

NEW MEXICO HEALTH POLICY COMMISSION



CHILDBIRTH INJURY AND OBSTETRICAL LIABILITY INSURANCE

PRINTED OCTOBER 2007

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EXECUTIVE SUMMARY

The New Mexico Health Policy Commission (HPC) was appropriated \$30,000 during the 2006 Legislative Session and \$20,000 during the 2007 session in order to “examine alternatives for resolving problems related to reducing the injuries suffered in the course of childbirth and the cost and availability of malpractice insurance for childbirth health care professionals and institutions.” The HPC assembled a task force including an obstetrician from the University of New Mexico (UNM) School of Medicine and president of New Mexico American College of Obstetrics and Gynecology, certified nurse midwives from the UNM School of Nursing, a community-based licensed midwife, an attorney from the UNM Law School’s Institute of Public Law and staff from the Insurance Division of the Public Regulation Commission.

The cost of malpractice insurance for medical providers continues to escalate in New Mexico and across the nation. The cost escalation threatens access to childbirth services for some New Mexico residents as costs of insurance threaten the financial viability of obstetrical providers, especially nurse midwives. The information collected by the task force indicated that this is an issue throughout the entire state, but has especially impacted rural obstetrical providers leaving fewer care options available to many New Mexicans.

This task force, which has been active since June 2006, has conducted written surveys; talked with New Mexico providers, reviewed prior analyses, studies, and literature, and consulted with experts in the fields of patient safety, professional liability insurance, and compensation reform. The workforce delivering babies outside of the governmental and corporate healthcare umbrella is thinly spread and strained to maintain services by continued increases in costs of malpractice insurance, particularly among certified nurse midwives. The task force’s next step is to build dialog to establish the extent to which this same set of problems is impacting large governmental and corporate organizations and if a common set of administrative solutions across sectors of the market can be developed.

Below are the task force recommendations:

Task force Recommendations-

- 1) **Establish a reinsurance program similar to that of Oregon for subsidizing medical professional liability costs to obstetricians, family physicians, nurse-midwives and licensed midwives who do births and provide substantial publicly funded and uncompensated care in their practices.** The goal of such legislation would be to maintain and improve statewide access to obstetrical health care by reducing the out of pocket medical malpractice premium costs thereby stabilizing, and ideally increasing, the numbers of such obstetrical medical professionals throughout New Mexico.
- 2) **Develop an administrative compensation system for patients incurring an injury in the course of childbirth.**

- 3) **Create or aid the establishment of a New Mexico Patient Safety Organization**, pursuant to the federal Patient Safety and Quality Improvement Act of 2005, upon finalization of federal rules for the Patient Safety Organization Program.

INTRODUCTION

The New Mexico Health Policy Commission (HPC) was appropriated \$30,000 during the 2006 Legislative Session and \$20,000 during the 2007 session to “examine alternatives for resolving problems related to reducing the injuries suffered in the course of childbirth and the cost and availability of malpractice insurance for childbirth health care professionals and institutions.”

As a result of this 2006 appropriation, a planning group was formed by the Health Policy Commission to look more closely at some of those options and to obtain further information. The goals of the task force were to: develop policy options for the legislature in the realm of obstetrical liability to minimize birth injury; provide a compensation strategy and system to individuals injured during childbirth; and ameliorate the escalating cost of professional liability insurance for New Mexico’s obstetrical professionals. The task force looked at existing models of insurance and patient safety with the ultimate objective being to propose legislative remedies to a developing problem in New Mexico, particularly with certified nurse midwives who are increasingly unable to procure professional liability insurance at affordable rates.

The 2005 Senate Memorial 7 (SM7) provided some recommendations to the New Mexico legislature about resolving issues associated with the provision of liability insurance for obstetrical professionals including the formulation of a joint underwriting association (JUA) open to all health care providers. Details of how the JUA could work were not agreed upon by individuals working on this memorial and other options that were also reviewed.

Background

The cost of malpractice insurance for medical providers continues to escalate in New Mexico and across the nation. The cost escalation threatens access to childbirth services for some New Mexico residents as costs of insurance threaten the financial viability of obstetrical providers, especially nurse midwives. The information collected by the task force indicated that this was an issue throughout the entire state, but has especially impacted rural obstetrical providers leaving fewer care options available to many New Mexicans. New Mexico already is a health professional shortage area state (every county except one has a federal shortage designation for medical professionals). The state’s continued ranking of last in the nation when measuring access to prenatal care in the first trimester and the absence of any intervention may leave the citizens with poorer access in the future. The trends portend one that could easily develop into an access crisis at a time in which policy makers are attempting to remove other access barriers via universal health insurance coverage. Losing ten to twenty percent of the obstetrical providers in the state would constitute an access crisis.

The task force reviewed survey and anecdotal data which indicates a significantly worsen financial position for many obstetrical providers in the state primarily due to increasing professional liability premiums. The data also showed that New Mexico’s birth morbidity and mortality rates are below that of the nation and that the outcomes of care delivery are largely positive compared with the nation.

New Mexico also has the highest rate of midwife use in the nation with thirty percent of births attributed to midwives being the care giver. Certified nurse midwives professional liability insurance is available in New Mexico, but primarily from one company, whose rates are unregulated, and at a cost that is rapidly increasing. The vulnerability of the providers to having a very limited number of insurers complicates this issue.

The task force examined existing models of insurance and patient safety including some in other states. The ultimate objective is to propose legislative remedies to a developing problem in New Mexico, particularly with nurse midwives who are increasingly unable to procure professional liability insurance at affordable rates. While the medical malpractice insurance debate usually focuses on the impact to providers, the impact on patients is equally important. These impacts include inter-related limitations of the current system to improve patient safety, increased healthcare costs due to defensive medicine and to malpractice claims, and limited access to health care providers.

Findings on Medical Malpractice Insurance

The task force has found the following regarding the cost and availability of professional liability coverage for providers of obstetrical services in New Mexico:

- Problems with the cost and availability of medical malpractice insurance are experienced primarily by those certified nurse midwives (CNM) who do births and are not employees of large systems.
- Obstetrician practices that employ CNMs confirmed to commission study members that the cost of CNM malpractice insurance to the practice has increased substantially and may threaten the practices ability to maintain them as employees.
- Professional liability insurance is unavailable to licensed midwives who provided care for most of the 1% of New Mexico births that occur in the home. Those providers who perform home births do so at their own legal and financial risk.
- For licensed midwives (LMs) who work in birthing centers, professional liability insurance is available from only one company, whose rates are unregulated, and at a cost that is rapidly increasing and threatens the ability of LMs to stay in business.
- For CNMs in private practice or in small clinics, professional liability insurance is available primarily from one company, whose rates are unregulated, and at a cost that is rapidly increasing and threatens the continued economic viability of CNMs.
- Professional liability insurance remains available in New Mexico, at a substantial though relatively stable cost, for most independent Ob-Gyns and family doctors who perform deliveries.
- The proportion of malpractice insurance premiums (in dollars) written by carriers on surplus lines increased from 15.0% in 2002 to 36.0% in 2006 for providers other than physicians and surgeons in New Mexico. These carriers are not subject to regulation under New Mexico insurance laws (see appendix A).
- Data is not available to the commission task force concerning the extent to which cost of obstetrical malpractice insurance, settlements and suits has influenced business costs for large governmental and corporate organizations.

Findings on Childbirth Safety

The task force has found the following regarding the safety of childbirth in New Mexico:

- Childbirth is safer for both the child and the mother in New Mexico than in the nation as a whole based on public health data. This may be attributable to New Mexico's lower rates of cesarean deliveries and instrument-assisted vaginal deliveries.¹
- New Mexico is exposed to the same safety concerns posed nationally by the trend of older women giving birth, of a growth in obesity and other chronic health problems among pregnant women, and the growth in multiple births caused by the increased use of fertility drugs.²
- Hospital discharge data routinely collected in New Mexico is not sufficient to draw inferences with confidence related to injury in the course of childbirth. New Mexico has not been a participant in a sample of states providing hospital data on pediatric injury to the federal Agency for Healthcare Research and Quality (AHRQ). AHRQ finds a very wide variation in birth injury rates across states.
- New Mexico has the highest rate of midwife usage in the nation, with midwives tending to service the more rural and poor parts of the state. Certified nurse midwives work with physicians in New Mexico communities to provide round the clock access to birthing services and emergent medical and surgical care as needed.³
- Safety of childbirth in New Mexico is threatened by a very limited supply of providers who do births in many New Mexico communities.

Findings on the Tort Based Malpractice Approach and Obstetrics

The task force has found the following regarding the tort based malpractice approach and obstetrics in New Mexico:

- The vast majority of medical injuries in the country as well as the vast majority of medical malpractice claims in New Mexico are not compensated or remedied through the tort system.
- The current tort system is slow, expensive, and tends to pursue those medical malpractice cases with a high potential for a large dollar verdict.
- Poor birth outcomes are rare, but have potential for the highest dollar verdicts. This factor keeps obstetrical malpractice insurance rates rising.
- Malpractice claim proceeds are the only current means to compensate birth injury. Despite preponderance of scientific evidence that many poor birth outcomes relate to prenatal factors or to life-saving actions in emergencies, suits, settlements and verdicts are involved when there is an imperfect newborn.

- The negligence-based malpractice approach encourages wasteful “defensive” care practices and discourages proactive reporting of shortcomings that could contribute to services improvement.
- Florida and Virginia have had successful administrative ‘no-fault’ systems for a small subset of childbirth outcomes in place. The systems encompass a very narrowly defined set of severe birth injuries and have had voluntary participation by providers. They have been difficult to evaluate because of the very narrow “carve out” and the potential for “cross-over” between administrative and tort remedies (see external consultant information in appendix B).

RESEARCH

The New Mexico Health Policy Commission (HPC) was appropriated \$30,000 during the 2006 Legislative Session and \$20,000 during the 2007 session to fund a study to examine alternatives for resolving problems related to reducing the injuries suffered in the course of childbirth and the cost and availability of professional liability insurance for obstetrical providers and institutions.

The 2005 Senate Memorial 7 provided some recommendations to the New Mexico legislature about resolving issues associated with the provision of liability insurance for obstetrical professionals including increasing Medicaid reimbursement for obstetrical providers, and the formulation of a joint underwriting association (JUA) open to all health care providers. Details of how the JUA could work were not agreed upon by individuals working on this memorial and other options that were also reviewed. The group working on SM7 ran out of time to explore those options further (see appendix C for findings of SM7).

As a result of this 2006 appropriation, a planning group was formed by the Health Policy Commission to look more closely at some of those options and to obtain further information. The goals of the task force were to: develop policy options for the legislature in the realm of obstetrical liability to minimize birth injury; provide a compensation strategy and system to individuals injured during childbirth; and ameliorate the escalating cost of professional liability insurance for New Mexico’s obstetrical professionals. The task force looked at existing models of insurance and patient safety, particularly with certified nurse midwives who are increasingly unable to procure professional liability insurance at affordable rates, and with the ultimate objective being to propose legislative remedies to a developing problem in New Mexico. While the medical malpractice insurance debate usually focuses on the impact to providers, the impact on patients is equally important. These impacts include failures of the current system in improving patient safety, increased healthcare costs due to defensive medicine and to malpractice claims, and lack of access to health care providers in impacted specialties.

The initial 2006 planning group consisted of representatives from the University of New Mexico School Of Nursing with two certified nurse midwife faculty members, staff from the Division of Insurance of the Public Regulation Commission, and staff from the Health Policy Commission. The planning group was quickly expanded into a larger task force to include UNM School of Medicine obstetricians, an attorney from the Institute of

Public Law of the UNM Law School, a licensed midwife in private practice, a certified nurse midwife and a physician working for the Department of Health, and a physician and attorney both of whom are in private practice, and a lobbyist/advocate. This task force and the planning group have met thirteen times since its initial June 2006 organizational meeting.

The initial activities of the task force consisted of compiling New Mexico specific data about the number of births, quantifying the number of obstetrical providers (ob-gyns, midwives, and family physicians doing obstetrics), the extent of injury during childbirth in New Mexico, and analyzing the professional liability coverage situation of midwives and obstetricians. An extensive literature review was performed and a “mini-library” was developed that could be electronically accessed by all members of the task force. The task force also initiated contracts with UNM Institute of Public Law for legal review of anti-donation clause issues associated with any state financial support that might be required on an initial and/or ongoing basis to develop a re-insurance proposal, and an alternative compensation system, and also with the UNM Center for Development and Disability to update midwife insurance information availability.

Number of Births, Providers, and their Distribution in 2004

The chart below provides a profile of 27,797 births in New Mexico in 2004. It shows that ninety-nine percent of New Mexico births occurred in a hospital, 43% of New Mexico births took place in Bernalillo County, and most of the Ob-Gyns, Certified Nurse Midwives (CNM), and Licensed Midwives (LM) were located in the more populated counties. Also, the more rural the county, the higher the probability that the birth occurred outside of a hospital.

