F I S C A L I M P A C T R E P O R T

SPONSOR Barela **ORIGINAL DATE** 2/25/07 **LAST UPDATED** **HB** 1063

SHORT TITLE Malpractice Insurance Limits of Recovery **SB**

ANALYST Earnest

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY07	**FY08**		
NFI	NFI		

(Parenthesis ( ) Indicate Expenditure Decreases)

Relates to House Memorial 25, requesting a study of revising the Medical Malpractice Act.

SOURCES OF INFORMATION
LFC Files

Responses Received From
Public Regulation Commission (PRC)
Health Policy Commission (HPC)
Administrative Office of the Courts (AOC)

SUMMARY

Synopsis of Bill

House Bill 1063 increases from $600 thousand to $1.2 million the maximum compensation that a medically injured patient can receive from a doctor or other health care provider who is covered under the Medical Malpractice Act. The bill increases from $200 thousand to $400 thousand the amount of coverage that the primary insurer must provide before the Patients Compensation Fund begins contributing to the payment of the claim.

The new $1.2 million limit applies only to malpractice occurring after July 1, 2007.

SIGNIFICANT ISSUES

According to the PRC, the current $600,000 limit of recovery in the Medical Malpractice Act has not changed since 1995. This bill, according to a recent projection provided by the actuarial firm retained by the Superintendent of Insurance to evaluate the Patients Compensation Fund, is likely

to increase by 7% to 14% the total malpractice losses incurred by doctors in the Fund. It would also shift more of these claim costs to the primary insurer and reduce the amount of losses paid by the Fund.

According to HPC, the language of the Act requires the use of occurrence coverage, which has effectively limited the coverage under the Act to physicians. Consequently the impact of what is proposed with HB1063 will almost entirely fall on New Mexico's physicians.

The Medical Malpractice Act, enacted in 1976, was intended to "promote the health and welfare of the people of New Mexico by making available professional liability insurance for health care providers in New Mexico."

The current law contains the following benefits for qualifying health care providers:

- $600,000 cap on damages other than medical bills and punitive damages
- 3-year statute of limitations on the filing of a claim (subject to extension for minors)
- Mandatory review of claims by a medical/legal panel prior to the filing of lawsuits
- State participation in malpractice insurance coverage via a "patients compensation fund"

HPC notes limited access to malpractice insurance reduces the number of practicing physicians, and thus results in reduced access to health care. "For example, given New Mexico's shortage of physicians even with caps in place for thirty-two years, a modification of caps could aggravate access to care in a primarily rural state that already has 30 of 33 counties well under the national average of number physicians per 1000 population. Compared with much of the nation, New Mexico is large, rural, poor and thinly populated. New Mexico is currently short between 310 to 550 physicians depending upon which ratio comparisons are used (2003 HPC data)."

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

House Memorial 25 mandates that the current limits of recovery in the Medical Malpractice Act be studied by a special commission composed of the Medical Society, the Trial Bar, the Superintendent of Insurance and a member of the House, and that the findings and recommendations of that study be submitted to the Legislature and the Governor.

OTHER SUBSTANTIVE ISSUES

The Health Policy Commission provided the following background information.

> The American Medical Association has listed New Mexico as one of only six states that, from the viewpoint of physicians and insurers, are not in crisis. This is largely due to physicians' access to the Act and the amount of the caps, which is widely viewed as the main stabilizing influence on their malpractice premiums. . . .
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> AP Capital is currently the primary insurer actively writing occurrence policies for physicians in New Mexico, and the primary insurer of physician who want coverage under the Act.
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> While physician liability rates in other states have soared—in some places to 500 percent—New Mexico's average rate increases from 1994 to 2004 totaled 18.6 percent.

Typical New Mexico physician annual professional liability rates in 2005 were family physician – $16,000; emergency medicine – $26,000; general surgeon – $76,000; orthopedic surgeon – $76,000; and Ob/Gyn – $90,000.

New Mexico has shared in the nationwide trend for doctors, particularly those in high-risk specialties, to leave private practice and seek facility-based employment, partly to avoid having to purchase their own malpractice insurance because of the increasing cost of insurance.

To understand how rising insurance costs are affecting health care providers, it is important to examine both the size of premium increases and what is happening to provider reimbursement. If physicians can charge more when their overhead costs increase, there will be no crisis from their perspective. If this pass-through of costs is not possible—for example because a single payer or small number of payers (Medicare, Medicaid, or a large HMO or a combination of the three) has a dominant market share and refuses to negotiate on this point (or operates under rate control as is the case with Medicare and many commercial providers who peg their reimbursement off of Medicare) then premium increases hurt providers more.

Compared to previous malpractice crises, the current era is characterized by greater use of non-fee-for-service reimbursement arrangements and greater payer consolidation. As a result, it is likely much harder for providers to negotiate upward adjustments in reimbursement. Moreover, Medicaid and Medicare reimbursement has been flat or declining for the last several years. The combination of lower income and higher overhead creates an economic squeeze on physicians.

