proportion of the total award in cases with the largest recoveries. For example, the GAO reported that in a national sample of 1984 claims, only 5% of the paid claims included noneconomic damages over $100,000, but the amount of such noneconomic damages accounted for 42% of the dollar value of total payment.17 Thus, arguably, limiting non-economic damages appears to make awards more predictable without depriving injured parties of compensation for economic losses.

SCREENING PANELS:

Section 2851 of the P.L. 1986, Ch.804 states that the purposes of prelitigation screening panels are: (1) to identify claims which merit compensation; (2) to encourage early resolution of those claims prior to the commencement of a lawsuit; and (3) to encourage early withdrawal or dismissal of nonmeritorious claims. We are not aware of any definitive studies evaluating the merits of claims before screening panels. Such a study would require extensive medical and legal assessments of each case. There are, however, a few descriptive studies of the time required to resolve claims and the extent to which panels may encourage early resolution, which are the second and third objectives of Maine's panel system.

In 1986, the U.S. General Accounting Office reported that a majority of consumer groups believed that panels decreased the

time required to resolve claims and reduced the number of claims going to trial.18 However, the research completed to date does not provide definitive evidence either to support or refute that belief. Few researchers have been able to collect adequate information to assess whether the panels are achieving their various purposes.19 The National Center for State Courts, in its 1980 study of the Arizona system, suggested that the panels were not yet effective in speeding up the resolution of claims, but cautioned that the information was not complete enough to permit a definite conclusion as to whether the panels should be retained.20

Danzon has found that screening panels had no demonstrable effect on the frequency or severity of claims.21 On the other hand, Sloan found that mandatory screening panels had a statistically significant association with lower malpractice insurance premiums for ophthalmologists, orthopedic surgeons, and non-surgical general practitioners.22 Interestingly, this was the only reform measure he found to have any effect on premiums.

Indiana established a pretrial medical review panel procedure in 1975 to make non-binding determinations of whether a provider adhered to the proper standard of care in individual cases.23 Until 1985, no action against any health care provider could be commenced in court until the panel had considered the case and rendered an opinion. In 1985, the statute was amended to permit two exceptions to the prescreening requirement. Claimants can go directly to court if (1) they seek no more than $15,000 in damages (in which case recovery of more than $15,000 is barred), or (2) all parties agree to bypass the panel (an apparently rare event). In addition, a provider who is not insured by the state's Patient Compensation Fund may be sued in court without the panel process and is not protected by the state's $500,000 cap on damages.

A recent report on Indiana's medical panel system offers some useful information.24 Claims are filed with the Insurance Commissioner who notifies the health care providers named. The parties themselves choose the medical review panel chair (who must be an attorney but has no vote). The claimant and defendant each choose a health care provider member who in turn selects the third member, also a health care provider. There does not appear to be any entity with authority to control or expedite panel proceedings. While the statute requires the panel to render its expert opinion within 180 days after the members are selected, the time limit is unenforceable and, in practice, cases may remain in process for more than one or two years. Most of the time is spent on discovery. Table 3 summarizes the panel experience between 1975 and 1987.

According to the Report, panels have rendered opinions in 22% of the cases filed. The panels found "malpractice" in 11.5% of these cases and no malpractice in 74% of such cases. There is

TABLE 3

Indiana Medical Review Panel Experience

Status of Claims Filed

	#Claims Filed each Year	Claims Pending	Settled/ Withdrawn before Opinion	Panel Opinion Rendered	Settled After Panel Opinion	Judgment Paid
1975	1	0	1	0	0	0
1976	18	2	8	7	1	0
1977	141	10	71	44	6	10
1978	272	18	150	80	12	12
1979	318	24	153	103	5	33
1980	400	67	187	108	9	29
1981	431	100	166	136	2	27
1982	555	146	185	165	9	50
1983	626	205	169	201	7	44
1984	687	330	166	155	2	34
1985	78	571	128	60	1	20
1986	683	635	37	2	0	9
TOT:	4,912	2,108	1,421	1,061	54	268
% of total	100%	43%	29%	22%	4%	5%

Source: Indiana Dept. of Insurance, Patients Compensation Authority, 1986 Year End Report

suggestive (not yet hard) evidence that the panels may reduce the proportion of claims that go to court. The Report noted that plaintiffs' attorneys feel that a panel opinion finding no malpractice will influence any subsequent court action and these may encourage pretrial settlement. One Indiana insurance company asserted that only 2% of the claims filed against it go to court. The GAO reported that the average amount of paid claims in Indiana declined between 1980 and 1984.25

Indiana University School of Law's current study of the effect of Indiana's pretrial medical review panel on the incidence of court filed claims under $15,000 will not be completed for several months. Preliminary results indicate that a high proportion of cases are settled or otherwise disposed of during the panel process.26 The panel process may be helped greatly by the active support of the State's medical societies which have encouraged participation in the process by well-respected, qualified physicians. The Report identified three main difficulties with panel review: (1) the likelihood of lengthy proceedings that delay claims resolution; (2) the absence of any central authority to monitor the process and enforce time limitations; and (3) the absence of a mechanism to collect data and evaluate the effect of the panels.

A recent report published by the Risk Management Foundation of the Harvard Medical Institutions provides a somewhat different, but also positive, picture of the Massachusetts pretrial screening panel experience.27 All claims alleging medical malpractice have been required to be submitted to a tribunal since January 1976.28 Tribunals consist of a superior court justice, a physician, and an attorney who decide whether the claimant's evidence "is sufficient to raise a legitimate question of liability appropriate for judicial inquiry." If the tribunal finds insufficient evidence, the claimant may not proceed to court without posting a bond to cover expenses. Under the law as amended in 1986, tribunal findings may be used as evidence relevant to determine whether the claim was frivolous.

The Risk Management Foundation (RMF), which is the second largest insurer of physicians and hospitals in Massachusetts, (the Massachusetts Joint Underwriting Association is the first) reviewed all 675 claims against 1164 of its insured physicians that were heard by tribunals from 1978 through 1987. About 34% of the tribunal decisions were for defendants, with 66% for plaintiffs during this 10-year period. Almost half (45%) of the cases in which the tribunals decided for the defendant were dismissed because the plaintiff failed to post the bond required to proceed to court. The State's Joint Underwriting Association had more than four times as many physicians involved in tribunals as RMF during the past five years. Their experience was similar to that of RMF, however. More than one-third of the tribunal decisions were in favor of the physician or hospital; about 47% of these were dismissed for failure to post bond.

The report notes that nearly 1 out of 6 defendants was dismissed from a claim after the tribunal process and concludes that the tribunals function effectively as a screening mechanism. It does not include data on the costs or length of the tribunal process. Possible problems with the system include some difficulty in locating physician panel members, especially for the increasing proportion of cases brought against high risk specialities. To avoid bias, the physician panel member must practice outside the defendant's county of practice or residence. Since most claims originate in Boston, it is increasingly difficult to find physicians who practice outside Boston to serve on a panel.

Maryland has required all malpractice claims exceeding $5,000 to be submitted to a pretrial screening panel (appropriately named the Health Claims Arbitration Office) since 1977. Three-person panels, consisting of an attorney as Chair, a health care provider and a layperson, determine liability and award damages, although either party may obtain a trial de novo in court thereafter. Preliminary results of a John Hopkins University study of the screening process's effect on claims frequency indicated that by 1985, approximately 2.3% of claims proceeded to trial.29 During the decade before screening panels were required, 9% of claims were resolved by jury verdict. More than half (55%) of the claims studied that were closed from 1977 to 1985 were disposed of without using the screening process. The average time required to resolve a claim was estimated to be no more than 22 months. This compares favorably with GAO's national study findings of 25 months for 1984. However, the length of time required to resolve claims in Maryland before institution of the screening panels was not available for comparison.

The Maryland study also indicated that almost 10% of claims filed with the screening panel were decided in favor of the claimant. This represents about 40% of those claims that completed a panel hearing, a larger percentage of decisions for claimants than ordinarily occurs in jury trials. Twenty-three percent of claims that completed a panel hearing went on to a jury trial. Panel decisions were upheld in 72% of these cases. The average panel award was $289,561, while the average jury award was $412,532. Insurer claims data showed that only 28% of all claims were closed with payment, compared with 43% in the GAO's 1984 national study.

MAINE SCREENING PANELS:

The study group conducted some preliminary research on the conduct of the screening panels in Maine focusing on the extent of their use by the Bar, their cost in relation to nonpanel suits, how they have affected the practice of attorneys who use them, and claims results. A structured survey was conducted with eight attorneys (four plaintiff and four defendant), the State Court Administrator, the Superior Court

Justice in charge of the panels, and a claims administrator from the St. Paul Companies. The attorney survey instrument is included in ATTACHMENT C. The Maine panel system and the survey results are described in ATTACHMENT D and summarized below.

PANEL USE AND RESULTS:

Between January 1, 1987 and April 13, 1989, 232 notices of medical malpractice complaints had been filed with the Superior Court. 32 panel hearings have been held. Insurance company data confirm that panel hearing decisions have been made in favor of defendants at a rate at least twice that of plaintiffs. Of the 18 cases involving Medical Mutual defendants, 12 had unanimous rulings in favor of the defendants and six resulted in split decisions. An indemnity of $7,000 has been paid by Medical Mutual in only one of these six claims to date. According to St. Paul's data, no panel decisions have resulted in favor of the plaintiffs and no indemnity payments have been made as a result of screening panel hearings. However, a number of cases were settled before final decisions were rendered.

The costs of panel use were considered by some as a detriment, especially where they may be incurred in addition to trial costs. Discovery is the legal term used to describe the various pretrial procedures that are used by one party to obtain facts and information about the case from the other party in order to assist in trial preparation. In most litigation cases, discovery requires considerable time and expense at the pretrial phase. The extent of discovery permitted during the panel process is likely to affect both the cost and the length of the proceedings. The law provides that if a party applies to the Chairman, he/she may permit "reasonable discovery." The term "reasonable discovery" is vague, however, and the attorneys and Justice McCarthy are not certain how much discovery preparation for the screening panel hearing is allowed, will be allowed, and should be allowed. All respondents considered this an important issue. Rules on the amount of discovery that will be allowed in preparation for panel hearings have been difficult to develop. A system of setting the amount of discovery has been developed, but it depends on the good faith agreement of the attorneys involved. However, if the attorneys choose to conduct full discovery, they must agree that it can be used at trial.