Medical doctors attended 68.5% and certified nurse midwives attended 29.1% of all 2004 births that occurred in New Mexico. For the last 20 years the proportion of births attended by medical doctors has decreased, from 81.0% in 1995 to 68.5% in 2004. Correspondingly, certified nurse midwives have attended births increasingly since 1995, with CNMs in attendance for 17.3% of births in 1995 compared to 29.1% in 2004. Of note for 2004 was 17.5% of the births were in New Mexico counties outside the mother’s county of residence and 4.1% were born out of state.

Table 1: Volume, Place of Birth and Provider Distribution by New Mexico County in 2004.

County in which birth took place	# births in 2004	# hospitals in 2004	Providers				Birthplace			
			OB-Gyn	CNM	FPD**	LM	Hospital	Out of Hospital		
								Total Home & Birth Center	Home	Birth Center
Counties with > 1000 births/year										
Bernalillo	12,082	4	89	74		14	11,980	102	92	10
Dona Ana	2,767	2	11	15		6	2,748	19	18	1
San Juan	2,063	*2	9	3		1	2,940	23	10	13
Santa Fe	1,795	*2	14	7		8	1,764	31	31	
McKinley	1,464	*4	8	8			1,461	3	3	
Chaves	1,063	1	8	4			1,041	22	1	21
Curry	1,347	1	3	2			1,344	3	2	1
Totals	22,581	16	142	113		29	22,378	203	157	46
Counties with 100-999 births/year										
Cibola	220	1		1			220			
Colfax	133	1	1				133			
Eddy	603	2	1	1		1	603			
Grant	468	1	4	1		1	457	11	11	
Lea (1 CAH)	870	2	4				864	6	6	
Lincoln (CAH)	304	1	3				304			
Los Alamos	333	1	2	1			331	2	2	
Luna	284	1		2			283	1	1	
Otero	709	*2	2	6			706	3	3	
Rio Arriba	308	1	2	2		2	301	7	7	
San Miguel	344	1	3	2			339	5	5	
Socorro (CAH)	184	1		1			182	2	2	
Taos	335	1	3	1		10	314	66	21	45
Totals	5,095	16	25	28		14	4,992	103	58	45
Counties with 1 – 99 births										
Hidalgo	2						1	1	1	
Quay	54	1					54			
Roosevelt	4	1					3	1	1	
Sandoval	6			1		1	0	6	5	1
Sierra (CAH)	8	1	1			3	7	1	1	
Torrence	3						0	3	3	
Union (CAH)	35	1					35	0	0	
Valencia	9						1	8	8	
Totals	121	4	1	1		4	101	20	19	1
NEW MEXICO TOTALS	27,797	36	168	142		47	27,471	326	234	92

Data on birth numbers is from *New Mexico Selected Health Statistics Annual Report 2004* from DOH. Data on CNM and LM location from declared location of practice at time of state licensure in 2005-06. Data on Ob-Gyn from New Mexico ACOG (American College of Obstetrics and Gynecology) practicing physicians & practicing fellows.

The physician data reflects those in practice, but not necessarily practicing obstetrics (e.g. Sandoval County).

(CAH) denotes Critical Access Hospital

* denotes one or more of the county's hospitals are Indian Health Service

** Some FPD (family practice doctors) provide maternity services in the state.

The geographic distribution of these providers is not known at this time.

There were no births recorded in Catron, DeBaca, Guadalupe, Harding, or Mora Counties in 2004.

Extent of Injury during Childbirth

Birth trauma is injury sustained during the process of labor and delivery. Some injury is avoidable, but many can also occur despite the most highly skilled and technologically available care. It is not unusual for there to be an infant who is injured as a result of some obstetrical manipulation with the most common injury being fractures of long bones or clavicle, lacerations, and traumas to the head and/or face.

The task force asked for a compilation of the data related to birth trauma during childbirth for New Mexico births. A review of the Health Policy Commission's Hospital Inpatient Discharge Database (HIDD) was conducted to see if there were any particular patterns of frequency and severity of errors during childbirth. The discharge data was examined and the task force concluded that discharge data using diagnosis codes does not provide sufficient detail to draw inferences with confidence about birth injuries in New Mexico. No such injury patterns were identified in the HIDD, perhaps because the use of the discharge data has inherent problems of coding accuracy, coding variation, and variation of discharge diagnosis between facilities making the identification of those patterns very difficult.

DOH information indicates that in 2004, 78.4% of all New Mexico births were by vaginal delivery and 21.6% percent were by cesarean. This rate compares favorably to the national cesarean delivery rate of 29.1% because operative delivery is a major source of both maternal and newborn morbidity. In New Mexico in 2004, 1.5% of all vaginal births were to women who had prior surgical cesarean delivery (VBAC or vaginal birth after c-section delivery).

Injury during childbirth to both women and infants is associated with rates of instrument and surgical delivery. New Mexico is fortunate to have lower rates of both cesarean and instrument-assisted vaginal delivery than rates across the nation as these are both associated with newborn trauma. In 2004 New Mexico's cesarean birth rate was almost one third lower than the national average and the instrument-assisted vaginal delivery rate was around 5.5% as contrasted with a national rate of 7.6%.

Infant death rates attributable to birth trauma and/or events in the perinatal period are lower in New Mexico than in the overall United States. The birth trauma mortality rate per 10,000 births reported in 2002 was 8.6 for the nation and 0.0 for New Mexico. The death rate per 10,000 births from intrauterine and birth asphyxia was 7.2 in New Mexico compared with 13.6 for the U.S. The death rate in 2003 per 10,000 births from maternal factors and complications of labor and delivery was 61.2 in New Mexico compared with 77.4 in the U.S. ⁴

While the state's overall delivery of obstetrical services is good when contrasted to other states, there still remains opportunity for improvement. However, this issue is being significantly overshadowed by the access issues which are beginning to develop as a result of the increasing cost of professional liability insurance.

Mini-Library

The task force had made available to its members a collection of journal articles that had been reviewed for the conduct of the Task force. The articles dealt with professional liability insurance and patient safety issues. The sixteen article collection was found at <http://ereserves.unm.edu/eres/courseindex.aspx?page=search> and consisted of background information, alternative compensation events articles, state liability reform articles, quality improvement articles, and childbearing specific articles. The articles placed in the electronic library were scaled down from a very large list of approximately one hundred articles researched for the task force.

Certified Nurse Midwives Survey

The task force asked that the HPC survey all of the certified nurse midwives in the state about their practice organization's handling of professional liability insurance and their own issues as of the survey date with the cost and availability of professional liability insurance. All licensed certified nurse midwives in the state were mail surveyed during the summer and fall of 2006 with follow up phone calls made.

A total of 119 surveys were completed and returned to the HPC for an overall response rate of 71%. The twenty-two questions used in the survey were designed by members of the task force. Of the 119 respondents, 105 participated in active full time or part time clinical practice with 80% of those in practice doing deliveries. Ninety-one percent of respondents did have professional liability insurance.

The data reflect practice arrangements for providers in New Mexico's health workforce. The majority of respondents were employees of physician or corporation-owned practices, health systems or the state. For these individuals, coverage was paid by a third party. In most cases, the employee midwife reported no knowledge of the premium. It was difficult to segment a specific midwife or group of midwives from an employer's master policy since the increases in the master policy do not break out midwives specifically.

Thirty-eight survey respondents reported purchasing individual policies. Thirty-two of those did deliveries. Table 2 presents data from this subgroup of certified nurse midwives on most recent premium, most recent premium increase and knowledge of future increases. There is a wide range of both premiums and increases, however the average median increases were 20% of the most recent median premium and the projected median increase is 25% of median premium. Within this subgroup of certified nurse midwives who are bearing the largest burden of malpractice rate increases, two thirds reported in the same survey that 75% or more of their patients were from rural communities. *Certified nurse-midwives in the first three years of practice have paid a minimal premium of \$5,000. This was not known at the time of the survey and it could not be captured (see appendix D).*

Table 2. Summer 2006 Recent Insurance Premiums and Increases for New Mexico Certified Nurse-Midwives Delivering Babies with Individually-Purchased Policies (n = 32)

	Most recent Premium	Most Recent Premium Increase	Next Premium Increase
# Responses	20	20	18 9: Do not know
Range:	\$2,870 – 61,197	0 - \$14,000	\$2,100 – 18, 797
Mean	\$16,566	\$3,379	\$7070
Median	\$15, 810	\$3,000	\$4000

Of the 67 respondents without individual policies, 88% report no significant changes or restrictions placed on their practice due to insurance or liability concerns of the organization, employer, or insurance carrier.

When asked “In what ways are malpractice premium increases influencing your future plans? (of 105 in practice), 42 or 40.00% noted that “Increased premiums have not affected me;” 11, or 10.48%, said they will pay the increase in premiums for the foreseeable future; 8, or 7.62%, said they will pay the premium increase this year but will not be able to sustain their practice if the rate increases again; 7, or 6.67%, noted that increased premiums are a big part of the reason that the midwife changed practice sites within the past two years; and 2, or 1.90%, said that increased premiums are a big part of the reason that the midwife was looking to relocate outside of New Mexico.

As background, ACNM (American College of Nurse Midwives) Insurance Services provided many midwives in New Mexico with professional liability insurance through mid-2004. After that date, The Insurance Division of the Public Regulation Commission has noted that the primary insurer became Contemporary Insurance Services with quadrupling of rates in 2006 at \$17,500 annually compared to \$4,200 in 2001 for many midwives.

National and New Mexico Medical Malpractice Insurance Environment

To be qualified under the New Mexico Medical Malpractice Act, health care providers must either obtain coverage from an insurer on an “occurrence” policy form or else maintain a substantial cash deposit with the Superintendent of Insurance. “Claims-made” policies cover incidents that are reported during the year the policy is in effect, while “occurrence” policies cover incidents that occur during the year the policy is in effect even if those occurrences are not reported until years later. As such, occurrence policies de facto would require the procurement of an expensive “tail policy” to cover claims made after the expiration of a policy. The benefit received from tail coverage is that it extends coverage for claims that are first made after termination of a policy.

In addition to their base coverage premium payments, qualifying health care providers must also pay an annual surcharge to the Patient Compensation Fund.

The list of health care providers that are eligible to be covered under the Act includes physicians, chiropractors, podiatrists, nurse anesthetists, physicians' assistants, hospitals and outpatient health care facilities. Any health care practitioners or facilities not on this list, such as midwives, nurse practitioners, dentists and nursing homes, are excluded from coverage under the Act.

The New Mexico Medical Malpractice Act also requires participating insurance companies to issue occurrence type policies with limits of \$200,000 per claim. In addition to the policy premium, these insurers collect a surcharge (determined by the state) from each policyholder. The surcharge amount is then submitted to the Department of Insurance and placed in the Patient Compensation Fund. These funds are used to pay judgments or settlements in excess of the \$200,000 per claim limit. Payments from the Patient Compensation Fund are subject to the specific terms of the Act, which includes a damage cap of \$600,000 plus past and future medical expenses.

Nationally, increasing medical liability insurance premiums and the fear of lawsuits continue to force ob-gyns to change how they practice medicine, according to a November, 2006 medical liability survey conducted by The American College of Obstetricians and Gynecologists (ACOG). According to the ACOG survey, 70% of ob-gyns have made changes to their practice because of the lack of available or affordable medical liability insurance, and 65% have made changes because of the risk or fear of liability claims or litigation. Between 7-8% have stopped practicing obstetrics altogether because of either insurance affordability or availability issues or the risk or fear of being sued.⁵

With many of the state's ob-gyns employed by large multi-specialty or large single specialty groups, a survey done of the ob-gyns would have likely resulted in similar results regarding a lack of knowledge about premiums and premium increases. However, those ob-gyns that have individual policies that are paid by the physician would show premiums that now cost over \$89,000 annually if purchased through American Physicians Assurance Corporation (APA), by far the largest insurer of physicians in New Mexico. These premiums have increased from almost 120% from the \$41,000 paid in 2001. Another carrier that provides physician professional liability insurance in New Mexico, the Medical Protective Company, writes ob-gyn policies that cost \$121,000 annually up from \$65,000 in 2002.⁶

Like midwives, individual physicians or small groups of physicians can be more readily found in the rural parts of the state, but especially in smaller communities. Rural communities may be at a greater risk of losing providers and have less access to services as a result of issues dealing with the cost of insurance.

External Consultant

The task force identified early on a need to access expertise on alternatives to tort based malpractice. The task force employed an external consultant who has written evaluations of the state-based experiments in Virginia and Florida and proposes an important link between patient safety, and liability insurance reform. This consultant had presented on Accelerated Compensation Events to SM7 committee on malpractice problems in 2005. Randall R. Bovbjerg, J.D. is a health policy analyst with the Urban

Institute in Washington, D.C. Mr. Bovbjerg was assisted by Dr. David Shapiro, a physician in California that has worked closely over the years on professional liability and patient safety topics.

The HPC obtained the services of Mr. Bovbjerg and Dr. Shapiro to provide the task force with two extensive multi-hour consulting sessions. Those sessions were recorded and can be found on the HPC's web site at <http://www.hpc.state.nm.us/meetings/default.htm>. Additional phone discussions without the entire task force took place at an on-site meeting in Washington, DC with a member of the task force.