As a result of the above mentioned economic squeeze on many of New Mexico's physicians, some higher risk medical specialist groups have chosen to be employed by integrated health systems that self insure or hospitals that employ them and can afford to pay the premium for the group. However, to the extent that this type of physician employment arrangements are not covering their own practice expenses (which all most all are not) , then they must be subsidized by other parts of the health system resulting in higher overall costs that are paid for by increasing health insurance premiums. More importantly, with more physicians being insured outside the Act, there may be a concern of a diminishing pool of revenue coming into the Patient Compensation Fund because of health system employment which could in turn impact the availability and cost of occurrence based policies. A self-reinforcing cycle may occur of fewer physicians left in private practice and insured under the Act due in part to their ability to afford professional liability insurance. This may be of particular concern to rural physicians not employed and not desiring employment but having few alternatives other than employment or departure from the state. Also, in rural areas, citizens may end up with fewer provider choices as a result of their employers insurance not being available through their local health system.

A national study (*Health Affairs -May 31, 2005)* found that the presence of caps on non-economic damage awards has an impact on where doctors choose to practice, particularly in rural areas. The study finds that the "27 states with caps on non-economic damages had 2.2% more physicians per capita than states without such caps. Rural counties in states with non-economic damage caps had 3.2% more physicians per capita than rural

counties in states without caps." Obstetricians and surgeons were noted to be the most influenced by the presence or absence of caps.

States that capped non-economic damages in malpractice cases experienced a 2.4% increase in overall physician supply compared with states that have no such caps, holding other factors constant, according to another study (*Journal of the American Medical Association- June 1,2005*). The study says physician services increased in every state from 1985 to 2001, but states with damage caps saw a higher than average increase in the number of doctors than states without tort reform.

An August 2003 GAO report with "limited available data indicated that growth in malpractice premiums and claims payments has been slower in states that enacted tort reform laws that include certain caps on non-economic damages. For example, between 2001 and 2002, average premiums for three physician specialties—general surgery, internal medicine, and obstetrics/gynecology—grew by about 10 percent in states with caps on non-economic damages of $250,000, compared to about 29 percent in states with limited reforms."

The evidence would seem to indicate that the presence of caps is associated with better physician supply.

"Defensive medicine" refers to the widespread practice of physicians to order excessive tests, treatments and referrals in order to reduce their exposure to potential lawsuits rather than to medically benefit their patients. The monetary costs of defensive medicine, however, remain difficult to measure, with estimates ranging from 5% to 9% of total health care costs (U.S. Department of Health and Human Services) to "small" (Congressional Budget Office).

There is considerable debate nationally over how often physicians alter their clinical behavior because of the threat of malpractice liability, or defensive medicine, and the consequences of those behavioral changes. The most recent study is a *Journal of the American Medical Association* study published in June 2005 of Pennsylvania physicians which suggests that " nearly all (93%) of the surveyed physicians reported practicing defensive medicine." Forty-two percent reported that they had taken steps to restrict their practice in the previous three years, including eliminating procedures prone to complications, such as trauma surgery, and avoiding patients who had complex medical problems or were perceived as litigious. Defensive practice correlated strongly with respondents' lack of confidence in their liability insurance and perceived burden of insurance premiums." Pennsylvania is one of the states characterized as "in crisis" by the American Medical Association. Malpractice insurance for a general surgeon in Pennsylvania more than doubled to $72,518 in 2003 from $33,684 three years earlier.

Market Conditions Nationally (Insurance Information Institute, February 2007)

Although the cost of medical malpractice insurance has stabilized or decreased for most specialties in most geographical areas, it is still much higher than it was five or six years ago and doctors who reduced their coverage at the height of the crisis are not yet rushing to raise it again, according to *Medical Economics*. Doctors who left the traditional market for a captive or risk retention group are for the most part still there.

Fewer medical malpractice claims are being filed, but the dollar amount of each claim is increasing. In its *Hospital Professional Liability and Physician Liability 2006 Benchmark Analysis*, which examined more than 47,700 claims representing more than $4.4 billion of incurred losses, the insurance broker Aon found that the overall frequency of medical malpractice claims has not increased for the second consecutive year. But while claim frequency is stabilizing, according to the study, the average size (severity) of malpractice claims continues to increase at a rate of 6 percent.

New Mexico's experience in this area for 2005 was an average claims payment of $226,974 (Source: Kaiser Family Foundation data).

The financial results of medical malpractice insurers show the crisis in medical malpractice insurance is lessening as premiums reach acceptable levels relative to costs. According to the National Underwriter Data Services, the medical malpractice combined ratio, a measure of profitability, was 100.1 in 2005. This means that in 2005 for every medical malpractice premium dollar collected, insurers paid out a little over one dollar in claims and expenses. This represents a significant drop from 2003, when the combined ratio was 138.8, and from the five previous years. The combined ratio does not take account of investment income.

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