To date the average loss expense to insurers for panel hearings has been $9,169 for the Medical Mutual cases. This is lower than the average loss expense of a voluntary settlement ($11,327) or a case that is won by defendant after trial ($33,789). Yet it is higher than the average loss expense for a defendant that is dismissed from an action prior to a settlement. According to Panel Chairman Justice McCarthy, one of the benefits of the panels is to reduce the number of defendants named in a case. Judging from these data alone, the cost of the panel is high for this outcome but low in relation to the voluntary settlement or

trial outcomes. One difficulty in assessing the effectiveness of the panels using these data is that one cannot tell the extent to which the cost of panel hearing will be added to or substituted for settlement and litigation costs.

Plaintiff attorneys interviewed were uniformly opposed to the panels and say they will always waive their use if the defense agrees. While both defense and plaintiff attorneys reserved judgment on the panels until more time has elapsed, both said they appeared to be disposing of cases earlier in the process. Plaintiff attorneys say that panel use may result in their refusing meritorious cases because the settlement will not cover expenses if the case has to go to both panel and trial.

CONCLUSIONS:

Nationwide the price of malpractice insurance has continued to climb, with some variations, over the period 1980 to 1988. Rate increases for OB/GYNs ranged from 116% in Indiana to 547% in North Carolina between 1980 and 1986. Moreover, the average cost incurred by insurers to defend a claim has increased over the same period. Some of this may be attributable to a continuing rise in the incidence of claims, although the increases vary from none (e.g. Minnesota) to substantial (e.g. Indiana), while in some states the rate of claims against hospitals has remained stable. In general, the dollar amount of the average paid claim has increased, although in Indiana it decreased for physicians and in New York it decreased somewhat for claims against hospitals.

Interestingly, in late April, the Wall Street Journal reported that several insurance companies plan to decrease premium rates this year.30 The reasons cited by insurers for the decrease are a reduction in the number of claims filed since the mid-1980's and a decrease in rate of increase in settlement costs. Others suggest that tort reforms like caps on damages have helped. Still others say that fewer claims are being brought because litigation is becoming too complex and expensive, jury awards to plaintiffs are decreasing both in number and amount, and lawyers are refusing to take smaller cases. Some fear that this reduction may parallel the slight decline in insurance rates that took place in the late 1970's, and that rates will climb again in the future. They note that current settlements may reflect the lower inflation rates in the early 1980's when many of the injuries now being settled occurred, and that future health care cost inflation will bring a rise in the expenses incurred by claimants that seek compensation.

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 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, or have been repealed or 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 certainly do limit the dollar volume of high-stakes claims (as well as introduce some consistency into estimates of damages), but may undercompensate claimants with extensive losses. 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. They may help to identify meritorious claims and encourage early settlement, but they may also increase transaction costs. It appears that the appeal of screening panels varies with the particular composition of the panels, the uses that can be made of their decisions in subsequent court proceedings, and the efficiency of their operation.

There is little doubt that resolving tort claims through a jury trial can be an inefficient and expensive system of dispute resolution. Any effort to improve its efficiency and reduce its cost, while not sacrificing its benefits, should be welcome. Virtually all such measures, however, operate by shifting the probability of success somewhat from one party to the other. All dispute resolution systems produce some false positives and false negatives. Efforts to reduce costs (and false positives) 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 eligible persons will go uncompensated (false negatives). Efforts to decrease both the false positives and false negatives by refining the mechanism to better identify meritorious claims may increase the complexity, time and expense of decision-making. At this point, ite cannot be demonstrated whether most tort reform will do what is being asked of them, namely to reduce insurance premiums or increase availability of care.

For these reasons, new tort reforms at this time, are questionable policy options to reduce insurance premiums and to insure medical care availability. Ongoing studies to be completed during the next two years may provide a clearer picture

of the trends in claims frequency and severity in states that have and have not enacted reforms. None, however, expects to be able to demonstrate any direct relationship between tort reform and the price of insurance.

If reforms are contemplated, the Legislature might consider designing them to expire after a fixed period, say five years if the price of insurance and the availability of essential medical services do not improve by some measure satisfactory to the Legislature. In this way, reforms that serve no purpose will not remain in effect to engender continued controversy. Moreover, under such a system, it will be far easier to evaluate the effectiveness of particular reforms in achieving their goals for the health care system in the future.

FOOTNOTES

1. P. Danzon. Medical Malpractice: Theory, Evidence, and Public Policy 4 (1985).

2. Abraham, Medical Malpractice Reform: A Preliminary Analysis, 36 Maryland Law Review 490 (1977).

3. B.R. Furrow, S.H. Johnson, T.S. Jost & R.L. Schwartz. Health Law: Cases, Materials and Problems 277 (1987).

4. Zuckerman, Koller & Bovbjerg, Information on Malpractice: A Review of Empirical Research on Major Policy Issues, 49 Law & Contemporary Problems 85 (1986).

5. U.S. General Accounting Office. Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms 14 (1986).

6. Report of the Minnesota Commissioner of Insurance on Medical Malpractice (1988).

7. Personal communication from Professor E. Kinney, May 16, 1989.

8. Danzon, The Frequency and Severity of Medical Malpractice Claims: New Evidence, 49 Law & Contemporary Problems 57 (1986); Danzon, The Effects of Tort Reforms on the Frequency and Severity of Medical Malpractice Claims, 48 Ohio St. Law Journal 413 (1987).

9. Brahams, Compensation: A Draft Bill, The Lancet 1088 (Nov. 5, 1988).

10. Dietz, Baird & Berul, The Medical Malpractice System, in: U.S. Department of Health, Education & Welfare, Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice (1973).

11. U.S. Congress, General Accounting Office. Medical Malpractice: A Framework for Action 23 (1987).

12. P. Danzon, The Frequency and Severity of Medical Malpractice Claims (Rand 1982); Danzon, The Frequency and Severity of Medical Malpractice Claims, 27 Journal of Law of Economics 115 (1984).

13. Danzon, supra note 8.

14. Id. at 78.

15. Id.

16. Kinney, Indiana's Medical Malpractice Act: Health Care Improvement and Medical Liability, in: Proceedings of the Research Conference on Health Care Improvement and Medical Liability 65, 68 (DHHS 1988). (hereafter "DHHS proceedings").

17. U.S. Congress, General Accounting Office, supra note 10 at 28.

18. U.S. Congress, General Accounting Office. Medical Malpractice: No Agreement on the Problems or Solutions (1986).

19. Comment, A Practical Assessment of Arizona's Medical Malpractice Screening System, 335 Arizona State Law Journal 367 (1984); Daughtrey & Smith, Medical Malpractice Review Panels in Operation in Virginia, 19 Univ. Richmond Law Review 273 (1985); One Thousand Seven Hundred Days: A History of Medical Malpractice Mediation Panels in Florida, 8 Florida State Univ. Law Review 165 (1980).

20. National Center for State Courts. Medical Liability Review Panels in Arizona: An Evaluation (1980).

21. Danzon, supra note 8; Danzon, supra note 12; Danzon & Lillard, The Resolution of Medical Malpractice Claims: Research Results and Policy Implications (Rand 1982).

22. Sloan, State Responses to the Malpractice Insurance "Crisis" of the 1970's: An Empirical Assessment, 9 Journal of Health Politics, Policy & Law 629 (1985).

23. Indiana Code 16-9.5-9-1.

24. Report on Indiana's Medical Review Panel.

25. U.S. Congress, General Accounting Office, supra note 5.

26. Kinney, supra note 16 at 65.

27. McDonough, Tribunal Success Could Improve with Greater Physician Involvement, 9 Forum 4 (Sept./Oct. 1988).

28. Massachusetts General Laws, c. 231, section 60B.

29. Morlock, Impact of State Reforms: The Maryland Experience, in: DHHS Proceedings 59,61.

30. Medical Malpractice Insurance Rates Fall, Wall Street Journal (Apr. 28, 1989).

CONSTITUTIONALITY OF TORT REFORM

INTRODUCTION:

An elementary precept of our government is that Acts of the Legislature must conform to the constitutions of Maine and the United States. Accordingly, the Legislature should give thoughtful attention to the constitutionality of proposed legislation, particularly in times of perceived crisis when fundamental values may, all the more casually, be overlooked. Evidence of today's medical malpractice crisis can be seen in the high price of liability insurance largely, although by no means exclusively, for physicians and other health-care practitioners. High insurance costs, like other free-market forces, affect human behavior and thus can produce unplanned and undesirable dislocations in availability of health care and other social pursuits. Among the remedies currently being considered by the Legislature are reforms in the rules and procedures of tort liability.

Tort reform legislation must accord with constitutional principles of due process of law, equal protection of the law, taking of property, and the right to trial by jury among others. When the Supreme Judicial Court assesses Legislative Acts against those constitutional values, it does so on the premise of a strong presumption in favor of constitutionality. The Court thereby extends great deference to the Legislature's judgment. Perhaps the most far-reaching example of sweeping changes in tort law sustained by the Supreme Judicial Court is the Maine Workers' Compensation Act. See Milkman's Case, 118 ME. 172, 106 Atl. 606 (1919). As a general matter, both the substantive and procedural rules of tort law were originally adopted as preferred policy choices either by the courts as rules of common law or by the Legislature as plain expressions of State policy. Because those rules were not compelled by the State or Federal Constitution, they may be changed at will. On the most general level, therefore, the conclusion is that legislative changes of tort rules and procedures will most probably be held by the courts to be constitutional. However, specific changes made may violate constitutional principles.

Constitutional standards are less, not more, exacting than standards of wisdom and good policy which legislators commonly apply. For that reason, no citizen legislator should be deterred from considering constitutional questions. Although the answers are matters of judgment to which the courts have the final say, ideas in the constitution are not the special providence of lawyers and judges, but are well within ordinary thoughtful citizens' reach. The Maine Constitution's due-process and equal-protection clauses provide:

> No person shall be deprived of life, liberty, or property without due process of law, nor be denied the equal protection of the laws .... [Me. Const. art. 1, S6-A]

Due process embodies a principle of basic rationality: "whether the means employed are appropriate to the achievement of the objective." State v. National Advertising Co., 409 A.2d 1277, 1288 (Me. 1979). Equal protection embodies a principle of treating like cases alike, an idea of evenhandedness: "a classification must not be arbitrary." Portland Pipe Line Corp. v. Environmental Improvement Commission, 307 A.2d 1,22 (Me. 1973). If a distinction between two groups is "based upon actual differences bearing a substantial relation to the public purpose sought to be advanced by such discrimination . . . it is not a violation of equal protection guarantees." (Ibid.) Most legislators are routinely forced to think about these two basic ideas because they bear as much on questions of policy as on constitutional law. Any conscientious legislator will question what a particular reform of tort law will do, whether it is a reasonable means of achieving the objective sought and whether the bill draws distinctions which are justifiable.