Key lessons learned in these consultation sessions include:

- The state experiments in Florida and Virginia were so small in scope with the ability to cross into the legal system that they are difficult to evaluate in relation to their benefits. The Virginia system did seem to cause insurance premiums for obstetrical providers to plateau.
- An administrative system of compensation is a substantial structural change. The decision to make such a shift depends upon the state's interest in increasing equity in compensation as a public good as well as focusing resources within the health system for reform to improve patient safety as contrasted to the legal system for litigation costs.
- The timing consideration of an administrative compensation system is appropriate as publicly-supported universal access is considered.
- The majority of costs of jury verdicts relate to the costs of providing health care and health services, the extent to which these services are currently provided by Medicaid and other public funds will impact the costs of implementing a system.
- Constitutionality of administrative compensation systems should be investigated.

Additional information on these sessions is noted in the appendix B.

Oregon Re-Insurance Model

The task force examined the Oregon model of re-insurance. The Rural Medical Professional Liability Reinsurance Program was created by the Oregon Legislature in 2003 (HB 3630) to provide state-funded subsidies of physician malpractice premiums for rural physicians. The legislation was the result of concerns about the significant increase in professional liability insurance premiums and the effects of rate increase on the availability of medical care in rural Oregon.

The Oregon program is managed by the State's Accident Insurance Corporation, which is reimbursed for the costs of the program through a credit against workers compensation premium assessment. Currently, all licensed rural physicians qualify for the program, although the level of premium reduction varies by the type of practice. Higher subsidies are provided to obstetricians and family practitioners whose practices

include obstetrics. 1,168 physicians have been reimbursed for portions of their medical professional liability insurance premiums since the program began. Over half of these recipients have been in primary care fields. The total program cost was originally set at \$40 million and it is estimated that \$21-\$22 million has been expended for the program since its inception.

In 2007, the Oregon legislature (SB183) extended the reinsurance program for medical professional liability insurance policies through 2011. In doing so, it now allows nurse practitioners and other obstetrical providers to qualify for the program. It requires physicians who receive the subsidy to serve a representative percentage of Medicaid and Medicare patients. Both HB3630 and SB183 are included in appendix E.

The new law also determined how funds will be distributed if available program funds do not cover maximum allowed reimbursement as well as limiting the maximum reimbursement levels to percentage of actual premium or premium paid by practitioner in 2007, not counting any step increase due to claims. It also sets reimbursement levels for all covered health care providers.

The Anti-Donation clause of the state's constitution (Article 9, Section 14) may preclude such a program being considered in New Mexico. However, the Oregon issues are similar in nature to New Mexico with both states having one large metropolitan area and much of the rest of the state being largely rural and having limited access to healthcare services.

New Mexico has for years ranked 50th in the nation in maternal access to pre-natal care during the first trimester. The state had that ranking again in 2006. See <http://www.unitedhealthfoundation.org/ahr2006/states/NewMexico.html> Much of this pre-natal access issue deals with the low income of many of New Mexico's pregnant women and subsequent lower reimbursement for their care facing obstetrical providers either via Medicaid or no insurance compared to reimbursement from commercial payers.

Given the significant rural population in New Mexico and the high rates of both rural and urban poverty, reinsurance efforts designed to increase, improve and ensure access to pre- and post- pregnancy-related healthcare for those populations is a goal that might fit within the Anti-Donation Clause's exception of the State providing for the care and maintenance of the sick and indigent.

Using the state of Oregon's legislation as a model, the state of New Mexico might establish a reinsurance program for medical professional liability policies issued by authorized carriers to obstetricians, nurse-midwives and midwives. The goal of the legislation would be to improve access to such health care state-wide by reducing the cost of medical malpractice premiums thereby stabilizing, and ideally increasing, the numbers of such medical professionals throughout New Mexico.

Recognizing the important limitations set forth in the Anti-Donation Clause of the New Mexico State Constitution, participating medical professionals must be willing to serve patients with Medicare coverage and patients receiving medical assistance through Medicaid on an unrestricted basis. Such a requirement from the medical professionals

participating in the reinsurance program may fit within the Anti-Donation Clause's allowance of the expenditure of public funds for the provision of care and maintenance of sick and indigent persons.

The Anti-Donation Clause of the New Mexico State Constitution sets forth important limitations on the ways in which government can directly or indirectly lend, pledge its credit or make a donation to or aid any private enterprise. However, the Anti-Donation Clause does not prohibit governments from making provisions for the care and maintenance of the sick and indigent. So as not to be in violation of the Anti-Donation Clause, the reinsurance program for obstetricians, nurse-midwives and midwives could require those medical professionals participating in the program be willing to serve patients with Medicare coverage and patients receiving medical assistance through Medicaid on an unrestricted basis.

A Medical Review Commission, similar to that provided for in the state's Medical Malpractice Act, Section 41-5-14, could be created to review all malpractice claims against health care providers participating in the insurance reinsurance reimbursement program.

A Schedule of Injuries and corresponding amounts of recovery might be fashioned similar to that found within the state's Workers' Compensation Act, Sections 52-1-1 to 52-10-1, as a means of administratively maintaining control over costs associated with recovery.

The Oregon model may be the best short term relief for many of New Mexico's obstetrical providers if the Anti-Donation clause is not a barrier.

No Fault Compensation Events

The task force and consultants discussed the shortcomings of the tort liability system. Some of those discussion highlights are that as a dispute resolution process and as medical quality and injury-prevention "system," the process/system needs improvement. The major shortcoming is that the tort system is designed for dispute resolution, not injury prevention. It omits some injuries that might be compensated and to some degree assigns responsibility on an inconsistent basis depending upon which jury and/or attorneys are involved. The system is slow and expensive to obtain results and as such makes it hard to predict much less insure. The tort system can be punitive and deterrent in nature, but also promotes wastefulness in the use of resources via "cover yourself" defensive medicine practices. Whatever its merits, the system has a track record of lots of preventable injury, and periodic crises in liability financing which is where New Mexicans are today.

Insurance may be available and not at a crisis stage for **all** providers, but is becoming less affordable to many which leads to more access issues in the future if providers are not available to procure insurance or willing to provide services because of lack of insurability.

Patients with very little evidence to demonstrate a physician's or midwife's negligence may be entitled to a large amount of compensation. To prevail, the patient need only

show that the provider deviated from the medically adopted standard of care. The problem today is that, depending on the expert witnesses used and the particular specialty being reviewed, there is a potential to view any provider's conduct as a deviation. However, when a patient does decide to go into the litigation system, only a small number recover anything.

The latest information from the New Mexico Medical Review Commission shows that "medical malpractice claims are some of the most complex and time-consuming cases that are filed in court." The New Mexico Medical Review Commission, whose authority derives from the Medical Malpractice Act, provides panels of volunteers from the medical and law professions who review all malpractice cases against health care providers covered under the Act before the cases can proceed to court.

Of the over 4,033 malpractice cases brought before the panels over the last thirty years against physicians insured by New Mexico's dominant carrier, 68% were eventually dropped or settled out of court. Of the cases that were litigated, only 18% went fully through trial. Furthermore, the plaintiff prevailed in only 18% of those trial verdicts.⁷

Nationally, the information is similar. One study found that only 8 to 13 percent of cases filed went to trial and only 1.2 to 1.9 percent resulted in a decision for the plaintiff. Fully 70 percent of all medical malpractice actions brought against physicians result in no indemnity payment being made to the plaintiff (or his/her lawyer). In other words, the vast majority of cases brought have no merit. Unfortunately, even these cases are costly to defend. The average cost to defend the merit less claims in 2001 was \$22,967.⁸

The possible key elements of a new system would include the use of an avoidability standard, more reliability, a tie to safe medical standards of care, the provision of giving providers a proactive responsibility for safety versus a retrospective blame assignment, the standardization of compensation standards, compensation improvement to more patients on a more consistent and timely basis, and a system of collecting and trending compensable events, and most importantly, predictability in a system created in advance by medical experts who can measure quality and quantify compensation for deviations in quality. Such a system may represent patient interests more so than what is in place today.

The task force as a result of our consultations is leaning towards a long-term recommendation for the development of a "no-fault" administrative compensation system for medical injuries. Such a system may offer the prospect of a simpler, possibly fairer, more efficient, and less contentious means of adjudicating claims, while facilitating more open discussion of the causes of medical errors. A "no fault" system would make compensatory payments upon occurrence of a specified event rather than after trial and proof of a provider's negligent actions in violation of a medical standard of care. Damage amounts would be assessed according to a prospectively fixed schedule of compensation for deviation from a list of preventable and avoidable medical events and medical injuries. This would eliminate the persuasiveness of attorneys, the admissibility of evidence decisions of a judge, and the award of a lay jury.

The current tort system gives emphasis to granting compensation to those injured patients who prove negligence but discourages the proactive reporting of shortcomings in patient safety. A no-fault system would give much greater emphasis to granting more timely compensation to a larger number of injured patients, ensuring some predictability of compensation, facilitating communication within the health care system to avoid causing injuries, minimizing legal costs.

A “no-fault” system could pay damages automatically, like disability insurance or workers compensation, without lawsuits and the extended periods of time between an event and a trial.

Florida and Virginia Programs

The Florida program is one which lists preventable injuries in advance as “avoidable classes of events.” Avoidable events are medically caused and moderately or highly preventable. A list of predefined avoidable categories of obstetrical events is prospectively developed which does not include all injuries, but ones that are agreed by the provider community to be generally preventable.

The ultimate measure of success was in the Florida alternative system. Successes in Florida maintained access to obstetrical liability coverage and cut obstetrical premiums two and a half times below the trend; it had cases settle in one-third of the time and at one fifth of the administrative cost. There was comparable compensation and satisfaction. Florida’s program was designed as a clear alternative that makes patients better off, not a take away from tort reform.

While Florida’s system has worked relatively well, Virginia's Birth-related Neurological Injury Compensation Program has had some solvency issues. The program bars malpractice suits against participating doctors and hospitals in cases where a child receives severe, lifetime injuries from lack of oxygen or spinal cord damage at birth. In return, the program promises lifetime medical care. As of 2006 “there were 100 children participating in the 18-year-old program, and key stakeholders are concerned that the fund's operating budget may not be able to sustain the climbing medical costs. A study released in September 2006 showed the state's birth-injury program's cash shortage grew by \$15 million to \$132 million last year. The study also predicted that the program's life span will be shortened from 20 years to 17 years, under the current financial constraints. The program, which at the end of last year had about \$147.1 million in assets, should have \$279.3 million in hand to guarantee lifetime medical care to children currently participating and those likely to qualify for help.”⁹

National Vaccine Injury Compensation Program

While the possible success of getting something like an administrative compensation in New Mexico is ambitious, a precedent was provided on the federal level by the National Childhood Vaccine Injury Act of 1986 which created a new approach to compensate for injuries caused by children’s vaccinations. The Act was enacted in part because Congress thought that too many lawsuits could drive the vaccine manufacturers out of business.

A National Vaccine Injury Compensation Program (VICP) was established to ensure an adequate supply of vaccines, to stabilize vaccine costs, and to establish and maintain an accessible and efficient forum for individuals found to be injured by certain vaccines. VICP was designed as a no-fault alternative to the traditional tort system for resolving vaccine injury claims by providing compensation to people found to be injured by certain vaccines.

The Act authorized the Treasury Department to establish and fund a Vaccine Injury Compensation Trust Fund through an excise tax on vaccines. The Act also authorized the U. S. Court of Federal Claims to administer the compensation of injury and death claims. As of January 31, 2007, the Trust Fund balance was nearly \$2.5 billion.¹⁰

Patient Safety Initiatives

An administrative system that caps, or limits, awards, like the New Mexico Medical Malpractice Act, may not require the development of systems of care to prevent injury, in this case birth injury. Discussion of this aspect of ameliorating this aspect of the issue needs to get as much attention as the legal issues and the solution to availability of professional liability insurance. The task force thus far has devoted only a small amount of its time in this area.

The federal "Patient Safety and Quality Improvement Act of 2005" will soon provide the healthcare community with a way to facilitate quality and self-improvement through the protected reporting and analysis of medical errors. The act mandates that the Agency for Healthcare Research and Quality (AHRQ) establish a nationwide network of Patient Safety Organizations (PSOs) to collect patient safety data from local healthcare providers. AHRQ will then aggregate and analyze this data and develop and promulgate "best practices" for improving patient safety and the quality of healthcare. The goal of the act is to improve patient safety by encouraging voluntary and confidential reporting of events that adversely affect patients.

Many health care providers fear that patient safety event reports could be used against them in medical malpractice cases or in disciplinary proceedings. The act ameliorates this issue by providing federal confidentiality protections to information that is assembled and reported by providers to a PSO or developed by a PSO for the conduct of patient safety activities. The act also significantly limits the use of any PSO collected information in a criminal, civil, or administrative proceeding. In the future these PSOs will collect, aggregate, and analyze confidential information reported by health care providers. Currently, patient safety improvement efforts are hampered by the fear of discovery of peer deliberations, resulting in under-reporting of events and an inability to aggregate sufficient patient safety event data for analysis. This has previously occurred in New Mexico even with the provisions in place under the state's Review Organization Immunity Act (Section 41-9-1NMSA 1978) where peer review deliberations always thought to be confidential were not and peer review activities were used in litigation. By analyzing patient safety event information PSOs may be able to identify patterns of failures and propose measures to eliminate patient safety risks and hazards.