Constitutionally-based court litigation is the typical method of asserting the rights protected by the law of torts. Tort litigation, however, like democracy, may not be pristinely efficient. The Maine Constitution provides:

> In all civil suits ...the parties shall have a right to trial by jury, except in cases where it has heretofore been otherwise practiced ... [Me. Const. art. 1, S20]

Both the plaintiff and defendant in a civil suit have a right to trial by jury. Juries composed of ordinary Maine citizens represent the public in deciding private disputes just as legislators represent the public in deciding issues of policy. Jurors find the facts, apply the statutory and common law under instructions from the court, and decide the damages.

Whether proposed changes in tort law are constitutional is a different question from whether those measures are wise and should be enacted. Tort rules and procedures are supposed to be designed to achieve justice. The rules of tort law were supposedly evolved to protect the best interests of all Maine citizens, both those who seek redress for injuries suffered by them and those who may have to pay for the damages done. Before some principle of tort liability is jettisoned, one should be sure that it was a mistake from its inception (that it did not achieve the justice originally supposed) or that it has outlived its usefulness (that its ill effects outweigh the good). Otherwise, today's solutions will be tomorrow's problems. States which have retreated from earlier-enacted tort reforms have learned that lesson by experience.

TORT LIABILITY:

Joint and several liability and the collateral source rule have been the focus of policy changes in tort liability. The first makes all defendants who are liable for a plaintiff's injuries answerable for the entire damage. (Joint and several liability has no effect on how defendants divide responsibility for paying among themselves, a matter governed by rules of contribution and indemnity.) The second, the collateral source rule, says that benefits obtained by a plaintiff, including his own insurance, workers compensation payments, and donations from family and friends, are not credited to a tort defendant to reduce the amount of the damages to be paid. (Collateral benefits may counterbalance a plaintiff's inability to recover litigation costs including attorneys' fees.) No serious constitutional objection could be raised to reversing either rule.

If a proposed change in tort law bears no more than a speculative relation to legislative goals of lowering insurance rates or increasing availability of quality health care, for instance, then it will founder on the idea expressed in the Constitution as due process of law. For example, reversing the rule of joint and several liability with an aim of reducing medical malpractice insurance premiums or increasing availability of quality health care bears little demonstrable relation to the goal because the rule does not figure prominently in malpractice cases. As discussed in Section IV-A, little evidence exists to prove that tort reforms achieve their desired goals.

If a change would unjustifiably discriminate against persons injured in one way rather than another or discriminate in favor of a special class of defendants, then it will conflict with the idea expressed as equal protection of the laws. Should the victim of a physician's negligence be required to subtract from his recovery the health insurance benefits he has already paid while the victim of an automobile driver's negligence is not so required? Can the distinction be justified? While abolishing the collateral source rule entirely may be constitutional, see Johnson v. Farmers Union Central Exchange, Inc., 414 N.W. 2d 425 (Minn. App.1987), repealing the rule only for medical malpractice may violate equal protection of the laws. See Farley v. Engelken,740 P.2d 1058,1068 (Kan. 1987)("the classifications created . . . treat both negligent health care providers and their victims differently from other persons similarly situated"). Cf. Austin v. Litvak, 682 P.2d 41, 53 (Colo. 1984); Kenyon v. Hammer, 688 P.2d 961 (Ariz. 1984) (statutes of limitation deny equal protection when applied to undiscoverable injuries). The Supreme Courts of New Hampshire and Rhode Island have held that certain tort-law changes could not be restricted to medical-malpractice actions without violating equal protection of the laws. See Carson v. Mauer, 424 A.2d 825 (N.H. 1980); Boucher v. Sayeed, 459 A.2d 87 (R.I. 1983).

To decide whether Maine citizens would be better served by reversing the rules of joint and several liability and of collateral source would require analyzing why those rules were thought to be proper means of promoting the ends of justice and thinking about the effects of reversal. Should an arsonist, for instance, obtain the benefits of his victim's fire insurance or be credited with the value of money and goods collected to help a family put out of their home? Eliminating the collateral source rule would have those effects.

PRETRIAL PROCEDURES:

Similarly, changing pretrial procedures, such as shortening the time within which a claim must be asserted (Statute of Limitations), imposing notice requirements, or requiring mediation or pretrial screening, should not be susceptible to serious constitutional challenge even if they increase the difficulty of asserting perfectly valid tort claims. See, e.g., Miller v. Fallon, 134 Me. 145, 147-48 (1936) (sustaining reduced statute of limitation for medical malpractice actions); Thut v. Grant, 281 A.2d 1 (Me. 1971) (sustaining replacement of bastardy act with paternity act); Giberson v. Quinn, 445 A.2d 1007, 1009 (Me. 1982) ("It is beyond dispute that the state may erect reasonable procedural requirements to the exercise of a right to an adjudication," sustaining ten-day notice requirement for hearing on suspending a driver's license.) The primary issues in all such cases are policy issues. Would Maine citizens benefit under the proposed changes and would the changes be likely to produce the desired results such as reduced insurance costs without inhibiting meritorious claims?

LIMITING DAMAGES:

Opinions are divided on whether maximum limits on damages or "caps" violate the Constitutional right to trial by jury. See Fein v. Permanente Medical Group, 695 P.2d 665 (Calif. 1985) (upholding limit on noneconomic damages); Hoffman v. United States, 767 F.2d 1431 (9th Cir. 1985) (upholding limit on noneconomic damages); Etheridge v. Medical Center Hospitals, 376 S.E, 2d 525 (Va. 1989) (upholding limit on medical-malpractice damages); Johnson v. St. Vincent Hospital, Inc., 404 N.E. 2d 585 (Ind. 1980) (upholding limit on medical-malpractice damages); Lucas v. United States, 757 S.W. 2d 687 (Texas 1988) (statutory limit on medical-malpractice damages unconstitutional); Kansas Malpractice Victims Coalition v. Bell, 757 P.2d 251 (Kan. 1988) (limit on medical-malpractice damages denies right to jury trial); Smith v. Department of Insurance, 507 S.2d 1080 (Fla. 1987) (limit on noneconomic damages unconstitutional); Richardson v. Carnegie Library Restaurant, Inc., 763 P.2d 1153 (N.M. 1988) (damage limit in dramshop act denies equal protection).

Any statutory figure establishing maximum damages is bound to be arbitrary. When applied to actual losses, especially provable noneconomic losses, statutory limits inescapably intrude upon the jury's traditional function in civil suits to assess damages

based on facts proven at trial. Moreover, a damage limit, by definition, gives a wrongdoer an immunity allowing him to inflict harm above the limit without obligation to redress the harm done.

The cap works only where the actual damages exceed the amount that a negligent defendant is required to pay. In effect, the limit takes property from the victim and gives it to the wrongdoer [Cf. Me. Const. art. 1, S.21 ("Private property shall not be taken for public uses without just compensation . . .").] (Damage limits in purely statutory actions, such as wrongful death, dramshop violations, and claims against the state, are distinguishable because the Legislature has in effect eliminated a common law immunity up to but not above the damage ceiling.) Maximum limitations on recovery of actual damages will therefore raise grave constitutional doubts.

Confining a damage limit to a disfavored class of injured persons, such as medical-malpractice plaintiffs, just compounds the constitutional hazard, to say nothing of the problems of policy. Should a person disabled for life by negligent surgery be treated differently from a person identically injured by someone's negligent use of a firearm? The Legislature must consider this question of policy: Are jury awards in Maine so excessive, so uncontrolled by the courts' case-by-case review of jury verdicts, to warrant a statutory limit? Evidence of excessive verdicts in Maine is hard to find.

SUPPORT PROGRAMS:

Finally, positive legislative support programs, such as patient compensation funds or malpractice insurance subsidies, would most probably withstand constitutional challenge. In comparable matters, the Supreme Judicial Court has deferred to the Legislature's judgment on the wisdom of compensation funds and subsidizing private enterprises to achieve broad public purposes. See Portland Pipe Line Corp. v. Environmental Improvement Commission, 307 A.2d 1, 24-25 (Me. 1973) (oil spill compensation fund); Common cause v. State, 455 A.2d 1, 20-26 (Me. 1983) (Waterfront development and rent-free lease of facilities to private corporation to promote employment).

CONCLUSION:

The Legislature can constitutionally change most rules of tort law and procedures of tort litigation. Placing a maximum limit on recoverable damages is the most constitutionally-suspect of all current tort reform proposals. Before tinkering with tort law, the Legislature should have some good reason to think that the changes proposed will achieve the desired goals and should also be careful to avoid drawing unjustifiable distinctions among tort claimants and among 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 its infringement, while constitutional, may not be wise policy.

SECTION V: RATE SETTING PRACTICES AND POLICY OPTIONS

RATE SETTING PRACTICES AND POLICY OPTIONS

HOW MEDICAL MALPRACTICE RATES ARE SET:

Although the detailed steps involved in setting medical malpractice rates are laborious and complex, the goals and the general methods are readily understood. Sellers of insurance obligate themselves to accept the financial consequences of certain risks of their insured. If insurers are to remain in business, they must be able to collect enough premiums to cover their claims payments and their expenses and to provide a profit. The rate setting process is the method by which insurers make these estimates.

Medical malpractice insurance poses particularly difficult challenges to the rate setter. First, unlike physical damage insurance, payment of medical malpractice claims may not take place until many years after the policy has been issued and the premium collected. It is usually these claims which are largest and if they result in a monetary settlement, a significant portion is likely to be covered by reinsurance.

When a company is notified of a claim, it establishes a reserve to cover its expected costs, but because this is such a "long tail" type of coverage, the correctness of the reserve may remain unknown for years. Secondly, there are so few claims and so few large claims payments in Maine that the data are volatile and may lack sufficient statistical credibility. The companies, therefore, depend to some degree on data from other jurisdictions which may not accurately reflect Maine experience.

Since 1976, only "claims made" medical malpractice policies have been sold in Maine. A claims made policy covers only those claims of which the company has received notification during the policy year. A policyholder who does not renew such a policy becomes liable for claims made after the expiration of the policy arising from events that took place during the policy period. To avoid this risk of future claims, a person can buy insurance which provides "tail" coverage. This coverage is usually purchased when a physician switches from one insurer to another, thereby obtaining coverage for the period when the physician was under the former insurance policy.

Medical malpractice premiums are used to pay claims costs, expenses, and to provide a profit to the insurance company. Insurance companies must estimate what claims costs and expenses are likely to be. First, companies group their policyholders into classes of similar risks, usually by practice specialty. Then, to estimate expected claims losses for each class, insurers examine the historical changes in pure premium that have taken place over a multi-year period. Pure premium consists of claims payments and reserves made for cases reported, but not yet settled as well as any expenses incurred in settling cases (known as allocated loss adjustment expense or "ALAE").