The federal Department of Health and Human Services (DHHS) will in the future certify as PSOs both public and private entities focused on improving patient safety and the quality of health care. Reports to PSOs will be permitted from any entity licensed under

state law (i.e. hospitals, long term care facilities, home health agencies, pharmacies, physician's offices and clinical labs) to provide health care services. The rules under which PSOs will be created and certified have not been finalized by DHHS.

The task force has reviewed different approaches on the question of patient safety. While providers try to ensure a positive outcome with every birth, the medical facts are that there are no guarantees for a perfect outcome in spite of every medical standard of care being precisely met. The 2007 birthing environment is filled with tremendous technology and skilled obstetrical practitioners, but that does not override what can happen in the birth process. Today, older women are giving birth. In 2005, there were more than 104,000 births in the United States to women ages 40 through 44, and over 6,500 to women 45 and older, raising the risk of birth defects. There are more chronic health problems such as obesity -- among women ages 18 to 44 obesity rose from under 9 percent in 1990 to almost 22 percent in 2005. The growth of multiple births, often the result of infertility treatment -- in 2004, they made up more than 3 percent of all live births, up from about 2 percent in 1980. Such babies are more likely to be born prematurely and to have health problems, including birth injury. Both the health care and legal systems cannot guarantee outcomes in spite of the best efforts of everyone, including the mother.

RECOMMENDATIONS

- **The task force recommends the establishment of a reinsurance program similar to that of Oregon for subsidizing medical professional liability costs to obstetricians, family physicians, nurse-midwives and licensed midwives who do births and provide substantial publicly funded and uncompensated care in their practices.** The goal of such legislation would be to maintain and improve statewide access to obstetrical health care by reducing the out of pocket medical malpractice premium costs thereby stabilizing, and ideally increasing, the numbers of such obstetrical medical professionals throughout New Mexico. Participation in the subsidy program would require the obstetrical provider to not have any payer classification access restrictions to their practice. So as not to be in violation of the Anti-Donation Clause, a reinsurance program for obstetricians, nurse-midwives and midwives should require those medical professionals participating in the program serve patients on an unrestricted basis.
- **The task force recommends the development of an administrative compensation system for patients incurring an injury in the course of childbirth.** Such a system may offer the prospect of a simpler, possibly fairer, more efficient, and less contentious means of adjudicating claims, while facilitating more open discussion of the causes of medical errors. A "no fault" system would make compensatory payments upon occurrence of a specified event rather than after trial and proof of a provider's negligent actions in violation of a medical standard of care.

- **The task force recommends the creation or aid the establishment of a New Mexico Patient Safety Organization**, pursuant to the federal Patient Safety and Quality Improvement Act of 2005, upon finalization of federal rules for the Patient Safety Organization Program. By analyzing patient safety event information PSOs may be able to identify patterns of failures and propose measures to eliminate patient safety risks and hazards.

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Appendix A

New Mexico Medical Malpractice Insurance Market (Other Health Care Practitioners)- Information from NM Public Regulation Commission Insurance Division.

New Mexico Medical Malpractice Insurance Market											
Other Health Care Practitioners											
Name of Insurer	Type of Insurer	Direct Written Plans									
		2002	%	2003	%	2004	%	2005	%	2006	%
American Cas Co Of Reading PA	Admitted	413,123	10.5%	502,806	10.8%	708,469	12.7%	806,923	14.5%	954,939	14.4%
Medical Protective Co	Admitted	505,902	12.8%	601,206	12.9%	659,853	11.8%	656,753	11.8%	692,829	10.4%
Lexington Ins Co	Surplus Lines	0	0.0%	92,176	2.0%	39,299	0.7%	167,234	3.0%	688,724	10.4%
Podiatry Ins Co Of Amer A Mut Co	Admitted	0	0.0%	0	0.0%	0	0.0%	0	0.0%	615,739	9.3%
Admiral Ins Co	Surplus Lines	0	0.0%	0	0.0%	312,791	5.6%	348,800	6.3%	543,385	8.2%
National Union Fire Ins Co Of Pitts	Admitted	131,117	3.3%	570,129	12.3%	808,678	14.5%	865,731	15.5%	467,558	7.0%
Ace American Ins Co	Admitted	231,817	5.9%	428,015	9.2%	-223,354	-4.0%	361,671	6.5%	392,812	5.9%
Landmark Amer Ins Co	Surplus Lines	0	0.0%	0	0.0%	146,500	2.6%	297,976	5.4%	355,694	5.4%
American Ins Co	Admitted	63,006	1.6%	222,238	4.8%	322,178	5.8%	330,061	5.9%	325,651	4.9%
Evanston Ins Co	Surplus Lines	166,535	4.2%	219,754	4.7%	277,622	5.0%	242,866	4.4%	307,171	4.6%
NCMIC Ins Co	Admitted	270,036	6.9%	270,037	5.8%	268,059	4.8%	285,466	5.1%	290,604	4.4%
Illinois Union Ins Co	Surplus Lines	74,919	1.9%	51,258	1.1%	444,441	8.0%	233,717	4.2%	207,046	3.1%
Columbia Cas Co	Surplus Lines	2,896	0.1%	22,065	0.5%	127,784	2.3%	188,874	3.4%	174,729	2.6%
Continental Cas Co	Admitted	77,719	2.0%	92,277	2.0%	161,160	2.9%	161,899	2.9%	168,400	2.5%
Allied Professionals Ins Co RRG	Risk Retention Group	0	0.0%	0	0.0%	0	0.0%	93,348	1.7%	155,938	2.3%
Western World Ins Co	Surplus Lines	35,643	0.9%	158,975	3.4%	163,444	2.9%	172,224	3.1%	115,564	1.7%
Pharmacists Mut Ins Co	Admitted	56,124	1.4%	59,741	1.3%	62,171	1.1%	62,458	1.1%	62,979	0.9%
Fortress Ins Co	Admitted	0	0.0%	0	0.0%	0	0.0%	0	0.0%	45,631	0.7%
American Assoc Of Othodontists RRG	Risk Retention Group	0	0.0%	0	0.0%	45,012	0.8%	43,172	0.8%	41,340	0.6%
Granite State Ins Co	Admitted	46,812	1.2%	71,694	1.5%	84,316	1.5%	32,086	0.6%	26,876	0.4%
American Home Assur Co	Admitted	0	0.0%	750	0.0%	8,470	0.2%	6,979	0.1%	6,162	0.1%
General Ins Co Of Amer	Admitted	5,373	0.1%	349	0.0%	405	0.0%	419	0.0%	1,898	0.0%
Travelers Ind Co	Admitted	0	0.4%	0	0.2%	0	1.7%	188,127	0.8%	1,466	0.7%
Church Mut Ins Co	Admitted	0	0.0%	96	0.0%	193	0.0%	423	0.0%	453	0.0%

Associated Ind Corp	Admitted	0	0.0%	2,230	0.0%	0	0.0%	0	0.0%	302	0.0%
All Other Carriers		1,858,781	47.2%	1,284,658	27.6%	1,156,811	20.8%	21,710	0.4%	0	0.0%
Total All Insurers		3,939,803	100.4%	4,650,454	100.2%	5,574,302	101.7%	5,568,917	97.4%	6,643,890	100.7%

Type of Insurer	Direct Written Plans									
	2002	%	2003	%	2004	%	2005	%	2006	%
Admitted Carriers	3,350,726	85.0%	4,084,041	87.8%	3,996,205	71.7%	3,759,871	67.5%	4,054,299	61.0%
Risk Retention Groups	0	0.0%	0	0.0%	45,012	0.8%	136,520	2.5%	197,278	3.0%
Surplus Lines Carriers	589,077	15.0%	566,413	12.2%	1,533,085	27.5%	1,672,526	30.0%	2,392,313	36.0%
Total All Insurers	3,939,803	100.0%	4,650,454	100.0%	5,574,302	100.0%	5,568,917	100.0%	6,643,890	100.0%

Notes:

Coverage not available for home births.

Evanston writes licensed midwives in birthing centers. Appears to be the only source for licensed midwives.

Lexington the primary carrier for certified nurse midwives.

Admitted carrier market share declining since 2003.

Appendix B

External Consultant Detail

Background information about New Mexico's medical malpractice act, the childbirth environment in New Mexico from a professional liability and patient safety perspective, and what the task force had done up to that point was provided to Mr. Bovbjerg and Dr. Shapiro. The task force provided the consultants some specific questions and their answers for the two phone consultations that are summarized and quoted below:

“Q1. Which policies are best to address three options below with respect to liability related problems in care for childbearing: (a) increasing cost of liability coverage, (b) improving quality of care, and (c) fairly compensating those with medical injuries, and what are their pros and cons.

A. These may all be desirable goals of public policy. Providing answers like this need to come at the end of information gathering, not at the beginning. It is desirable to address the Commission's goals and their priority order relatively early on, so as to focus effort more effectively. Another way to put this is that what the responses should be depends on the nature and extent of problem(s) being addressed--with “problems” being a negative way to state a positive goal. Additional potential goals include (d) promoting access to a full scope of prenatal and delivery services throughout New Mexico, and (e) promoting fair payment levels and relativities for prenatal and childbirth services under Medicaid and state employees health plan(s).

We need to better understand the nature of existing practices and problems as well as potential solutions of interest before giving much of an answer to any aspect of this question.

As a rule, however, if the issue is affordability of liability premiums or access to care, there are two general solutions in each case--reducing costs or increasing revenues. Actually reducing costs or increasing revenues of course raise complex issues.

Q2. How do (relevant) characteristics of New Mexico compare with other states that have moved away from tort liability?

A. Only two states have moved away, and only in part—Virginia and Florida, which have tort “carve outs” in favor of administrative compensation for severe neurologically birth-injured live born infant injuries. Both enactments were prompted by concerns about access to liability coverage, and hence to physician ability to deliver care, especially in inner city and rural areas. Just what characteristics are important depends on whether the concern is ability to enact a reform or something else.

Q3. What are the best state models, how are they working?

A. If model means alternative to tort, there is only the single, Virginia and Florida model. Good information is available only for Florida, and only thru the mid to late 1990s.

Q4. Would #3 alternatives work in New Mexico?

A. Can't say as yet.

Q5. Will decreasing the risk of injury reduce premiums?

A. Yes, in theory, to extent that injuries decline among class of people and cases that now result in claims. Anesthesiologists reduced their premiums dramatically starting in the late 1970s by establishing better standards of care and taking advantage of new technology to monitor blood oxygen levels more effectively. On the face of it, there appear to be few similarities between the causes of birth injuries and defects and those of anesthesia accidents. However, reducing childbearing-related injury is a worthy goal in its own right.

Q6. What about systems bringing together (injury) compensation and patient safety?

A. The system that comes closest to doing this is the VA health system. The Indian Health Service may have some similarities, which remains to be investigated. There are no such systems in the private sector in the US. Australia and New Zealand have limited aspects of systemness but would probably not be seen as achievable systems for any American state.

Q7. How have these systems related to managed care?

A. As yet, not at all, in the common sense of discounted fee-for-service practice covered under US private health plans. The VA does manage care to a greater extent than private health plans, being able to coordinate across all aspects of care and with a lifetime relationship with its beneficiaries (though many veterans get most of their care privately). Private closed-panel HMOs or capitated delivery systems manage care in part through their control over health care delivery as well as financing. They have the greatest capacity to organize patient safety efforts, as well as to promote cost-effective decision making about what practitioners should deliver what sorts of care under what circumstances. To the consultant's knowledge, they do not yet integrate care-delivery, patient safety, and injury-compensation--but Kaiser or the Mayo health plan, for example, are probably a good place to look for effective systems safety efforts.

Q8. Can safety occur in a non-closed system?

A. Uncoordinated fee-for-service "systems" do not really have much systemness to them--unlike the VA or Kaiser--whether for siting of care, sharing of health plan and patient payments, organization of patient safety, or liability risk bearing and claims resolution. The most systemness exists within entities that have comprehensive responsibility for a delivering and financing care for a defined population; some "systems" are more comprehensive in scope and integrated in functions than others. Certain safety practices can be adapted by any provider on a piecemeal basis, but without the financial incentives or coordinated support that a true system can bring to bear.

Safety-promoting measures that relate to discrete activities or purchases--e.g., drugs, devices, and medical records, whose functioning is relatively independent of the setting of their use--can be borrowed by any provider from the "earlier adopters." By analogy, over time race car technology and Volvo safety measures have eventually found their way into Hyundais and Saturns ... where consumers are willing to pay for them or

regulators to mandate them. Similarly, any provider can buy electronic medical records software “off the shelf” after others have helped make the market for them (or can get the VA records system free). But the late adapter may still lack the specialized support systems and economies of scale available in integrated systems. Other things that any provider can implement include automatic reminders to patients of needed diagnostic or therapeutic interventions, or more automation to make caregivers take notice of abnormal test results. To what extent this type of borrowing from more advanced practice is possible for childbearing care merits some investigation, and overlaps with the quality questions.