Pure premium is the product of the frequency and severity of claims. Company actuaries choose among a number of possible statistical methods to project expected pure premium trends. In making such projections, the rate setter should take into account conditions affecting frequency or severity which existed in the historical period, but which are expected to differ in the projection period as well as new conditions likely to affect severity or frequency of claims in the projection period. An obvious example of the latter is the effect of changes to the Medical Malpractice and Liability Insurance System passed by the Legislature in 1986 (P.L. 1986, Chapter 804).

The next step in setting rates is to add expenses to pure premium. These expenses include commissions, company incurred acquisition expenses, taxes, licenses, fees and general administrative expenses. As in the case of projecting pure premium, the companies make their expense estimates on the basis of past experience.

Insurers invest the premiums they receive and keep them invested until they are used to pay losses or expenses. In a long-tail line such as medical malpractice, many premium dollars remain invested for years. It is recognized that the rate setting process should include an adjustment to the rate to reflect this investment income. However, what method to use to reflect an appropriate amount of such future income is in dispute. Until now, the Maine Bureau of Insurance has accepted the industry's approach, one which does not reflect the income which the industry actually receives from its investment of premiums.

In the absence of full and accurate cash flow data, it is impossible for the Bureau to know how much income is available for investment. The question may be of less relevance to medical mutual companies, such as the Medical Mutual Insurance Company of Maine (MMIC), because the insured physicians will presumably benefit from investment income by a reduced rate in the form of dividends or by their ownership of the company. It should be noted, however, that the history of mutual companies shows that they have frequently maintained large surpluses and have not been subject to effective control by the policyholders. MMIC is a case in point. Its surplus has nearly doubled in each of the last two years. With 9.2 million dollars surplus in 1988, its premium to surplus ratio is now almost 1:1 which means that the company has between two and three times the amount of surplus generally considered to be adequate.

Medical malpractice rates are set for a basic level of coverage such as $100,000/300,000 limits. This rate is then adjusted by a so-called "increased limits factor" to reflect the added risk to the insurer of policies with higher than the basic limits. As St. Paul's noted in its April 28, 1988 filing, [Increased limits factors are difficult to compute from actual data because of the great statistical variations of large losses.] In the absence of sufficient data, rate setters use various theoretical models to arrive at increased limits factors

which include the use of countrywide data.

Periodically, insurers analyze the class "relativities" to ensure that each class of insured contributes its fair share of premium based on its claim experience. Although changes in class relativities do not affect the overall premium amount, they can combine with rate changes to produce large rate fluctuations for classes of insured in a single year.

It is common for insurance companies to spread their risks to other companies by the process of reinsurance. Companies selling reinsurance products are beyond effective regulatory oversight by state regulators. In the case of MMIC, because its business is limited to writing medical malpractice in Maine, the company has found it advisable to reinsure its larger risks. Approximately forty percent of MMIC's exposure is reinsured. It uses two reinsurers, and there is now (unlike in the recent past) a competitive market for reinsurance.

St. Paul's, as do most other writers of medical malpractice insurance, attempts to collect enough premium to include a profit. A recent MMIC filing states that MMIC has not included any amount which was intended to add to surplus. For companies which do attempt to make a profit, the filings express their plans in terms of a target rate of return. In selecting such a target, companies take into account the risk posed by the line of insurance and comparable rates of return in other lines of insurance.

INSURANCE SYSTEM OPTIONS TO REDUCE OR STABILIZE RATES:

In suggesting changes that will tend to reduce or stabilize medical malpractice rates, one should bear in mind that any system must provide sufficient premium to pay a company's losses and expected losses, its reasonable expenses, and a reasonable profit. Any rate-setting system which does not meet these needs would either be struck down by a court as biased rate making or would lead to withdrawal of insurers from the market.

Those who complain about medical malpractice rate increases are affected by two related phenomena: large rate increases over time and rapid annual rate fluctuations. Insurers recognize that sudden rate changes, up or down, are disruptive; but because of the volatility of medical malpractice data, insurers have not succeeded in avoiding such market disruptions. The following considerations are designed to address both issues.

A. Stronger Oversight By The Insurance Bureau:

Rate Filings: Maine, like many other states, employs a "file and use" system for most insurance products. Medical malpractice rates go into effect thirty days after they are filed with the Bureau of Insurance. The Bureau sometimes approves filings without the scrutiny afforded by a public hearing as was the case with the most recent St. Paul's Companies filing. Moreover, the Bureau makes no filing of its own so that even if it holds a

hearing, it is limited to the largely passive role of approving or disapproving the filing on the basis of the filings before it. The problem is compounded by the fact that filings by parties other than the insurer are generally limited in scope to he particular interest of the filing organization. The Bureau's August 1, 1988 decision on St. Paul's filing provides explicit recognition of this problem. For example, considering the reasonableness of St. Paul's target rate of return, the hearing officer notes that there was no evidence in the record upon which a different rate of return could be determined. The Legislature might effect a stronger oversight role for the Bureau of Insurance by considering passage of statutory amendments such as:

1. That a hearing be required to be held for every medical malpractice rate filing.

2. That medical malpractice rate filings become effective only after a hearing and decision.

3. That the Bureau of Insurance be empowered to make advisory filings in response to filings by medical malpractice companies and that the Bureau use expert witnesses at the hearings to support the Bureau's filings. The costs of such activities should be made accessible to the insurers.

Investment Income: Because the treatment of investment income can have a substantial impact on rates in a long-tail line like medical malpractice insurance, it would be advisable to provide the Bureau with explicit statutory authority and a mandate to take such income fully into account. Therefore, the Legislature could consider the addition of the following to the insurance statutes:

> That the Superintendent of Insurance shall develop and periodically update a model for estimating investment income earned in the business of medical malpractice which takes into account both risk and market rates of return and that no filing is to be approved that does not substantially meet the income projections of such model.

Closed Claim Studies: Not only does the Bureau of Insurance lack alternative recommendations by experts at hearings, but it is forced to rely on industry data, much of which is not based on Maine claims. Recently the Minnesota Insurance Commissioner issued a report based on a detailed study of all medical malpractice claims in three states over a six year period. Although the insurance industry disputes his conclusion that the industry has consistently and substantially overestimated losses and has thus over-reserved, the data developed in the study will be useful for anyone setting or reviewing rates. Therefore, the Legislature might consider additions to the insurance statutes:

1. That the Superintendent of Insurance be directed to undertake a periodic detailed study of all medical

malpractice claims in Maine as well as whatever additional claims deemed to be advisable in other jurisdictions relied upon in the filings of the insurers and to issue reports thereon. The costs of such studies and reports shall be assessed to the insurers.

2. That the Superintendent of Insurance be directed, at least every five years, to undertake a study of the reserving practices of writers of medical malpractice insurance in Maine.

B. Minimizing Disruption:

The fact that St.Paul's proposed almost a 20% increase in rates in 1988 and has proposed an approximately 20% decrease in 1989 demonstrates the extreme rate volatility in this line of insurance. Such rate changes not only alarm policyholders, but make it difficult for them to make financial plans. The Legislature might consider an expression of public policy to avoid market disruption in medical malpractice. The following additions to the insurance statutes could affect this:

1. That it is the intent of the insurance laws that changes in medical malpractice rates not be so great as to be disruptive and that in regulating this line of insurance the Superintendent take such reasonable steps as is possible to avoid disruption including limiting the amount that class relativities may be changed at any one time.

2. That to prevent market disruption which would be caused be the size of a proposed change in rates, the Superintendent be authorized to spread the adjustment over a period not to exceed three years, to the extent that such action does not threaten the financial stability of the insurer.

C. Steps To Improve Efficiency Of Insurers:

A large portion of medical malpractice premiums is used to pay company expenses. In fact, it is remarkable how few premium dollars are actually used to pay claims. For example, Schedule P of MMIC's 1988 Annual Statement shows that in the ten-year period ending December 31, 1988, MMIC made loss payments of $6,185,994. In that same period, the company's expenses were almost exactly the same amount, or $6,011,000. Historically, such expenses have been accepted in rate filings without serious challenge; however, the reasonableness of expenses should not be accepted unless the company demonstrates that it has in place an adequate program to control them. The Legislature could consider the adoption of an amendment to the Maine insurance laws to provide a requirement similar to that imposed in Massachusetts, on filings by Blue Cross Blue Shield (Mass. G.L.c. 176A, s.6) and on private passenger automobile filings (Mass. G.L.c. 175, s.113b).

That the Superintendent, on the basis of information provided in every medical malpractice filing, determine whether the company making the filing utilizes adequate programs to control costs and expenses, in accordance with standards to be determined and approved by the Superintendent. At a minimum, such programs shall be designed to have a material impact on premium charges by reducing costs and expenses. No filing shall be approved if the Superintendent determines that the filing is deficient or that the programs are inadequate.

D. Merit Rating:

Classification of risks are not necessarily limited to medical specialties. The insured can also be classified according to the degree of claims risk determined by prior claims experience. However, because there are relatively few claims payments, a merit rating system would not be likely to result in a significant moderation of rates for those in the lowest risk classifications. If it chooses to do so, the Legislature could direct the Superintendent to require merit rating plans.

E. Removing Risk from the Insurance System:

One well known way of reducing insurance rates is to make the insured share some of the risk. The use of copayments or deductibles does not reduce the risk--except to the extent that the insured is thereby encouraged to be more careful. However, such a shift of risk does make those whose actions result in claims losses pay relatively more than those without a history of such claims. Moreover, any reduction in the risk covered by insurance eliminates some of the expenses and profits built into insurance rates. Perhaps because many people are not familiar with the nature and purpose of insurance, it is frequently difficult to persuade individuals to accept part of the insurance risk even when the potential loss would not be financially embarrassing and when it would be likely to save them money. The Legislature may wish to consider mandating a minimum deductible, such as $5,000, to remove some of the costs from the insurance system.

CONCLUSIONS:

There is an opportunity to realize savings in medical malpractice insurance premiums without causing financial injury to insurers. To obtain these saving will require a more vigorous public (regulatory) oversight of the medical malpractice insurance industry in Maine. Specifically, it will require that the Superintendent of Insurance implement existing and new powers voted by the Legislature including the development of a database of Maine's claims, settlements, and insurance practices. These data are essential if the Bureau is going to have the information

necessary to carry out these functions and if the Legislature and general public are going to oversee both the Superintendent's and insurance industry activity.

Promoting efficiency is a principal role of government in a regulated industry such as insurance. To guard against inefficiency, which comes from the insurance industry practice of understating investment income, the Superintendent of Insurance should be authorized and directed to promulgate an investment income model. To guard against the present lack of incentive to control expenses, the Legislature might require that the Superintendent of Insurance mandate that insurers demonstrate an effective cost control program prior to rate increases.