Q9. What patient safety programs are recommended for New Mexico?

A. This remains to be determined, and the answer(s) will surely vary by site of care, characteristics of caregiver, and willingness of health payers to pay for safety measures (including taxpayers and uninsured people).

Q10. Barriers to reducing injury exist; how can they be surmounted?

A. Knowledge of what safety measures are effective is imperfect, and no dedicated external funding streams support upfront investments in safety, and no single payer (e.g., Medicaid) is well motivated to pay for measures to be made available to all patients. Individual and institutional providers thus need to have sufficient capital to finance acquisition, implementation, training, and ongoing operations of new safety measures even where effectiveness is clear. Some improvements may pay for themselves over time, but the savings need to accrue to the same entity that bears the costs of implementation. Only if the business case is quite clear will lenders consider advancing the needed capital. Beyond finances, disinclination to change existing practices may be a bigger and harder to address problem, not only among providers but also among patients. Better information is the most obvious place to start, and perhaps the Commission can be helpful there.

Q11. Best practices in obstetrics and adaption for New Mexico?

A. This issue goes well beyond liability or liability insurance and even beyond patient safety. The Commission needs input from others on this topic and probably needs to filter any findings through a New Mexico specific expert panel of local providers in order for win local acceptance of them as well as to craft implementation strategies appropriate to various local situations.

It bears noting that only a portion of birth injuries are avoidable with known best practices. Moreover, unlike anesthesia incidents, which are mainly iatrogenic, many childbirth problems are not caused by medical care.

It may be, however, that this project could usefully consider the same question with respect to management of adverse incidents in childbearing and settlement of potential and actual claims against caregivers. COPIC, the lead malpractice insurer in Colorado, is a national leader in such case management in obstetrical liability, and its geographic proximity might make its practices more readily adapted to New Mexico. Again, involvement of leading and trusted New Mexico practitioners would be desirable, along with enthusiasm within New Mexico liability carrier(s).

Q12. Demonstrable relationship between lower injury rate and lower claims rate?

A. In theory, yes, as noted above in discussion of anesthesia. To what extent relationship will occur in practice depends on existing patterns of injury, claiming, and claims settlement. The general wisdom is that only a small share of injuries result in claims, although higher where injuries are more severe, as childbirth cases tend to be (typically having to pay for a lifetime of palliation). Few areas of care seem likely to have the experience of anesthesiology.

Q13. How get trial lawyers “on board”?

A. The consultants were not aware of any significant liability reform supported by either the plaintiffs or the defense bar. The trial bar has supported compensation funds or other measures to expand access to liability coverage, though not where associated with cutbacks in remedies or damages. Washington state and Washington, D.C., recently both enacted minor reforms with some support from the trial bar as well as providers, but these reforms do not much affect the number or size of claims, nor traditional access to trial by jury for claimants (and lawyers). It is more plausible that non-trial attorneys might offer support--attorneys who work for corporate interests or represent poor people with constrained access to care. It seems a truism that people whose financial interests are adversely affected by change can be expected to resist change, whatever their profession or workplace.

Q14. What strategies can get stakeholder “buy in”? How can one take action without stakeholder buy in?

A. The consultants perspective is that few lasting big policy changes happen without broad political support. Leadership from a bully pulpit can help but not make major changes without enlisting support from some external constituencies. Unions, workers, and health plans ought to care about the burdens of medical injury, of which malpractice costs are the smallest, though most visible share. The difficulty is convincing them that reform(s) will do more to improve patient safety/reduce health costs than those reform(s) will to take away accustomed rights to sue, which people do value. Opinion surveys show that people understand that there are substantial problems of patient safety in US medical care, but they think that more lawsuits are the answer, not the problem. On a more positive note, childbearing is literally a “motherhood” issue, and supporters can argue that children are the future. Still, it is notable that Medicaid economizing more often addresses parents and children than elderly and disabled persons.”

Appendix C

2005 Senate Memorial 7 Findings

Despite much effort, the 2005 SM7 task force failed to achieve full consensus on any legislative proposals. The various legislative initiatives that were discussed include:

- ✓ Creating a state-sponsored Joint Underwriting Association
- ✓ Amending the Medical Malpractice Act of 1976
- ✓ Creating a parallel Medical Malpractice Act
- ✓ No-fault carve-outs for providers of obstetric services

These initiatives are described below.

Joint Underwriting Association

The entire task force was favorably inclined toward the creation of a state-sponsored insurance facility called a Joint Underwriting Association (JUA) that would provide malpractice coverage to classes of health care providers that cannot find coverage elsewhere. All agreed that such a JUA should be self-supporting with rates that are actuarially sound, should exercise normal underwriting authority, including the right to deny coverage to health care providers who have an adverse claims history, and should adjust individual policyholders' premiums to reflect their claim experience.

Divisions arose regarding whether the JUA should have caps and whether it should be open to providers who are not "in crisis." The majority supported a JUA that would be open to all classes of providers, that would offer both occurrence and claims-made products, that would qualify as a base coverage insurer under the Act, and that would have relatively high caps on non-economic damages for providers not under the Act.

The provision for caps was opposed by the New Mexico Trial Lawyers Association. The Medical Society and the Trial Bar oppose the creation of a JUA that would insure providers who can find coverage elsewhere and thereby to compete with AP Capital and other private insurers.

Amending the Medical Malpractice Act of 1976

The majority of task force members believe that amending the 1976 Medical Malpractice Act to (1) allow the use of claims-made policies for the required base coverage and (2) expand the list of eligible health care providers, would ameliorate New Mexico's medical malpractice dilemma and promote the stated purpose of the Act. These efforts to amend the Act were opposed by the Medical Society, which fears that the introduction of other health care providers may financially endanger the fund, and by the Trial Bar.

Creating a "Mirror" Medical Malpractice Act

In view of the effectiveness of the Act for physicians and of the opposition to its amendment, the task force discussed the creation of a "mirror" act with its own patients compensation fund that would be open to all health care providers. This was not

pursued due to anticipated difficulties in obtaining appropriate medical/legal review panels and caps on non-economic damages.

No-Fault Carve-Outs for Providers of Obstetric Services

Many on the task force were intrigued with the concept of an alternative, non-judicial compensation system that would serve as an exclusive remedy for obstetric injuries. Such a system could resemble those in Virginia and Florida or could extend further and include all obstetric injuries, either on a voluntary or a mandatory basis.

RECOMMENDATIONS

The task force did agree on the two recommendations described below.

Increased Medicaid Reimbursement to Providers of Obstetric Services

The task force has recommended that Medicaid reimbursements to midwives and obstetricians be increased and that the maintenance of malpractice coverage not be a condition for reimbursement

New Mexico Patient Safety Organization

The federal Patient Safety and Quality Improvement Act of 2005 encourages individual states to create Patient Service Organizations (PSOs) for certification by the U.S. Department of Health and Human Services. The purpose of these PSOs is to collect confidential reports of medical errors from local health care providers and share them with the Department of Health and Human Services for analysis of patterns of unsafe medical practices that can then be addressed in a systematic way. The task force recommends that interested parties consider forming a PSO.

Appendix D

Information Regarding Obstetric Providers and Medical Malpractice (MedMal) Insurance collected by Elaine Brightwater, RN, CNM, MSN

August 30, 2007

The following information does not attempt to be an exhaustive compilation of all providers and complete data for MedMal premiums. It is a targeted look at the dynamics of MedMal premium increases in the most recent years, the effect on both practice patterns of providers and the resultant situation for client families in key areas of New Mexico.

Many of the licensed obstetric providers do not have extensive data available for this overview.

- Licensed midwives, regulated by the New Mexico Department of Health, are currently unable to purchase a MedMal (Medical Malpractice) policy anywhere in the United States (see following letter from Dean Insurance Agency, Inc.)
- Family practice physicians who practice obstetrics do not have comprehensive data available on either their practice or the effect of MedMal premiums on their practice in the state. Dr. Lawrence Leeman, Associate Professor jointly appointed to the Family Practice and Obstetric faculties of the University of New Mexico, gave a summary of the situation of Family Practice physicians based on his experience in this environment (see following letter from Larry Leeman, MD, MPH.).
- The professional organization for Obstetrician Gynecologists is the American College of Obstetrics and Gynecology (ACOG). The Chair of the Bernalillo County ACOG is a member of this Task force on Childbirth Injuries and Obstetrical Liability Insurance, as well as an Associate Professor in the University of New Mexico Obstetrics Department has stated that there is no survey available of the effect of MedMal premiums on OB-Gyns, however it is his observation that the effect is presumably more dramatic in those collaborative practices in which OB-Gyns and certified nurse midwives (CNMs) are closely integrated. This is due to the pronounced effect of premium rate increases on the CNM portion of the practice.
- An important issue regarding MedMal insurance data is the large component of both professional providers and hospitals that are organized as “self-insured” entities. In this component, professional providers are employees of the self-insured corporation, covered by an institutional policy. In addition, governmentally based hospitals (state, federal or Indian Health) are covered under state or federal Tort Claims legislation. In these cases, the information regarding costs of insuring providers and hospitals is not readily available, even to the providers themselves. Informal communication indicates that within these institutions that when the institution enters the market to bid for underwriters, the premiums have been rising, and while this rise has a generally negative effect on budgets within an institution, more specific actions have not been forthcoming.

The one data set that has been developed for “real time” collection of MedMal information has been that of the certified nurse midwives. In addition to the formal survey produced by the HPC a year ago, there has been an on-going effort to collect information from CNMs as to their MedMal premiums and the effect on their practices. This data base is incomplete, but has sufficient information to make some summary statements. The plan is for the collection of data in this database to continue.

In reviewing this data (obtained by direct email and telephone inquiries to New Mexican CNMs) is that it is helpful in understanding more than just CNM providers. Due to the interactive nature of CNM/physician practices in communities, it is clear that there are three important factors in all those communities which appear in varying intensity. These are:

- The steeply rising MedMal insurance premiums in recent years, which comprise an increasingly larger budgetary drain on CNM practices
- The effect of physician MedMal premiums as they affect the physicians, as well as the availability of consulting “back-up” physicians for midwifery practice. (CNMs are required by both their professional standards of practice, as well as NM state regulations, to have consultative physicians who can care for midwifery clients if those clients become higher risk than appropriate for the CNM practice situation).
- The interaction of the above factors when seen in context of New Mexican capacity to safely care for all childbearing women and their families.

To appreciate what is happening across New Mexico, we have to highlight some actual communities as to the interplay of these factors.

First, we need to look at what has happened for CNMs who are delivering babies and who are purchasing their own policies in the last few years of their premiums. (figures below). These data were acquired after the end point of the HPC formal survey of CNMs.

Private Practices

Certified Nurse Midwife	2004	2005	2006	2007	Comments
K.A. (rural)			\$17,000	\$28,000	Reimbursements down-Medicaid is up-“Need competition” just to get the prenatal done in community
D.L. (rural)			\$19,297	\$38,647	Did over 50% Medicaid--closed this year to OB due to loss of OB physicians—can’t afford “tail” (\$30,000)
E.W. (rural)	\$17,000	\$17,000	\$26,000	Employer	“Never had a claim; can’t keep going for long.”
D.L. (urban)		\$17,000	\$19,000	\$29,000	Told there would be minimal increase in 2007.
K.L. (rural)				\$29,000	Will have to close OB portion if another increase this week.
C. V. (rural)		\$14,000	\$28,000	left	15 years in the community—Lost OB consultant. Can’t afford “tail” (\$30,000)

Case 1—Southern community

- Two CNM practices:

1. Private practice, Professional Corporation, CNMs are employees of Lead Midwife. Deliver 30-40 babies at month, over 50% Medicaid and increasing. Reimbursement for the practice is decreasing. Has one primary consultation “back up” physician for practice. Practice is very crowded, just trying to get prenatal care done. Whole area needs more providers. Pays MedMal through the P.C. “We’ll just have to work more.”

2. Public type practice has been through many “owners” recently. Last year the CNM staff was “fired” twice, but the practice continued. Deliver 99% of undocumented women in area—no payor source. Midwives work 24 hour shifts, deliver 40-50 babies a month. Now “owned” by private hospital corporation that also owns one hospital, publicly traded (stocks decreasing). 501c3 midwifery clinic will be now be managed by the same corporation because the clinic couldn’t support itself. Corporate hospital owners losing \$1 million / year on the CNM practice (per CNM director).

This practice is in process of trying to acquire OB consulting for Practice 1.

- 420 babies plus 540 babies = 960 babies
- This hospital delivers 1893 babies / year.
- These two CNM practices deliver more than half of the babies for this hospital, which is the primary OB hospital in the area.

(The other hospital delivers 740 babies a year, and the OB and (1) CNM staff are employees.)

- This community is losing two OB-Gyns to OB now, partly due to the cost of MedMal for OBs (\$75,000/yr).
- The community has lost a Family Practice physician who was practicing some OB due to loss of OB-Gyn consultant.
- The community is losing three private practice CNMs due to a combination of their MedMal cost and the loss of the physicians for consultation

Summary: this situation is a fragile balance of consistently shrinking resources and increasing need.

Risks are high for decreasing patient safety, additional provider attrition, and institutional failure.

Case 2—Urban practice

1. CNM practice fully integrated with OB-Gyns in a collaborative practice with each component responsible for budgetary balance.

- Four CNMs at a special “FTE” MedMal rate of \$31,300 for two CNMs with max of 40 hours per week that can be worked per CNM=\$62,600, plus 7 other CNMs at the individual policy rate of \$29,000=\$203,000 Total:\$265,600 per year.
- Assessment by Director: any additional significant increase would cross the line of profitability, clear danger of having to lose practice
- CNM staff has now been working at “peak performance” for years...not sustainable
- OB-Gyn’s practice predicated on the ability of the CNMs to handle volume and non-surgical reimbursables.
- This CNM practice delivers 400 babies a year plus maintains large women’s health practice.

2. The same hospital has another CNM practice, this one owned by the hospital. The CNMs, therefore, are employees and their MedMal is an institutional policy. There is not enough capacity to absorb either this many additional employees or clients.

Case 3—Northern community

- A small community hospital is dependent upon the two-CNM practice that has been there for many years, and which recently recruited a new graduate Nurse-Midwife. The hospital has hired as employees one full-time OB-Gyn and one “part-time prn” OB. The CNMs deliver 20-25 babies a month, which is approximately the total number of deliveries for that hospital in 250.
- The CNMs are now employees of a medical management company, which pays their MedMal premiums.

Summary: While this situation is reasonably stable on the face of it, the intertwining factors of increasing MedMal costs for the private management company as well as the difficult financial picture of a rural hospital that has had to hire the OB physicians for the community point to a somewhat tenuous obstetrical safety net.

Implications from provider information:

- We need much more comprehensive data from OB-Gyns and Family Practice physicians as to their MedMal situations
- We need data from institutional policy holders, both professional providers and hospitals
- However, this initial information suggests that New Mexico depends upon an essentially integrated model of obstetrical providers that has developed to serve childbearing families with a variety of risk and cost levels.
- Generally, obstetrical capacity is stretched to the level of adaptability throughout the state. There is very little margin for assurance or improvement of safety measures in childbearing practice.

- The risk is high that the professional providers will not be able to maintain the ever increasing financial strain with some structural change.
- It is noteworthy that the Licensed Midwives are essentially the only licensed providers of home birth in the state. They are completely outside the MedMal insurance system, and need to be addressed as some policy availability is developed.



DEAN INSURANCE AGENCY, INC.

230 N. Westmonte Drive
Suite 2100
Altamonte Springs, FL 32714

Local: (407) 865--7477
Toll Free: (800) 721-3326
Fax: (407) 865-7557

October 9, 2007

2 pages

Re: **Feasibility Study for Midwives**

Dear ,

You may have heard about this project over the past several months and I'm now contacting you directly for your support and leadership role. A financial investment in this study will potentially benefit all the midwives in your organization, so please share this letter with your membership. Due to my long time devotion and programs for your profession, the insurance industry respects my opinions regarding the insurance needs for midwives/birthing centers/schools. I was contacted mid-2006 by reinsurers who would like to support us in any efforts we may have to provide an insurance program in the future.

Before any undertaking can take place for another insurance program, I identified two critical areas:

- 1) past and current insurance programs have not been profitable for insurance companies due to claims. How do we prevent claims? How do we control their outcome and the costs? The only solution I could find is...arbitration...binding arbitration. And if it is implemented properly, will keep all claims out of the traditional legal system where we cannot win, even if we can defend, we cannot win with lay judges and juries.
- 2) The midwives/birthing centers need to "own" their insurance program and control their destiny to stop the roller coaster cycles that have occurred since the mid-70's. This is now possible through many different cost effective arrangements...captives, risk retention groups, etc.

Simply put, we need to control rates and claims outcomes. After conducting two "brainstorming" meetings last year (Albuquerque and Baltimore) attended by anyone interested in discussing this further, there was general consensus that this makes sense. Midwives are tired of insurance companies telling them how to practice, charging them rates that are unexplainable and settling claims that should be defended.

The next step...employ an actuary (a mathematician) to conduct a feasibility study. The actuary takes our data/outcomes/exposures/demographics, factoring in the effect of arbitration to produce a rate that is actuarially sound, adequate, fair to all and can be interpreted by reinsurers, who help assume frequent or catastrophic losses to the group.

The initial study will cost \$15,000. This document will take about 60 days to produce and the results will be available to all members funding the project. It will be a landmark study, one that

has not been done before, with no bias placed by any one insurance company/reinsurer/underwriter. This is not just about homebirth midwives, hospital only births, or exclusive to birth centers.

Dean Insurance has set up an escrow account/trust account to hold the contributions it receives until we raise enough to finance this much-needed study.

This is not an easy process and one usually left up to the insurance company but wouldn't you want to know the outcome? I'm willing to continue investing time, effort and money (Dean Insurance has contributed \$1,500) so all midwives will have a meaningful document to support and validate their professions goals to many audiences (consumers, peers, regulators, hospitals, managed care, and others). I'm hoping you will seriously consider this project and welcome your call!

Sincerely,

Ann A. Geisler, CPCU
CEO

(800) 721 – 3326, x202
ageisler@deaninsurance.cc

Information from Larry Leeman, MD, MPH On Family Practice in New Mexico Childbearing (July, 2007)

Although there has not been a recent formal survey of Family Practice physicians who attend births in New Mexico, Dr. Larry Leeman provided the following information available to him in his position as Associate Professor jointly appointed to the Family Practice and Obstetric faculties. Additionally, he serves as the Director of UNM Health Science Center Family Medicine Maternal /Child Care and is Co-Director of the Mother/Baby Unit at UNM Hospital in Albuquerque, New Mexico.

Dr. Leeman is confident that there are some Family Practice physicians attending births in “almost every hospital in the state of New Mexico” with exception of Los Alamos and Women’s Hospital (Lovelace) and Presbyterian Hospital in Albuquerque. Large urban practices include the UNM Family Medicine Maternal and Child Health Service that works closely with the First Choice community clinic system and the La Familia practice in Santa Fe with each of these urban practices having over 500 deliveries per year. The Family Medicine physicians are an especially strong presence in the rural areas. . There are several communities in which Family Medicine physicians perform the majority of the deliveries including Socorro, Zuni, Raton, and Crownpoint. While the majority of Family Medicine physicians do not offer cesarean delivery (referring these patients to Ob/Gyns) there are several communities where Family Medicine physicians’ cesarean services are integral to the maintenance of the maternity services.

There is a history of limited cooperation between Family Medicine and AP Capitol, the supplier of medical malpractice insurance in the state. Two years ago the medical malpractice insurance premium for Family Practice physicians was about \$18,000 for FM doctors performing less than 40 deliveries per year with higher rates for FM physicians having higher volumes or offering cesarean services. The malpractice rate was scheduled to be raised to \$75,000 (the rate for OB-Gyns) for any FP with over 32 deliveries or offering cesarean deliveries. Since the obstetric volume for almost all Family Physicians would not support such an increase, the insurer moderated planned increase for those FPS with higher volume or offering cesarean delivery in rural areas. The dynamics had already had an effect, however, and some Family Medicine obstetrical providers had already closed that part of their practice. That practice decision is difficult to turn around, so some providers were lost, notably in the Silver City and Grants areas. Often the best that can be hoped for due to high malpractice

One issue that requires attention is the situation of malpractice insurance for Family Medicine physicians who want to offer prenatal care without offering deliveries. The major malpractice carrier in the state will charge these providers the same rate as if they offered obstetric deliveries. This is financially untenable due to the minimal Medicaid payments for prenatal care. If the malpractice rate is increased by \$12,000 per year for pregnant care only a physician would have to care for over 50 women per year just to break even on the malpractice and there would be no financial resources to pay for the time and office expense of providing the prenatal care itself! The Bernalillo El Pueblo Practice does not qualify as a Federally Qualified Health Care facility, such as 1st Choice Health Care System or Indian Health Service. This problem could potentially be addressed by state regulation mandating that malpractice insurers include prenatal care in the basic package for outpatient clinical care by family medicine and ob/gyn physicians and nurse midwives.

Appendix E

Oregon Legislation HB 3630 (2003) and SB 183 (2007)

72nd OREGON LEGISLATIVE ASSEMBLY--2003 Regular Session

Enrolled

House Bill 3630

Sponsored by COMMITTEE ON JUDICIARY CHAPTER

AN ACT

Relating to physicians; creating new provisions; amending ORS 656.632; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. { + (1) The State Accident Insurance Fund Corporation shall establish a reinsurance program for medical professional liability insurance policies issued by authorized insurers in the calendar years 2004, 2005, 2006 and 2007 to doctors of medicine and doctors of osteopathy licensed under ORS chapter 677 who:

(a) Have a rural practice according to the criteria established by the Office of Rural Health for purposes of ORS 316.143;

(b) Hold an active, unrestricted license to practice medicine;
and

(c) Have an in-force policy of medical professional liability insurance with an authorized insurer with minimum limits of coverage of \$1 million per occurrence and \$1 million aggregate.

(2) The reinsurance program established in accordance with this section must be carried out in accordance with the plan approved under section 2 of this 2003 Act.

(3) The coverage provided under the reinsurance program shall be priced by the State Accident Insurance Fund Corporation, in accordance with rate standards or percentage reductions determined by the Director of the Department of Consumer and Business Services after consultation with the Office of Rural Health, at rates that will significantly reduce premiums for doctors to whom this section applies so as to make the medical professional liability insurance reasonably affordable.

(4)(a) The State Accident Insurance Fund Corporation may provide coverage as authorized in this section on such terms and conditions as the State Accident Insurance Fund Corporation determines to be reasonable, subject to the requirements and other terms of the plan approved under section 2 of this 2003 Act.

(b) Notwithstanding paragraph (a) of this subsection, the State Accident Insurance Fund Corporation must make all reasonable efforts consistent with the goals of sections 1 to 7, 10 to 12 and 14 of this 2003 Act to transfer any assumed reinsurance liability.

(5) The State Accident Insurance Fund Corporation is not required to provide coverage for risks under this section that exceed the amount the director is authorized to credit against assessments in section 7 of this 2003 Act, but the State Accident

Insurance Fund Corporation is liable for all risks that it covers under this section. + }

SECTION 2. { + (1) The State Accident Insurance Fund Corporation shall submit to the Director of the Department of Consumer and Business Services and to the Office of Rural Health a plan for carrying out the provisions of section 1 of this 2003 Act. The director and the office shall approve the plan following a determination that the plan:

(a) Satisfies the purposes of sections 1 to 7 of this 2003 Act.

(b) Obligates the State Accident Insurance Fund Corporation to carry out the reinsurance program established under section 1 of this 2003 Act by any appropriate coverage, which may consist of financial reinsurance, on an insurer-to-insurer basis.

(c) Provides administrative management for the reinsurance program.

(d) Is financially sound.

(e) Facilitates payments from the Rural Medical Liability Reinsurance Fund established by section 5 of this 2003 Act and is otherwise fair and reasonable to the participating primary insurers and their insureds.

(f) Establishes appropriate underwriting and rating standards.

(g) Minimizes transactional and claim costs for the State Accident Insurance Fund Corporation and for primary users.

(h) Is appropriate in relation to the insurance market in this state.

(i) Effectively reduces premiums for medical professional liability insurance for doctors eligible for coverage under the plan.

(2)(a) The plan approved under this section must provide, to the extent funds are available from the credit provided in section 7 of this 2003 Act for the annual assessment owed by the State Accident Insurance Fund Corporation under ORS 656.612, for a reduction in premiums as provided in this subsection for medical professional liability insurance for eligible doctors of medicine and doctors of osteopathy. The reduction of premium shall be:

(A) Up to 80 percent for doctors specializing in obstetrics;

(B) Up to 60 percent for doctors specializing in family or general practice who provide obstetrical services; and

(C) Up to 40 percent for all other eligible doctors.

(b) If the funds available to provide premium reductions are insufficient to provide the maximum reduction, the plan shall provide for proportional reductions to all eligible doctors.

(c) Premium reductions shall be a percentage of the actual premium charged for medical professional liability insurance in the market of authorized insurers for limits purchased of up to \$1 million per occurrence and \$3 million annual aggregate.

(d) Premium reductions shall be effective beginning with the first premium payment in each calendar year under the reinsurance program.

(3) The plan adopted under this section may not obligate the State Accident Insurance Fund Corporation to provide coverage under section 1 of this 2003 Act at a cost to the State Accident Insurance Fund Corporation that exceeds an average of \$10 million for each policy year for the four years for which the coverage is provided. The cost to the State Accident Insurance Fund Corporation shall be the actuarially determined costs of the reinsurance program.

(4)(a) The State Accident Insurance Fund Corporation shall submit the plan required under this section to the director and the office not later than September 30, 2003.