To promote efficiency in the reinsurance needs of MMIC and achieve premium savings, the Legislature could direct the Superintendent of Insurance to set standards for reinsurance which, to the extent feasible, reduce dependency on outside reinsurance. Secondly, the Legislature could consider a patient compensation fund such as that suggested in L.D. 762.

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 significant rate increases over a three year period. To spread the risk of claims payment and resulting increases in premiums to those policy holders responsible, the Legislature might consider implementing a merit rating system or a system of deductibles.

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.

SECTION VI: MEDICAL SERVICE REFORMS

A. Medicaid Fees

B. Medical Review Provisions

MEDICAID FEES

It is apparent from the literature and from the results of the physician survey that the difficulties Medicaid recipients have in obtaining medical care are due in part to the lower reimbursement fees for services to these patients compared to those insured by Blue Cross or commercial insurers. Inadequate reimbursement was the primary reason physicians gave for not treating or limiting Medicaid patients in their practices. Other factors include administrative paperwork and physician concern over perceived noncompliance of Medicaid patients. Transportation was also a problem as cited from a recent study of Medicaid recipients in Maine (USM, 1984).

While the access issue for Medicaid recipients is complex, removing the price barrier could alleviate one of its primary obstacles. It would not guarantee physician participation in the Medicaid program. However, it could act as an incentive for those already in the Medicaid program to remain, particularly Family Physicians who provide much of the obstetrical care to these patients. Since both the price of medical malpractice insurance premiums and the fear of being sued are the principal reasons physicians give for dropping obstetrics, policies aimed at reducing these could have a positive effect on access for all classes of patients including Medicaid recipients.

Since the early 1980's, states have been afforded significant leeway in running their Medicaid Programs. This gives the Legislative and the Executive Branches of government more authority in the program's structure and management. Currently the Legislature has an ongoing Commission on Access to Medical Care. That Commission could be charged with developing a plan to meet the potential access problems of Medicaid recipients for the Legislature. Developing the plan with the State Medicaid Agency (Bureau of Medical Services) and its Physician Advisory Committee on Medicaid would be advantageous.

MEDICAL REVIEW PROVISIONS

INTRODUCTION:

This section of the report describes current practices in Maine relative to improvement in the quality of medical care and subsequent reduced likelihood of malpractice incidents. It includes discussion of professional licensure, performance review, hospital policies relative to credentialing and privileges, and developing standards for care. These considerations must be put into the broader context of what is taking place at the National level which may have significant impact on Maine's medical malpractice and health care delivery problems as well as on solutions in the not too distant future.

Patricia Danzon has conducted extensive research on the 1976 tort reforms' effect 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 improve peer review and other efforts aimed at preventing the number of malpractice incidents. Activities on several fronts have been implemented in Maine's health care delivery system which show promise of improving quality of care and reducing incidents of malpractice. There are several others that the Legislature might encourage.

NATIONAL CHANGES:

A recently released report, For the Health of a Nation, by The National Leadership Commission on Health Care, indicates that serious strains in the health care system "are raising the frustrations of all who participate in it. Physicians are concerned about outside parties intruding on their clinical decisions and damaging the doctor-patient relationship. Hospitals find it increasingly difficult to cope with pressures for cost containment and with rapidly changing laws and regulations. Government and major private payers are trying with limited success to control rising costs. Patients are faced with higher costs, but they don't see care improving sufficiently to justify their increasing payments--and they continue to present the system with ever-increasing demands."(National Leadership Commission on Health Care) The report also suggests that these strains will be exacerbated by the rapidly aging population in the United States, the AIDS epidemic, and the continuing technology explosion which spawns more and more new treatments, which, though often beneficial, are also costly.

The National Leadership Commission sets forth a strategy to address these serious health care problems, problems which they deem <u>un</u>necessary since the United States has the knowledge to solve them now. There will always be some art and some uncertainty in the medical profession since science expands continually into new areas and because each patient presents a unique set of problems. That is also precisely why it is not

possible at this time to delineate hard-and-fast rules to which physicians must adhere without seriously restricting the delivery of health care in this country.

PHYSICIAN LICENSURE:

The Board of Registration in Medicine is responsible for new licensing of allopathic physicians in Maine and ensures that minimal training standards and qualifications are met. A 60-90 day background check on training and experience is made on all applicants. All hospitals where privileges were reported by applicants are independently contacted by the Board to confirm these reports. The Board also requests that applicants disclose hospital privilege reduction/revocations which may have taken place in other states.

The Board requires all physicians licensed in Maine (5,900 of whom 2,100 currently practice in Maine), at every biennial re-registration, to report under penalty of license revocation any malpractice paid claims against them since the preceding registration. These reports are subject to review by the Board and investigated through contact with the malpractice insurance company by the Executive Director. Reports which are deemed by the Board as not due to negligence or incompetence are designated on a consent list as such. Those potentially due to negligence or incompetence are referred to the Attorney General's office for investigation. A similar review is made of all claims paid notices received by the Board from other sources.

The Board maintains files of qualitative data from a variety of sources which are subject to similar review. These include reports submitted by hospitals and individual physicians received under their respective obligations to report suspected impaired physicians, mandatory hospital reports of reductions or revocation of privileges (voluntary reductions need not be reported), and reports of incidence or notice of establishment of reserve accounts by malpractice insurers. In addition, consumer complaints (15-20 per Board meeting) are reviewed for possible action. Other more subjective reports from informal sources are also filed. Action can only be undertaken in response to legally-mandated requirements or when sufficient evidence is available to warrant review by the Board for possible recommendation to the Attorney General's office for investigation.

The Board of Osteopathic Examiners and Registration is responsible for licensure and relicensure of osteopathic physicians in Maine. Initial licensure procedures are similar to those described for allopaths with checks of past education, training, and experience done routinely based on information not only from the applicants, but prior institutions as well. There are currently 400 osteopathic physicians licensed in Maine and 270 who are actively practicing in the State according to the Board's Executive Secretary. Relicensure of osteopaths is

required yearly and reportedly close attention is paid by the Board of Examiners to any reports received relative any physician who has been disciplined, suspended, or had privileges curtailed or revoked. The Board has remedial action available at the Attorney General's Office if further investigation is required.

Changes in the medical malpractice liability law passed in 1986 by the Maine State Legislature (PL 1986 C.804) required the State Superintendent of Insurance to send notice of all first dollar claims paid by any carrier to the Boards. The Boards must review any physician who has three such claims in ten years. The Executive Director of the Board of Registration in Medicine indicated that this practice has been followed since 1978. Out of the 230 settled/awarded malpractice cases reported since 1978 against allopaths, only seven have been reviewed under this mechanism since 1980. Five were prior to or during 1986; the two more recent cases are pending. All five closed cases have resulted in loss of license to practice in Maine either through voluntary withdrawal or administrative court procedure. Specific data are not available relative to osteopathic practitioners; however, indications are that the numbers are very small and would follow the allopathic trend. It does not appear that rates of physician review have increased since the reforms of 1986.

These data also suggest that speculation by some (FAIR, 1988) that a small number of physicians are responsible for most of the cases may not be true in Maine since only seven out of approximately 3,000 physicians who have practiced in Maine during this period have had three or more claims in ten years resulting in monetary settlements. Most of this speculation is based on calculations of total money awards. A few very large cases settled against a few physicians account for most of the total monetary outlay. For example, a Washington Post study quoted by FAIR in 1988 stated that 1% of Maryland's physicians insured by its largest malpractice carrier were responsible for 54% of paid claims and legal costs. Since very large claims against a few physicians (at one case each) could account for a large proportion of the total amount, such analyses do not address the bad-apple hypothesis. Multiple claims settled against individual physicians do not appear to be the most effective indicators for identifying those most at risk for malpractice suits.

There is misunderstanding of many of the differences between malpractice settled/awarded claims and actual negligent or incompetent physicians. The Boards have no power over the volume of malpractice suits and cannot formally act until allegations result in paid claims. While the Board's Executive Director had no suggestions for changes in the Board's current oversight rules or procedures that would result in changes in malpractice suits, filed or settled, other members of the Board suggested that there could be changes to improve the Board's ability to gather other information, such as requiring hospitals to report "Failures to Renew" privileges and encouraging other health care personnel (nursing and other staff) to report incidents to the Board.

There is a general concern about defensive medicine and its relationship to access, overall cost of care, and its limited impact on malpractice suits. This concern may be germane to practice standards as well. One action taken by other states has been to require notification to the Board of licensure of voluntary withdrawals, under threat of disciplinary action, as well as administrative reductions/revocations of hospital privileges. This may be a loophole which allows physicians to relocate and resume practice which would be impossible at the previous location.

OPTIONS FOR STRENGTHENING PHYSICIAN LICENSURE:

The method used by Maine in structuring its professional licensing boards is to rely on the Attorney General's office for investigatory and disciplinary actions. Some Board members feel this restricts the Board to statutory/legal responses to evidence brought to its attention by the Superintendent of Insurance, hospitals, consumers, and individual physicians rather than permit it to actively search and review for incompetence. Regardless, some restructuring might be considered to permit the Board to play a more active role.

The 1986 medical malpractice liability reforms allowed the Board of Registration in Medicine to increase dues in order to create a more active investigative staff as some other states have done. This apparently has not yet happened. L.D. 1407 (which is currently under consideration) is designed to address this concern mandating a budget to include funding for one full-time investigator in the Attorney General's office per 1,000 medical doctors. Relatively few consumer complaints appear to be handled by the Board.

A potential consideration would be to create an Ombudsman's Office to investigate consumer concerns. All consumer inquiries throughout the State could be handled through that office, and perhaps reduce the number of suits filed. (It is also possible, however, that this process could do exactly the opposite.) This office could provide an additional source of data when reviewing complaints about individual physicians. Such an office would require an (800) telephone number, appropriate public education, and more staff, but could provide an early warning system regarding physicians at high risk for future malpractice suits. The Board would need some mechanism to ensure appropriate medical input regarding the investigative procedures such as awareness of confidential nature of physician/patient relationship. Some features of this recommendation are included in L.D. 1407, but not the toll-free 800 number.

Secondly, qualitative data reviews by the Boards of Licensure could be formalized through the development of written guidelines for collection and use of these data. Regional physician teams might be established to contact physicians reported or suspected of substance abuse problems even in the absence of actual malpractice evidence. Such activities may happen on an informal basis now, but no guidelines are used.

Thirdly, Board policy changes could be encouraged for increased use of lesser penalties (probation and/or censure) combined with written guidelines for increased monitoring of physicians disciplined under these actions. L.D. 1407 requires yearly reporting of such activities to the Legislature.

HOSPITAL RESPONSES TO MALPRACTICE:

In order for a hospital to be accredited by the Joint Commission on Accreditation of Hospital Organizations (JCAHO), a number of policies and procedures must be in place relative to risk management. These include hospital licensure, physician credentialing procedures, ongoing quality assurance programs, morbidity and mortality reviews, and other educational programs.