(b) The director and the office shall approve, disapprove or require changes to the plan as promptly as reasonably possible in order to enable the State Accident Insurance Fund Corporation to have the plan operational by January 1, 2004. The plan may be implemented only after joint approval by the director and the office. + }

SECTION 3. { + (1) For the purposes of the reinsurance program for medical professional liability insurance established under section 1 of this 2003 Act, the State Accident Insurance Fund Corporation is subject as a domestic insurer to ORS 731.248, 731.252, 731.256, 731.258, 731.260, 731.296 to 731.316, 731.488, 731.574, 731.592, 731.594, 731.730, 731.731, 731.735, 731.737, 731.988, 731.992, 733.010 to 733.060, 733.140 to 733.170 and 733.210. The requirements of the Director of the Department of Consumer and Business Services under ORS 733.010 to 733.060, 733.140 to 733.170 and 733.210 govern in the case of a conflict between those requirements and the requirements of any accounting system prescribed by the Oregon Department of Administrative Services.

(2) The State Accident Insurance Fund Corporation is an authorized assuming insurer with respect to reinsurance for medical professional liability insurance for the purposes of ORS 731.509. + }

SECTION 4. { + In addition to the purposes and functions for which the State Accident Insurance Fund Corporation is created under ORS 656.752, the State Accident Insurance Fund Corporation is also created for the purpose of carrying out the reinsurance program for medical professional liability insurance established under section 1 of this 2003 Act. + }

SECTION 5. { + (1) The Rural Medical Liability Reinsurance Fund is established separate and distinct from the General Fund and shall be held by the State Treasurer. The Rural Medical Liability Reinsurance Fund is established for the purpose of providing coverage under the reinsurance program established under section 1 of this 2003 Act. Interest earned by the Rural Medical Liability Reinsurance Fund shall be credited to the fund.

(2) The State Accident Insurance Fund Corporation shall provide the resources necessary to support and fund coverage provided by the corporation as authorized under section 1 of this 2003 Act.

(3) All moneys received by the State Accident Insurance Fund Corporation for payment to the Rural Medical Liability Reinsurance Fund shall be deposited to and shall become part of the Rural Medical Liability Reinsurance Fund.

(4) All payments authorized to be made by the State Accident Insurance Fund Corporation for coverage under the reinsurance program established under section 1 of this 2003 Act shall be made from the Rural Medical Liability Reinsurance Fund.

(5) Any excess or residual moneys remaining in the Rural Medical Liability Reinsurance Fund after the State Accident Insurance Fund Corporation has made all payments for which the corporation is obligated under section 1 of this 2003 Act, other than moneys that are owed to the State Accident Insurance Fund Corporation, shall be transferred to the Consumer and Business Services Fund. + }

SECTION 6. { + (1) If an insurer obtains coverage with the State Accident Insurance Fund Corporation for medical professional liability insurance issued by the insurer to a

doctor to whom section 1 of this 2003 Act applies, the insurer shall reduce the premium charged to the doctor in a manner that fully recognizes savings made available by coverage offered under section 1 of this 2003 Act.

(2) An insurer to which subsection (1) of this section applies shall demonstrate the difference in its rates for medical professional liability insurance for purposes of subsection (1) of this section in its filing of rates with the Director of the Department of Consumer and Business Services.
+ }

SECTION 7. { + (1) When the State Accident Insurance Fund Corporation provides coverage through the reinsurance program established under section 1 of this 2003 Act, the Director of the Department of Consumer and Business Services shall credit the purchase price or the amount of the payment, net of any income, to the annual assessment owing by the State Accident Insurance Fund Corporation to the Department of Consumer and Business Services under ORS 656.612. The amount the director credits under this subsection may not exceed an average of \$10 million for each policy year for the four years that coverage is provided under section 1 of this 2003 Act.

(2) The director shall establish by rule the accounting procedures and requirements by which the credit is determined for the assessment under ORS 656.612. + }

SECTION 8. { + Notwithstanding ORS 656.632 and 656.634, the State Accident Insurance Fund Corporation may transfer funds from the Industrial Accident Fund to the Rural Medical Liability Reinsurance Fund for the purposes of sections 1 to 7 and 10 to 12 of this 2003 Act and the amendments to ORS 656.632 by section 9 of this 2003 Act. + }

SECTION 9. ORS 656.632 is amended to read:

656.632. (1) The Industrial Accident Fund is continued. This fund shall be held by the State Treasurer and by the State Treasurer deposited in such banks as are authorized to receive deposits of general funds of the state.

(2) All moneys received by the State Accident Insurance Fund Corporation { + for workers' compensation purposes + } under this chapter, shall be paid forthwith to the State Treasurer and shall become a part of the Industrial Accident Fund. However, any assessments collected for the Director of the Department of Consumer and Business Services under this chapter and deposited in the Industrial Accident Fund may thereafter be transferred to the director and deposited in the Consumer and Business Services Fund.

(3) All payments authorized to be made by the State Accident Insurance Fund Corporation { + for workers' compensation purposes + } by this chapter, including all salaries, clerk hire and all other expenses, shall be made from the Industrial Accident Fund.

SECTION 10. { + (1) There is created the Professional Panel for Analysis of Medical Professional Liability Insurance consisting of six members appointed as follows:

(a) The President of the Senate shall appoint two members, one of whom must have professional expertise in gathering, evaluating or applying research data.

(b) The Speaker of the House of Representatives shall appoint two members, one of whom must have professional expertise in gathering, evaluating or applying research data.

(c) The Governor shall appoint two members, one of whom must have professional expertise in gathering, evaluating or applying research data.

(2) Members of the panel may not have a financial or professional affiliation with:

- (a) Medical care providers;
 - (b) Insurers providing professional liability insurance; or
 - (c) Personal injury litigation.
- (3) The panel shall:

(a) Advise the State Accident Insurance Fund Corporation in its selection of the consulting firm required under section 11 of this 2003 Act;

(b) Establish a work plan to be carried out by the consulting firm;

(c) Review and approve the work product of the consulting firm; and

(d) Evaluate the data reported by the consulting firm and make findings incorporating the data. The findings shall be included in the report required under subsection (10) of this section.

(4) The panel is subject to the provisions of ORS 171.605 to 171.635.

(5) The panel shall use the services of permanent legislative staff to the greatest extent practicable.

(6) All agencies of state government, as defined in ORS 174.111, are directed to assist the panel in the performance of its duties and, to the extent permitted by laws relating to confidentiality, to furnish such information and advice as the members of the panel consider necessary to perform their duties.

(7) A majority of the members of the panel constitutes a quorum for the transaction of business.

(8) Official action by the panel requires the approval of a majority of the members of the panel.

(9) The panel shall elect one of its members to serve as chairperson.

(10) The panel shall submit a report to the Governor and to the Legislative Assembly in the manner provided by ORS 192.245, no later than December 15, 2004.

(11) Members of the panel who are not members of the Legislative Assembly are not entitled to compensation, but may be reimbursed for actual and necessary travel and other expenses incurred by them in the performance of their official duties, in the manner and amounts provided for in ORS 292.495. Claims for expenses shall be paid out of funds in the Rural Medical Liability Reinsurance Fund established under section 5 of this 2003 Act.

(12) The panel may seek public and private funds to assist in the work of the panel. + }

SECTION 11. { + (1) The State Accident Insurance Fund Corporation shall select a consulting firm to perform services required under this section. The firm selected must be a regional or national consulting firm with at least 10 accredited casualty actuaries on staff and must possess demonstrated accounting, financial and research capabilities. The firm must also have experience in the casualty insurance industry and particularly in the field of medical professional liability insurance.

(2) Under the direction of the Professional Panel for Analysis of Medical Professional Liability Insurance created under section 10 of this 2003 Act, the consulting firm shall gather, analyze and evaluate data on the availability, costs and transaction of medical professional liability insurance that consider Oregon market trends on premiums and losses, other factors affecting the competitiveness of the Oregon market and regulatory options for minimizing cyclical trends.

(3) The costs of the services of the consulting firm selected under subsection (1) of this section shall be paid by the State Accident Insurance Fund Corporation from the amount available for credit to the annual assessment owing by the State Accident Insurance Fund Corporation under section 7 of this 2003 Act. The cost of services may not exceed two percent of the maximum average amount that may be credited to the State Accident Insurance Fund Corporation for one year under section 7 of this 2003 Act. + }

SECTION 12. { + The Office for Oregon Health Policy and Research and the Office of Rural Health shall make recommendations to the Governor and to the Seventy-third Legislative Assembly concerning methods to attract and retain doctors in rural areas of the state. + }

SECTION 13. ORS 656.632, as amended by section 9 of this 2003 Act, is amended to read:

656.632. (1) The Industrial Accident Fund is continued. This fund shall be held by the State Treasurer and by the State Treasurer deposited in such banks as are authorized to receive deposits of general funds of the state.

(2) All moneys received by the State Accident Insurance Fund Corporation { - for workers' compensation purposes - } under this chapter, shall be paid forthwith to the State Treasurer and shall become a part of the Industrial Accident Fund. However, any assessments collected for the Director of the Department of Consumer and Business Services under this chapter and deposited in the Industrial Accident Fund may thereafter be transferred to the director and deposited in the Consumer and Business Services Fund.

(3) All payments authorized to be made by the State Accident Insurance Fund Corporation { - for workers' compensation purposes - } by this chapter, including all salaries, clerk hire and all other expenses, shall be made from the Industrial Accident Fund.

SECTION 14. { + (1) The State Accident Insurance Fund Corporation shall continue paying reinsurance claims incurred or made prior to January 1, 2008, from the Rural Medical Liability Reinsurance Fund until the State Accident Insurance Fund Corporation has extinguished its liabilities for reinsurance issued under section 1 of this 2003 Act by payment of claims or by purchase of reinsurance. Purchase of reinsurance under this subsection shall be subject to approval by the Director of the Department of Consumer and Business Services.

(2) Sections 1 to 8 and 10 to 12 of this 2003 Act are repealed January 2, 2014.

(3) The amendments to ORS 656.632 by section 13 of this 2003 Act become operative January 2, 2014. + }

SECTION 15. { + (1) The Director of the Department of Consumer and Business Services shall report in the manner provided by ORS 192.245 to the Seventy-third and Seventy-fourth Legislative Assemblies on the performance of the program established under section 1 of this 2003 Act.

(2) The State Accident Insurance Fund Corporation shall provide all data and other information required by the director to prepare the reports required under this section. + }

SECTION 16. { + This 2003 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2003 Act takes effect on its passage. + }

Enrolled House Bill 3630 (HB 3630-B)

Passed by House June 16, 2003

Repassed by House August 23, 2003

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Chief Clerk of House

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Speaker of House

Passed by Senate August 22, 2003

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President of Senate

Enrolled House Bill 3630 (HB 3630-B)

Received by Governor:

.....M.,....., 2003

Approved:

.....M.,....., 2003

.....
Governor

Enrolled

Senate Bill 183

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with pre-session filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Governor Theodore R. Kulongoski for Department of Consumer and Business Services)

CHAPTER

AN ACT

Relating to reinsurance program for medical professional liability insurance policies provided by State Accident Insurance Fund Corporation; creating new provisions; amending sections 1, 2, 6, 7, 14 and 15, chapter 781, Oregon Laws 2003; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 1, chapter 781, Oregon Laws 2003, is amended to read:

{ + Sec. 1. + } (1) The State Accident Insurance Fund Corporation shall establish a reinsurance program for medical professional liability insurance policies issued by authorized insurers in the calendar years 2004, 2005, 2006 { + , + } { - and - } 2007 { + , 2008, 2009, 2010 and 2011 + } to doctors of medicine and doctors of osteopathy licensed under ORS chapter 677 { + and nurse practitioners certified by the Oregon State Board of Nursing + } who:

(a) Have a rural practice { - according to - } { + that meets + } the criteria established by the Office of { - Rural Health for purposes of ORS 315.613; - } { + Rural Health that applied as of January 1, 2004, for purposes of ORS 315.613, excluding urbanized areas, as defined by the United States Census Bureau according to the most recent federal decennial census, pursuant to the authority of the United States Department of Commerce under 13 U.S.C. 141; + }

(b) Hold an active, unrestricted license to practice medicine { + or are currently certified as a nurse practitioner + }; { - and - }

(c) Have an in-force policy of medical professional liability insurance with an authorized insurer with minimum limits of coverage of \$1 million per occurrence and \$1 million aggregate { - . - } { + ; and

(d) Are willing to serve patients with Medicare coverage and patients receiving medical assistance provided under Medicaid in at least the same proportion to their total number of patients as the Medicare and Medicaid populations represent to the total number of patients in need of care in the rural areas of the counties in which the doctors or nurse practitioners practice, as determined by the Office of Rural Health. The Office of Rural

Health shall establish by rule criteria for and procedures for the annual attestation of compliance by participating doctors and nurse practitioners with the requirements of this paragraph. The requirements of this paragraph do not apply to nurse practitioners participating in the program who are employed by licensed physicians. + }

(2) The reinsurance program established in accordance with this section must be carried out in accordance with the plan approved under section 2 { - of this 2003 Act - } { + , chapter 781, Oregon Laws 2003 + }.

(3) The coverage provided under the reinsurance program shall be priced by the State Accident Insurance Fund Corporation, in accordance with rate standards or percentage reductions determined by the Director of the Department of Consumer and Business Services after consultation with the Office of Rural Health, at rates that will significantly reduce premiums for doctors { + and nurse practitioners + } to whom this section applies so as to make the medical professional liability insurance reasonably affordable.

(4)(a) The State Accident Insurance Fund Corporation may provide coverage as authorized in this section on such terms and conditions as the State Accident Insurance Fund Corporation determines to be reasonable, subject to the requirements and other terms of the plan approved under section 2 { - of this 2003 Act - } { + , chapter 781, Oregon Laws 2003 + }.

(b) Notwithstanding paragraph (a) of this subsection, the State Accident Insurance Fund Corporation must make all reasonable efforts consistent with the goals of sections 1 to 7, 10 to 12 and 14 { - of this 2003 Act - } { + , chapter 781, Oregon Laws 2003, + } to transfer any assumed reinsurance liability.

(5) The State Accident Insurance Fund Corporation is not required to provide coverage for risks under this section that { - exceed - } { + exceeds + } the amount the director is authorized to credit against assessments in section 7 { - of this 2003 Act - } { + , chapter 781, Oregon Laws 2003 + }, but the State Accident Insurance Fund Corporation is liable for all risks that it covers under this section.

{ + (6) As used in this section:

(a) 'Medicaid' means medical assistance provided under 42 U.S.C. 1396a, section 1902 of the Social Security Act.

(b) 'Medicare' means the 'Health Insurance for the Aged Act, 'Title XVIII of the Social Security Amendments of 1965. + }

SECTION 2. Section 2, chapter 781, Oregon Laws 2003, is amended to read:

{ + Sec. 2. + } (1) The State Accident Insurance Fund Corporation shall submit to the Director of the Department of Consumer and Business Services and to the Office of Rural Health a plan for carrying out the provisions of section 1 { - of this 2003 Act - } { + , chapter 781, Oregon Laws 2003 + }. The director and the office shall approve the plan following a determination that the plan:

(a) Satisfies the purposes of sections 1 to 7 { - of this 2003 Act - } { + , chapter 781, Oregon Laws 2003 + }.

(b) Obligates the State Accident Insurance Fund Corporation to carry out the reinsurance program established under section 1 { - of this 2003 Act - } { + , chapter 781, Oregon Laws 2003, + } by any appropriate coverage, which may consist of financial reinsurance, on an insurer-to-insurer basis.

(c) Provides administrative management for the reinsurance program.

(d) Is financially sound.

(e) Facilitates payments from the Rural Medical Liability Reinsurance Fund established by section 5 { - of this 2003 Act - } { + , chapter 781, Oregon Laws 2003, + } and is otherwise fair and reasonable to the participating primary insurers and their insureds.

(f) Establishes appropriate underwriting and rating standards.

(g) Minimizes transactional and claim costs for the State Accident Insurance Fund Corporation and for primary users.

(h) Is appropriate in relation to the insurance market in this state.

(i) Effectively reduces premiums for medical professional liability insurance for doctors { + and nurse practitioners + } eligible for coverage under the plan.

(2)(a) The plan approved under this section must provide, to the extent funds are available from the credit provided in section 7 { - of this 2003 Act - } { + , chapter 781, Oregon Laws 2003, + } for the annual assessment owed by the State Accident Insurance Fund Corporation under ORS 656.612, for a reduction in premiums as provided in this subsection for medical professional liability insurance for eligible doctors { - of medicine and doctors of osteopathy - } { + and nurse practitioners + }. The reduction of premium shall be:

(A) { - Up to - } 80 percent for doctors specializing in obstetrics { + and nurse practitioners certified for obstetric care + };

(B) { - Up to - } 60 percent for doctors specializing in family or general practice who provide obstetrical services; { - and - }

{ - (C) Up to 40 percent for all other eligible doctors. - }

{ + (C) Up to 40 percent for doctors and nurse practitioners engaging in one or more of the following practices:

(i) Family practice without obstetrics.

(ii) General practice.

(iii) Internal medicine.

(iv) Geriatrics.

(v) Pulmonary medicine.

(vi) Pediatrics.

(vii) General surgery.

(viii) Anesthesiology; and

(D) Up to the following percentages for doctors and nurse practitioners other than those included in subparagraph (A), (B) or (C) of this paragraph:

(i) 35 percent, for calendar year 2008.

(ii) 25 percent, for calendar year 2009.

(iii) 15 percent, for calendar year 2010.

(iv) 15 percent, for calendar year 2011.

(b) Notwithstanding section 1 (1)(a), chapter 781, Oregon Laws 2003, a doctor who meets all the criteria for eligibility for a reduction in premiums established in section 1 (1)(b), (c) and (d), chapter 781, Oregon Laws 2003, who has a rural practice that meets the criteria established by the Office of Rural Health that applied as of January 1, 2004, for the purposes of ORS 315.613, and is located in an urbanized area of Jackson County, as defined by the United States Census Bureau according to the most recent federal decennial census taken pursuant to the authority of the United States Department of Commerce under 13 U.S.C. 141(a), and who specializes in obstetrics is eligible for a reduction in premiums as provided in paragraph (a)(A) of this subsection, and a doctor who specializes in family practice and provides

obstetrical services, or in general practice and provides obstetrical services, or a nurse practitioner who is certified in obstetrical care, is eligible for a reduction in premiums as provided in paragraph (a)(B) of this subsection. + }

{ - (b) - } { + (c) + } If the funds available to provide premium reductions are insufficient to provide the maximum reduction, the plan shall provide for { - proportional reductions to all eligible doctors. - } { + lowering or eliminating the amount provided for premium reductions for the doctors and nurse practitioners eligible for a reduction in premiums under paragraph (a)(D) of this subsection. If, after eliminating all premium reductions for the doctors and nurse practitioners eligible for a reduction in premiums under paragraph (a)(D) of this subsection, the remaining funds are insufficient to provide the maximum reductions provided under the plan, the amounts provided for a reduction in premiums for doctors and nurse practitioners eligible under paragraph (a)(C) of this subsection shall be lowered or eliminated. + }

{ - (c) - } { + (d) + } Premium reductions shall be a percentage of the actual premium charged for medical professional liability insurance in the market of authorized insurers for limits purchased of up to \$1 million per occurrence and \$3 million annual aggregate. { + However, the premium education for a doctor or nurse practitioner referred to in paragraph (a)(C) or (D) of this subsection shall be the lesser of the percentage of the actual premium or the premium paid by the doctor or nurse practitioner for calendar year 2007. For a doctor or nurse practitioner who first becomes eligible for the program on or after January 1, 2008, the premium reduction shall be the lesser of the percentage of either the actual premium or the premium for the first eligibility year determined according to 2007-based rates. When determining the lesser amount under this paragraph, any step increases in the premium owing to the claims-made nature of the policy may not be considered. + }

{ - (d) - } { + (e) + } Premium reductions shall be effective beginning with the first premium payment in each calendar year under the reinsurance program.

(3) The plan adopted under this section may not obligate the State Accident Insurance Fund Corporation to provide coverage under section 1 { - of this 2003 Act - } { + , chapter 781, Oregon Laws 2003, + } at a cost to the State Accident Insurance Fund Corporation that exceeds an average of { - \$10 - } { + \$5 + } million for each policy year for { - the four years for - } which the coverage is provided. The cost to the State Accident Insurance Fund Corporation shall be the actuarially determined costs of the reinsurance program.

{ - (4)(a) The State Accident Insurance Fund Corporation shall submit the plan required under this section to the director and the office not later than September 30, 2003. - }

{ - (b) The director and the office shall approve, disapprove or require changes to the plan as promptly as reasonably possible in order to enable the State Accident Insurance Fund Corporation to have the plan operational by January 1, 2004. The plan may be implemented only after joint approval by the director and the office. - }

SECTION 2a. Section 6, chapter 781, Oregon Laws 2003, is amended to read:

{ + Sec. 6. + } (1) If an insurer obtains coverage with the State Accident Insurance Fund Corporation for medical professional liability insurance issued by the insurer to a

doctor { + or nurse practitioner + } to whom section 1 { + , chapter 781, Oregon Laws 2003, + } { - of this 2003 Act - } applies, the insurer shall reduce the premium charged to the doctor { + or nurse practitioner + } in a manner that fully recognizes savings made available by coverage offered under section 1 { + , chapter 781, Oregon Laws 2003 + } { - of this 2003 Act - }

(2) An insurer to which subsection (1) of this section applies shall demonstrate the difference in its rates for medical professional liability insurance for purposes of subsection (1) of this section in its filing of rates with the Director of the Department of Consumer and Business Services.

SECTION 3. Section 7, chapter 781, Oregon Laws 2003, is amended to read:

{ + Sec. 7. + } (1) When the State Accident Insurance Fund Corporation provides coverage through the reinsurance program established under section 1 { - of this 2003 Act - } { + , chapter 781, Oregon Laws 2003 + }, the Director of the Department of Consumer and Business Services shall credit the purchase price or the amount of the payment, net of any income, to the annual assessment owing by the State Accident Insurance Fund Corporation to the Department of Consumer and Business Services under ORS 656.612. The amount the director credits under this subsection may not exceed an average of { - \$10 - } { + \$5 + } million for each policy year for { - the four years that - } { + which + } coverage is provided under section 1 { - of this 2003 Act - } { + , chapter 781, Oregon Laws 2003 + }.

(2) The director shall establish by rule the accounting procedures and requirements by which the credit is determined for the assessment under ORS 656.612.

SECTION 4. Section 14, chapter 781, Oregon Laws 2003, is amended to read:

{ + Sec. 14. + } (1) The State Accident Insurance Fund Corporation shall continue paying reinsurance claims incurred or made prior to January 1, { - 2008, - } { + 2012, + } from the Rural Medical Liability Reinsurance Fund until the State Accident Insurance Fund Corporation has extinguished its liabilities for reinsurance issued under section 1 { - of this 2003 Act - } { + , chapter 781, Oregon Laws 2003, + } by payment of claims or by purchase of reinsurance. Purchase of reinsurance under this subsection shall be subject to approval by the Director of the Department of Consumer and Business Services.

(2) Sections 1 to 8 and 10 to 12 { - of this 2003 Act - } { + , chapter 781, Oregon Laws 2003, + } are repealed January 2, 2014.

(3) The amendments to ORS 656.632 by section 13 { - of this 2003 Act - } { + , chapter 781, Oregon Laws 2003, + } become operative January 2, 2014.

SECTION 5. Section 15, chapter 781, Oregon Laws 2003, is amended to read:

{ + Sec. 15. + } (1) The Director of the Department of Consumer and Business Services shall report in the manner provided by ORS 192.245 to the { - Seventy-third and - } Seventy-fourth { + and Seventy-fifth + } Legislative Assemblies on the performance of the program established under section 1 { - of this 2003 Act - } { + , chapter 781, Oregon Laws 2003 + }.

(2) The State Accident Insurance Fund Corporation shall provide all data and other information required by the director to prepare the reports required under this section.

SECTION 6. { + (1)(a) The State Accident Insurance Fund Corporation shall submit any proposed modifications to the plan required under section 2, chapter 781, Oregon Laws 2003, to the Director of the Department of Consumer and Business Services and to the Office of Rural Health not later than September 30, 2007.

(b) The director and the office shall approve, disapprove or require changes to the plan or to the proposed modifications to the plan as promptly as reasonably possible in order to enable the State Accident Insurance Fund Corporation to have the modified plan operational by January 1, 2008. The modified plan may be implemented only after the joint approval by the director and the office.

(2) The plan modified under subsection (1) of this section must provide that a doctor or nurse practitioner whose coverage is provided through a health care facility as defined in ORS 442.400, and who otherwise meets the requirements of section 1 (1), chapter 781, Oregon Laws 2003, is eligible to participate in the program beginning January 1, 2008, if the office determines that the doctor or nurse practitioner, as of the later of January 1, 2007, or the date on which the doctor or nurse practitioner first commences a rural practice:

(a) Is not an employee of the health care facility;

(b) Is covered by a medical professional liability insurance policy that names the doctor or nurse practitioner and separately calculates the premium for the doctor or nurse practitioner; and

(c) Fully reimburses the health care facility for the premium calculated for the doctor or nurse practitioner. + }

SECTION 7. { + Notwithstanding section 1 (1)(a), chapter 781, Oregon Laws 2003, for the purpose of establishing eligibility of doctors of medicine and doctors of osteopathy for participation in the reinsurance program for medical professional liability insurance policies established by section 1, chapter 781, Oregon Laws 2003, for calendar year 2007, a rural practice is defined as a practice that meets the criteria established by the Office of Rural Health that applied as of January 1, 2004. + }

SECTION 8. { + The amendments to sections 1, 2, 6, 7, 14 and 15, chapter 781, Oregon Laws 2003, by sections 1 to 5 of this 2007 Act become operative on January 1, 2008. + }

SECTION 9. { + This 2007 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2007 Act takes effect on its passage. + }

Enrolled Senate Bill 183 (SB 183-B)

Passed by Senate May 9, 2007

Repassed by Senate June 13, 2007

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Secretary of Senate

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President of Senate

Passed by House June 8, 2007

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Speaker of House

Enrolled Senate Bill 183 (SB 183-B)

Received by Governor:

.....M.,....., 2007

Approved:

.....M.,....., 2007

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Governor