A. Credentialing:

Each hospital establishes it own methods of credentialing physicians on its staff. These are usually administered by a committee which depends on recommendations from subcommittees specific to individual specialties such as internal medicine, OB/GYN, family practice, and surgery. Training, past hospital experience, and procedures are reviewed. When approved by the Credentials Committee, recommendations are then reviewed by the medical staff and the executive board.

The increased supply of physicians, especially in more populous areas of Maine, has allowed this process to become more rigorous. In most hospitals, board certification in the appropriate specialty is required for active hospital privileges. Policies currently regulate the extent of privileges (surgical /invasive procedures) as well as steps to rescind privileges. Hospitals are required to report suspension or required reduction in privileges to the licensing Board. The threat of such action often results in voluntary reduction or relinquishing of privileges neither of which is required to be reported. This approach may be seen as either facilitating quality control, (avoiding legal entanglements and allowing hospitals to negotiate rather than formalize removal) or as a loophole which may result in moving the physician to another locale without addressing competence issues. New JCAHO requirements will require physicians to report such voluntary actions when applying for new or renewed privileges.

B. Quality Assurance Activities:

Traditionally, hospitals have focused on how care was delivered. Only recently have they begun to measure the impact of that care on patient outcomes. Currently, hospitals are mandated by the JCAHO, as well as Federal and State government, to monitor the quality of care they provide and must document these activities. In Maine, each hospital must have a quality assurance plan with written policies and procedures. These are locally developed and thus vary by institution. Generally, committees are set up to monitor specific aspects of care such as medical record review

(ensure appropriate documentation), tissue committee, infection control, and tumor board. The committees meet periodically and review findings. Proposals for changes in policies or procedures are submitted to the administration or Medical Directors.

Hospitals must also submit to a review of Medicare services conducted by the Maine Professional Review Organization (PRO) which includes utilization reviews (Are people being appropriately hospitalized?) as well as quality reviews (Are appropriate antibiotics being used?). Hospitals receive a summary of findings and physicians are given individual performance profiles. If received by the hospitals, these individual physician reports might provide useful information highlighting patterns of inappropriate care since potential quality problems can be identified such as patients with unplanned return to surgery during a single admission, multiple blood transfusions during a surgical stay, and hospital-acquired infections to name a few.

In general, quality assurance activities are most effective in terms of affecting provider performance if the providers themselves are involved in setting the quality standards. In-hospital quality assurance activities are limited, however, by the time and money required to effectively monitor care.

C. Morbidity/Mortality Reviews:

Medical staff departments of hospitals (surgery, internal medicine, family medicine) conduct periodic meetings at which each death and any unusual morbidity are discussed. While these have been criticized as ineffective (see Millman, 1983)3, they theoretically create an opportunity for peer review and continuing education. Such meetings can result in medical record review by the Chief of Service and can lead to a peer review hearing if deemed appropriate. Hospitals are not required to report such hearings unless they result in a disciplinary reduction in privileges.

D. Other Educational Activities:

Hospitals host educational sessions for their medical staffs in a variety of formats usually including case conferences, noon presentations by internal and external experts, and other variations.

E. Risk Management Plans:

In addition to these activities, hospitals have risk management plans which range in scope and quality from patient advocate/complaint departments to more comprehensive monitoring of problems and early intervention. Some critics see these as mostly public relations, but insurers are attracted to these approaches to anticipating problems.

OPTIONS FOR STRENGTHENING HOSPITAL REVIEW:

Hospitals could receive individual physician as well as aggregate data from Medicare PRO reviews. This would allow closer monitoring and might lead to earlier identification of problem providers. Discovery issues in cases of disciplinary action need to be considered.

Secondly, each hospital staff could develop practice standards and use hospital quality assurance staff to compare actual care against such standards. It is thought that Statewide standards would be less likely to be adhered to and thus have less likelihood of having an impact on actual performance.

PROFESSIONAL STANDARDS:

There is a great deal of activity taking place at the National level as well as at various state levels relative to health care in general and the accessibility, cost, and quality of health care in particular. The National Leadership Commission on Health Care in its 1989 Report, For the Health of a Nation, indicates that there is insufficient information on the quality and outcomes of medical services and insufficient means of monitoring the quality of care and fostering its improvement. Citing studies showing large regional variations in the use of medical services that seem not to be based on medical need as well as stories of unnecessary and equivocal care in the use of inappropriate and excessive procedures, the Commission reports that this is not an isolated problem, but is generic to the whole health care system. In their words, the nation's quality control systems are at best rudimentary. Patients particularly have few tools to help them assess the quality and appropriateness of their treatment.

As part of the Commission's proposal to respond to the serious problems of quality health care, and others, in this country, it sets forth a nine point strategy which includes specific recommendations relevant to professional standards of care. Five recommendations out of the nine in this Report are included herewith which may impact on quality of care and malpractice issues:

1. Greatly increase research on the appropriateness, effectiveness, and quality of care and publicize the results widely to help patients, provider, and payers assess treatment.

2. Control costs by reducing the amount of inappropriate care as a result of the expanded research and National guidelines.

3. Develop a strong public-private partnership to improve quality and control costs by coordinating the expanded research on appropriateness and quality and disseminating the results through health professional and other appropriate organizations.

4. Develop and continually update National guidelines to enable practitioners, patients, and payers to make more informed decisions.

5. Promote nationwide the current, promising State reforms in malpractice and consider new Federal initiatives if necessary.

In addition to this call by a broadly-based group of distinguished leaders to establish National guidelines for health care, the Physician Payment Review Commission, created by law in 1986 to advise government on the reform of Medicare's physician payment methods, recommends that "the federal government actively encourage the development and dissemination of practice guidelines so that they are incorporated into physicians' practices, made available to patients, and used as the basis for coverage and payment, and for medical-review criteria by hospital medical staffs, carriers, and PROs." (Inglehart, 1989)

In Maine, if the intent is to improve quality with a National or community standard, educational research in medical settings indicates that a method which directly involves each practitioner would be the most effective. The Maine Medical Assessment Foundation (MMAF) has created a model program using exactly this type of local data collection and review process. (Wennberg, et al, 1988) In creating quality standards for hospital care, issues of the overall cost and effectiveness of standards appropriate to each institution's setting and population must also be considered. It would, therefore, seem appropriate to continue to encourage activities such as MMAF's which are both statewide and locally-based and have the capability to provide real data on which procedures are effective. This holds potential for reducing the number of procedures and ultimately malpractice risk.

Additionally, Medical Mutual Insurance Company, the physician-owned and operated malpractice insurer in Maine, has taken a statewide approach with its insured physicians by recommending guidelines of practice in three clinical areas: anesthesia, diagnosis of breast cancer, and obstetrics. The program began in January of 1988 and no data are yet available on its effects. MMIC has requested that physicians it insures and who practice in these specialties follow the proposed standards or document why they were not followed. Physicians who get sued and have not followed the standards or documented the reasons for not following them will be covered by the company, but will likely be dropped in the following year. The standards are based on those of the National organizations for each specialty. They are adopted following review (and revision) by internal MMIC physician committees. MMIC plans to adopt additional standards for other procedures and services. Physicians have, however, expressed concern about coverage if guidelines are not followed or adequately documented. Health services research studies indicate that it is impossible to rely on any one source of

information (medical record, patient report, physician report) for a valid reflection of what takes place in clinical encounters (Gerbert and Hargreaves, 1986),

CONCLUSIONS:

A number of ideas have been set forth for consideration relative to strengthening physician licensure procedures; monitoring and, hopefully, improving quality of care; and developing written guidelines to serve as a baseline for quality medical care. It is important to keep in mind that any approach to malpractice which attempts to be preventive, using some method of quality assurance, has multiple unresolved issues. Is quality the most cost effective care, most expensive care, best care, or usual practice? Is quality related to outcome? Despite National Medical Specialty Board promulgation of practice standards, the relationship of outcome and quality is still unclear nor has it been firmly established in many aspects of clinical care. While standards appears to be the wave of the future, any approach which relies on overly-specific protocols to be followed may lead to expensive and unnecessary care.

It may not be possible at this time to assure quality in medicine in the same way that quality is assured in a manufacturing process. It is extremely important to encourage both physicians and consumers to upgrade the integrity of the doctor/patient relationship. In so doing, physicians should be very involved in the process and assist in developing better guidelines for providing high quality care. Patients should become more informed and pragmatic relative to their expectations of what outcomes are possible and probable. Health care may be a right and a privilege, but it has to be a partnership as well.

REFERENCES

Campaign for Fair Rates and Equal Justice (FAIR). Medical Malpractice and Doctor Discipline: Are We Treating the Symptoms Instead of Curing the Disease? Mimeo, 1988.

Gerbert,B, Hargreaves, WA: Measuring Physician Behavior. Medical Care, 24(9): 838-847, 1986.

Iglehart, John K.: Health Policy Report, The Recommendations of the Physician Payment Review Commission. NEJM, April 27, 1989, No. 17, p. 1156-1160.

Millman, M: Medical Mortality Review: A Cordial Affair, Reprinted in Conrad, P. and Kern, R. (eds), The Sociology of Health and Illness: Critical Perspectives (second edition) New York, St. Martin's Press, 1986.

National Leadership Commission on Health Care: For the Health of a Nation, Executive Summary, Report in Print, February 1989.

Wennberg, J., Mulley, A., Hanley, D. et al: An Assessment of Prostatectomy for Benign Urinary Tract Obstruction: Geographic Variations and Evaluation of Medical Care Outcomes. JAMA, 259(20): 3027-3030, 1988.

ATTACHMENTS

ATTACHMENT A: Physician Survey Instrument

ATTACHMENT B: Physician Survey Analysis

ATTACHMENT C: Attorney Survey Instrument

ATTACHMENT D: Attorney Survey Analysis

ATTACHMENT A

MEDICAL MALPRACTICE LIABILITY STUDY ID#: (1-3)

OBSTETRICS AND MALPRACTICE IN MAINE - 1989

PHYSICIAN SURVEY

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1. Please indicate your primary practice specialty:

(4)
__ a. Family physician
__ b. General practitioner
__ c. Obstetrician/gynecologist
__ d. Other (please specify)_____

2. Approximately what percent of your practice is in:

(5-6) ___% Obstetrics
(7-8) ___% Gynecology
(9-10) ___% Other (please specify)_____
(11-12) ___% Other (please specify)_____

3. Please estimate how many deliveries you personally attended in:

(13-21) 1987____ 1988____ Estimated total for 1989____

4. If you have changed your obstetrics practice since January 1987, indicate how? (Check all that apply.)

(22) __ Stopped or reduced providing care to UNINSURED patients
(23) __ Stopped or reduced providing care to MEDICALLY HIGH-RISK patients
(24) __ Stopped or reduced providing care to MEDICAID patients
(25) __ Changed practice location
(26) __ Put a limit on the number of patients accepted.
(27-28) If yes, number per year: _____
(29) __ Other (please specify)_____

5. If you have reduced/stopped (circle one) your obstetrics practice since January 1987, rank the three most important reasons why. (Please respond with 1 for most important, 2 for second most important, and 3 for third most important)

(30) __ Limited back-up and consulting available for patients with high risk of a poor birth outcome
(31) __ Fee limit on Medicaid reimbursement
(32) __ Concern over obstetric malpractice suit
(33) __ Cost of malpractice insurance premiums in obstetrics
(34) __ Unavailability of occurrence type insurance coverage
(35) __ Inconvenience of practicing obstetrics (on-call responsibilities, sleep deprivation, etc.)
(36) __ Other (please specify)_____

IF YOU ARE NOT CURRENTLY PRACTICING OBSTETRICS PLEASE SKIP TO QUESTION 10.

6. Medicaid patients made up what percentage of your obstetrics practice during: (Please exclude those you were called on for delivery only.)

(37-42) 1987____ 1988____ Estimated for 1989____

7. What is your policy regarding providing total obstetrical care to Medicaid obstetric patients? (Please check one.)

(43)
__ a. DO NOT limit care for Medicaid obstetrical patients
__ b. DO NOT provide care for Medicaid obstetrical patients
__ c. Provide care for a LIMITED NUMBER of Medicaid obstetrical patients

(44-45) If yes, how do you choose which patients you will accept?_____

8. If you do not provide total obstetrical care to Medicaid patients, or provide care to only a limited number, please rank the 3 most important reasons why. (Please respond with 1 for most important, 2 for second most important, and 3 for third most important.)

(46) __ Reimbursement is inadequate
(47) __ Dissatisfaction with DHS policies.
(48) __ Pregnancies are high medical risk
(49) __ Fear of malpractice suit
(50) __ Too much paperwork
(51) __ Patients are noncompliant
(52) __ Patients sue more
(53) __ Other (specify)_____

9. If you plan to drop obstetrics, indicate the year this will occur:

(54) a. 1989__ d. Not sure__
b. 1990__ e. No plans to drop__
c. 1991__

10. What is the current annual malpractice insurance premium for you personally (cost of liability premium per physician)?

(55-58) $_____/yr.

11. Please indicate who is currently paying your malpractice insurance premium.

(59-60) __ a. I personally pay the premiums __ b. My employer (other than practice)
__ c. My practice pays the premiums __ d. My hospital
__ e. Other (specify)_____

12. What are your current malpractice insurance coverage limits? (case limit/total limit)

(61) __ a. $100,000/300,000 __ b. $200,000/600,000
__ c. $1 mil/3 mil __ d. Other($_____/_____)

13. Have you ever been named in an obstetrics personal injury or malpractice suit?

(62) __ 1 Yes __ 2 No

If Yes, how many culminated in each of the following outcomes? (Provide actual number.)

(63-64) __ Filed and dropped __ Court settlement in your favor
(65-66) __ Settled out of court __ Court settlement for plaintiff
(67) __ Still pending
(68) __ Other (please specify)_____.

(69-70) How many of these suits were filed by Medicaid recipients? ____

14. If a judgment was awarded for your most recent suit, please
(71-74) indicate the amount. $_____

Were you satisfied with this outcome?

(75) __ 1 Yes __ 2 No

(76) a. If not, why?_____

15. In 1988, what was the total gross income to your practice
(77-80) per physician before deductions and taxes? $_____

In 1988, what was your net income from your practice
(81-84) per physician before deductions and taxes? $_____

If you were on salary in 1988, what was the total
(85-88) gross income before deductions and taxes? $_____

(89)

Please return in the enclosed envelope to: Ronald Deprez, Ph.D., Public Health Resource Group, Inc., P.O. Box 5068, Portland, ME 04101

THANK YOU FOR YOUR PARTICIPATION

Attachment B

Survey Methods and Response/Non-response Comparison

Physicians to be included in the sample were identified through the "Cooperative Health ManPower Resource Inventory", a data bank containing demographic information on all practicing Maine physicians. Physicians were included in the sample if their primary specialty was Family Practice or Obstetrics/ Gynecology, they were Osteopathic doctors, or their second or third specialty was listed as Obstetrics. Six hundred and twenty-one physicians were identified and sent surveys using this criteria. Of this number thirty surveys were returned undelivered because of the physicians death or lack of a forwarding address.

Fifty percent (300) of those surveyed returned questionnaires. There were only slight variations in percentage results between respondents and non-respondents. In addition, both the non-respondents and respondents were similar to the original pool, again only showing slight variation in some areas.

There was a slight over representation by urban physician in the respondents. Thirty eight percent of the physicians who returned questionnaires worked in urban areas, in comparison to thirty-four percent of the original sample. The opposite was found for non-respondents, with urban physicians slightly under represented with thirty percent and rural physicians slightly over represented with seventy percent.

Physician Location

Location	Respondents	Non Respondents	Original Sample
Urban	38%	30%	34%
Rural	62%	70%	66%

By age categories, the percentage of respondents and non-respondents under forty was similar to the original sample. From forty to fifty-nine there was a slight over representation by respondents when compared to the original sample. For physicians sixty and over, the original sample contained twenty-four percent. Twenty-six percent of non-respondents fell into this category while only twenty-one percent of the respondents were sixty or over, showing a slight under representation by respondents.

Age

	Respondents	Non Respondents	Original Sample
Under 40	33%	31%	32%
40 - 59	46%	43%	44%
Over 60	21%	26%	24%

Seven percent of the original sample were residents. Six percent of the respondents classified themselves as residents and eight percent of nonrespondents were classified as residents.

A slightly higher percentage of respondents were male than found in the original sample and the nonrespondents sample. The opposite was found with female physicians respondants. Only twelve percent of the respondents were female while fourteen percent of the original sample and fifteen percent of non-respondents were female.

Sex

	Respondents	Non Respondents	Original Sample
Male	88%	85%	86%
Female	12%	15%	14%

A greater percentage of physicians who responded to the survey treated medicaid patients than non-respondents or than in the original sample. In addition, the percentage of blank responses found in the respondent sample was slightly lower than found in the non-respondents or original sample.

Treat Medicaid Patients

	Respondents	Non Respondents	Original Sample
Yes	89%	81%	84%
No	5%	8%	7%
Blank	6%	11%	9%

Of the four categories of physicians found in the sample, the percentage of Family Practice physicians were higher in respondents than in the orignal sample or the nonrespondents. Similar percentages were found for respondents, non-respondents, and the original sample for Obstetrics/Gynecology. The category Other MD's, which included all physicians whose second or third specialty was listed as Obstetrics, was slightly under represented in the respondents. The same results were found for the Doctors of Osteopathic Medicine.

Physician Categories

	Respondents	Non Respondents	Original Sample
Family Practice	55%	42%	48%
Obstetric/ Gynecology	16%	15%	15%
Other MD	12%	21%	17%
Osteopaths	17%	22%	20%

Respondent physicians were slightly under represented for 36-110 deliveries per year compared to the original sample while slightly over represented for 16-35 to deliveries and 111-550 deliveries per year. The percentages of respondents, non-respondents, and original sample were similiar for 0 Deliveriers per year and 2-15 deliveries per year.

Number of Deliveries

Per Year	Respondents	Non Respondents	Original Sample
0	3%	2%	2%
2-15	2%	3%	3%
16-35	8%	5%	6%
36-110	79%	85%	82%
111-550	9%	5%	7%

ATTACHMENT C

MEDICAL MALPRACTICE LIABILITY STUDY
ATTORNEY SURVEY

ATTORNEY NAME:_____ DATE___/___/___

FACE-TO-FACE OR TELEPHONE INTERVIEW (Circle one)

PLAINTIFF OR DEFENDANT ATTORNEY (Circle One)

PRACTICE QUESTIONS:
What Proportion of your practice/caseload are liability cases?

What types of liability cases are they? (product, medical, etc.)

How many Medical Malpractice cases have you had in the last five years?

How many Medical Malpractice cases do you have pending now?

What are they about? (type of medical procedures/diagnoses/???)

What is the trend in your malpractice cases compared to other personal injury cases in your practice? Are they increasing or decreasing? Are awards getting larger?

(P) What motivates malpractice case clients to seek legal assistance? (Emotional issues/cost of medical care/ ??)

(P) On average, how many reports of alleged malpractice incidents (different clients) do you consider before taking on a case?

(P) What goes into the decision to take on a malpractice case?

(D) Have you ever felt pressured by your clients (insurance co. and/or physician) to settle a case when you felt it did not have merit?

MEDICAL MALPRACTICE LIABILITY STUDY

SCREENING PANEL QUESTIONS:

How many of your cases have gone before the screening panels?

What was the result?
- How many ruled in your favor?
- How many reached settlement?
- How many went on to a lawsuit?

How many resulted in an indemnity payment to the plaintiff?

Have you ever not adhered to the panel decision to settle and proceeded to a lawsuit? Why?

What was the outcome of the case?

How do you decide whether to use the panel for a case? (size of potential award?/ merits of the case?/????)

How do you decide when to settle a case? (what do you look for in the case that suggests a settlement is the best course of action?)

Have the availability and use of screening panels had an effect on this? How?

How much leeway do you have in the decision to settle or adjudicate a case?

How have the use of panels affected this?

Has your time involved in a case increased or decreased with the use of panels?

On average how have panels effected litigation expenses?

Have you filed more or less notice of claims since the panels have been active?

Have you ever by-passed the panels altogether? Why?

Other impressions of the panels???

ATTACHMENT D

ATTORNEY SURVEY SAMPLE--PRETRIAL SCREENING PANELS

INTRODUCTION:

An assessment of the tort law changes passed in 1986 by the Maine State Legislature was conducted as part of this study. Of the six reforms passed, two have been in effect for a sufficient time to evaluate, the prelitigation screening panels and the increased disciplinary power of the Board of Registration of Medicine. This report addresses the screening panel reform and the second reform has been addressed in Section VI

SCREENING PANEL PROCESS:

In Maine, the prescreening panel system is set in motion when the Clerk of the Superior Court receives a notice of claim in a medical malpractice case. The Chief Justice of the Superior Court is informed and he then appoints a retired judge to serve as panel chairman. Two or three additional panel members are then selected by the panel chair from a list of doctors, health care providers, and attorneys. (If the defendant is a health care provider, then one of the panel members would be chosen from the defendant's subspecialty if such exists.)

Discovery is the legal term used to describe all of the various pretrial procedures that are used by one party to obtain facts and information about the case from the other party in order to assist in trial preparation. In most cases, there is considerable time and expense involved at the pretrial phase. Relative to the screening panel process, there is the question of how much discovery will be allowed. This was a very important issue with all those interviewed. The law provides that if a party applies to the chairman, he/she may permit "reasonable discovery." The words reasonable discovery are vague, however, and the lawyers and Justice McCarthy are not certain how much discovery preparation for the screening panel hearing is allowed, will be allowed, and should be allowed. Since all respondents considered this such an important issue, it will be more fully discussed in the summary section of this report.

Shortly after the notice of claim, the panel chairman sets up a meeting with the attorneys and they decide upon a date when discovery must be completed and on a hearing date. The parties must agree on a timetable within twenty days of the filing of a notice of claim. The hearing date must be set within 120 days of the notice of claim.

Under Maine law, the parties may bypass the panels if they mutually agree on resolution by trial alone. The panel can only decide the legal defense of comparative negligence; it may not hear any other defense the outcome of which might ultimately decide the case. The Rules of Evidence do not apply at panel hearings, and the parties are permitted to cross examine the

witnesses against them. Further, a unanimous panel decision against either the plaintiff or the defendant as to negligence and/or causation is admissible at trial.

SCREENING PANEL DATA:

Superior Court Administrator, Robert Miller, has been compiling limited data as to the number of notices filed, panel hearings, and complaints filed in medical malpractice cases since the enactment of the screening panels. That data has been updated to reflect the medical malpractice caseload as of April 13, 1989. No one is responsible for keeping track of the number of panel decisions and whether the decisions are for the plaintiffs or defendants. Nor was data available prior to the screening panel system as to the number of medical malpractice complaints filed. Nevertheless, an attempt has been made to briefly summarize the data available.

For the period beginning January 1, 1987 through April 13, 1989, 232 notices of medical malpractice were filed. Of those notices, 118 were disposed of by April 13, 1989. There were 71 complaints filed, and 32 panel hearings were held during that same time period. These data are set forth in TABLE 1 which follows:

TABLE 1
SCREENING PANEL DATA
(through 4/13/89)

COUNTY	NOTICES FILED	NOTICES PENDING	NOTICES DISPOSED	PANEL HEARINGS	COMPLAINTS FILED
Androscoggin	15	7	8	1	5
Aroostook	20	11	9	3	4
Cumberland	57	27	30	7	19
Franklin	0	0	0	0	0
Hancock	10	4	6	1	2
Kennebec	26	11	15	8	8
Knox	6	4	2	2	2
Lincoln	0	0	0	0	0
Oxford	12	6	6	3	5
Penobscot	36	19	17	6	13
Piscataquis	2	2	0	0	1
Sagadahoc	3	0	3	0	1
Somerset	8	5	3	0	3
Waldo	4	0	4	1	1
Washington	3	2	1	0	0
York	30	20	11	1	7

ATTORNEY SURVEY:

A. Purpose:

The purpose of this survey was to obtain information from practicing attorneys relative to the effect, if any, of tort reforms passed in Maine in 1986. Specific information was gathered relative to the pretrial screening panel system which has been implemented. This is the only reform that has been in place long enough to permit some analysis. In addition, general information was elicited from the respondents relative to such things as caseload, type of cases being pursued, and suit motivation. These findings reflect only the opinions of those interviewed in this select sample, and are by no means meant to be predictive of all attorneys in Maine.

B. Method:

Structured interviews were conducted with eight individuals involved with the medical malpractice screening panels. The survey instrument is appended. Survey respondents included three attorneys who do primarily plaintiffs' work, one attorney who does 60% defense and 40% plaintiff work (hereafter, defense/plaintiff attorney), two attorneys who do only defense work, the panel chairman who has been involved in 119 cases and presided over 20 panel hearings, and a claim manager for St. Paul Fire and Marine Insurance Company. Those interviewed were from Rumford, Augusta, Bangor, Lewiston and Portland. Of the attorney interviewed, over 50% of their practice consists of medical malpractice. The attorneys could not specify a typical type of medical malpractice that they handle. All considered medical malpractice cases to be different and could not generalize about a particular type of case. The number of cases the attorneys have had go to the panels ranges from 4 to 12. The claim manager has had 30 cases go to the panels and the panel chairman has received 119 notices of claims and presided over 20 panel hearings.

Findings: Case Trends:

When asked about trends in the medical malpractice caseload compared to other personal injury cases, there was agreement among all four defense attorneys that the trend in their caseload suggests that the number of medical malpractice claims is decreasing while the severity of these claims is increasing. The experience of the claim manager was in agreement with the defense attorneys that the number of medical malpractice cases is decreasing, following the national trend, while the cases are becoming more complex and the damages more significant. The experience of the plaintiff attorneys, however, was that there was no particular trend in the number of claims and severity of these claims over the last five years.

Suit Motivation:

The plaintiff attorneys had differing views as to what motivate clients they represent to sue physicians and other health care providers. For one attorney, it was purely compensation for injury, simply to pay the hospital and medical bill. For another, compensation is a motivation in a low percentage of his cases. In his experience, medical expenses are usually covered by Medicaid or some other means. The motivation in most cases was "quality of care." He explained that the mother of a child who is completely incapable of caring for him/herself as a result of malpractice is a slave to that child for the rest of the child's life. In that type of case the mother is suing for more than just reimbursement for expenses. The third plaintiff attorney interviewed considered the motivation to sue a combination of compensation for extreme injury and a response to either a doctor's poor bedside manner or to a subsequent doctor's declaration that the former doctor caused them serious injury and pain. He felt that there are a number of motivations in many cases and added that many people want to help prevent what happened to them or their families from happening to others.

Plaintiff attorney generally spend an average of six months reviewing a medical malpractice case to determine its viability. Hospital records must be obtained, and at least one expert witness from out of state must be hired to review the case. Before a notice of claim may be filed, two determinations must be made. First, did the defendant breach an accepted standard of care and did this breach cause injury? Second, given the considerable time and expense involved in the process of litigation, are the expected damages from a case going to be high enough to justify the cost of a suit?

Case Disposition:

As a result of case review, many cases are dismissed as non-meritorious or cost inefficient. One attorney conducted an informal survey within his law firm and concluded that out of 20 possible medical malpractice cases, only three cases are accepted for review based on an initial interview with potential clients, and only one case out of those three results in the filing of a notice of claim. Another attorney, who has a rural practice in Rumford, turns down 90% of clients who come to him to sue for medical malpractice injury. He confirms what the other plaintiff attorneys have experienced-- that given the costs of litigation, the damages must be very high for the case to be pursued in this manner.

Impact of Pretrial Litigation Panels:

The plaintiff attorneys agreed that the pretrial screening panels have had an effect on their decisions to accept certain types of medical malpractice cases. The time and expense of a medical malpractice case has doubled because the attorneys must now prepare and try the case twice, once before the panel,

and once before the jury. A result is that damages must be even higher in order for a case to be economically viable and some cases that were economically viable before the screening panels were instituted are no longer.

One attorney who does 40% plaintiff work claims that he does not take the screening panels seriously and considers an adverse decision by the panel irrelevant. He does not hire an expert witness nor engage in complete discovery and preparation for the panel hearings. He feels that if he has a good case showing clear negligence and significant damages he will win at trial despite an adverse panel decision. The other plaintiff attorneys are concerned about the effect of a 3-0 panel decision against a plaintiff and thus, they fully prepare for the panel hearing. Justice McCarthy noted that most of the attorneys take the attitude that they must do whatever they can to win before the panel. He agreed, however, that if the plaintiff has a good case, a 3-0 panel decision could be explained to a jury and would not affect the trial. To date, there has not been an adverse 3-0 panel decision that has gone to trial so it is unknown what effect this type of decision will really have when admitted into evidence.

The defense attorneys believe that the screening panels have reduced the time and expense that they must put into their cases by reducing the overall number of claims, weeding out the non-meritorious claims, and encouraging early settlement. The result, they maintain, are lower fees.

The plaintiff attorneys vehemently disagreed that the screening panels have reduced the time and expense of their cases. They feel they do their own weeding out of non-meritorious cases and thus, they consider the panels to be superfluous. They point out that Rule 11 of the Maine Rules of Civil procedure, as well as the Rules of Professional Responsibility, prohibit the filing of a claim that is frivolous. The plaintiff attorneys bypass the screening panels in every case if possible because it saves them time and money. (If both parties agree they may bypass the panels). In addition, all the attorneys remarked that most of the panel decisions were in favor of the defense (3-0 or 2-1). They explained that the doctors who are on the panels are usually from the same geographical area as the defendant doctor and are almost always reluctant to rule against a fellow doctor.

There was agreement among all the attorneys interviewed that the screening panels generally help to encourage settlement. It is easier to convince a plaintiff to settle a case if the screening panel decision is adverse. Some noted, however, the reverse is sometimes true-- that when there is a 3-0 decision, the winning side becomes adamant against settling because they are convinced they have a good case.

All the attorneys interviewed are concerned about the extent of discovery being conducted to prepare for the screening panel hearings. The plaintiff attorneys believe that the defense

bar generally tries to "spend the plaintiff dry" and that unlimited discovery before the screening panel is excessive, time consuming, expensive, and must be duplicated at the trial stage. In their view, many attorneys turn the panel hearing into a minor trial which can take three to four days to complete.

Panel Chairman Justice McCarthy has developed a system to counter excessive discovery. Plaintiff and defense parties decide in advance what method of discovery they will follow. They may agree to limited discovery according to Rule 26(b)4 of the Maine Rules of Civil Procedure or they can conduct full discovery. However, if they choose to conduct full discovery they must agree that it will be used at trial so that the discovery will not be duplicated.

The excessive duration of the screening panel sessions is another issue Justice McCarthy faces. He is concerned that it is going to become increasingly difficult to attract lawyers, doctors and other health care deliverers to sit on the panels if the hearings last three to four days. He advocates the use of prepared reports as opposed to live testimony.

Summary:

The plaintiff attorneys felt there was little to gain from the screening panels. They will always waive the screening panel trial if the defense agrees. All of the others interviewed except one defense attorney were reserving judgment on the panels until more time has gone by. Nevertheless, they did think that the panels were weeding out some frivolous claims and encouraging early settlement in certain cases. Judge McCarthy agreed that not enough time has passed and at least eight months should be allowed before the panels can be evaluated in a meaningful way. He considers a value of the panels to be their ability to have a case dismissed against at least some of the defendants. He explains that in most medical malpractice cases the plaintiff sues four to five people or organizations. He believes the screening panels help to acquit two to three people from the lawsuit before it goes to trial. He also believes the panels help to narrow the issues for a subsequent trial.