ATTACHMENT 1

MEDICAL LIABILITY COMMITTEE

FINAL REPORT

January 1985

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EXECUTIVE SUMMARY

Medical Liability Report

EXECUTIVE SUMMARY

BACKGROUND

Beginning in the mid-70's physicians throughout the country began to experience difficulty in purchasing medical malpractice insurance. This difficulty had broad implications for the consumer as well as the provider of health services. In 1975, in response to this situation, the State of New Hampshire established, the Medical Malpractice Joint Underwriting Association (JUA). The JUA is, in essence, a state authorized and regulated medical liability insurance company for the state's health providers. In 1981, however, problems surfaced with the JUA. Over the six-year period, the number of claims filed, settled, or awarded in court had increased. In addition, several large medical malpractice decisions had been awarded by the court system.

In the early part of 1983, the JUA informed the N.H. Insurance Department that it faced substantial future deficits in meeting expected claims from the financial resources available to it. The actuarially estimated deficit ranged between $30 million and $60 million. As a further complication, the number of health care providers insured by the JUA was falling because a voluntary market for the medical liability insurance was starting to reappear in New Hampshire.

This problem affected not only individual health care providers and hospitals, and the insurance industry in New Hampshire, it also affected consumers of health care services, and indirectly, the business community through the rising cost of health care.

In the fall of 1983 the New Hampshire Insurance Department began action to deal with the problem of a potentially mounting JUA deficit. The Department issued directives effectively restricting the voluntary market for medical liability insurance to renewal of existing coverage for physicians and surgeons. The Insurance Department also moved to change the assessment formula of Ins. 1702.07, proposing a rules change which would assign 20% of the responsibility for JUA deficits to health care providers, 60% of the responsibility for such deficits to insurance companies writing voluntary medical liability insurance in New Hampshire, and the remainder of such responsibility to all insurance companies writing liability insurance in New Hampshire, including automobile insurance. At a hearing held in December of 1983, objections to the department's proposal were raised by interested parties including health care providers interested in purchasing insurance from the voluntary market and private medical liability insurance carriers.

In the Spring of 1984, Governor John Sununu appointed a Medical Liability Committee, chaired by Senator George Freese, and consisting of three subcommittees, to recommend to him a wide range of solutions to deal with the existing New Hampshire situation. The JUA Subcommittee was chaired by Commissioner Louis Bergeron of the New Hampshire Insurance Department; the Risk Management Subcommittee was chaired by Frank Jillson, President of New Hampshire Blue Cross/Blue Shield; the Tort Reform Subcommittee was chaired by Commissioner Sylvio Dupuis of the New Hampshire Department of Health and Welfare.

EXPLORATION OF UNDERLYING CAUSES AND PROBLEM DEFINITION

The presenting problem to the Medical Liability Committee was twofold:

- How should the JUA deal with the projected large deficit?

- What could be done to mitigate the further rapid escalation of premiums which physicians were being charged in anticipation of future incurred losses?

Underlying causes of the problem fall into two main categories: (a) national trends which are impacting New Hampshire, and (b) specific New Hampshire conditions. Within the medical system two major national trends impact on medical liability. First, the rapid technological advance in medicine and increasing utilization of high technology health care have increased the risk for consumers of an unfavorable or unanticipated medical outcome. Second, the specialization of health care and the rise of the group practice has contributed to the impersonalization of medical care. Within the legal system, there has been an unmistakable trend towards more frequent medical malpractice claims being brought and higher verdicts being awarded by the courts.

Data reported on the New Hampshire JUA history of frequency and severity of claims by Johnson and Higgins, current JUA administrators, reveal a sharp increase in frequency and severity of claims, 1980-1983. These data paint a picture of a frequency and severity problem to which the JUA premiums are still adjusting. 1984 estimated figures indicate that the frequency and severity of claims appears to be stabilizing. However, it must be emphasized that due to the smaller number of insureds in New Hampshire, one or two large claims in the future could alter this situation.

The recommendations of the three subcommittees address the following two problems:

- What steps can be taken to deal with the JUA deficit without imposing excessive costs on any one segment of the health care system?

- What steps can be taken to reduce the frequency and severity of medical liability claims including (a) changes in the medical system which would reduce or prevent the incidence of medical malpractice or medical liability claims, and (b) changes in the tort system?

RECOMMENDATIONS

A. JUA Subcommittee:

1. TO STABILIZE THE PRESENT JUA, THE INSURANCE DEPARTMENT SHOULD CONTINUE UNTIL DECEMBER 31, 1985, ITS ADMINISTRATIVE ORDERS OF SEPTEMBER 7 AND NOVEMBER 9, 1983, RESTRICTING THE ISSUANCE OF PRIVATE MEDICAL MALPRACTICE POLICIES TO RENEWAL ONLY. THE INSURANCE DEPARTMENT'S ORDERS SHOULD BE REMOVED ON JANUARY 1, 1986 AND THE VOLUNTARY MARKET WILL THEN BE ALLOWED TO DEVELOP FURTHER.

2. THE INSURANCE DEPARTMENT SHOULD ADOPT A RULE ESTABLISHING A STABILIZATION RESERVE FUND TO HELP SUPPORT JUA CASH DEFICITS WHICH MAY ARISE IN THE FUTURE. THE STABILIZATION RESERVE FUND WOULD BE FUNDED BY A 15% PREMIUM SURCHARGE ON ALL MEDICAL MALPRACTICE INSURANCE POLICIES WRITTEN OR RENEWED ON OR AFTER MARCH 1, 1985, OR 30 DAYS AFTER THE EFFECTIVE DATE OF THE RULE ESTABLISHING THE FUND, WHICHEVER DATE OCCURS LATER. PREMIUM SURCHARGES WOULD BE DEPOSITED IN THE STABILIZATION RESERVE FUND. THE SURCHARGES WOULD REMAIN IN EFFECT UNTIL THE INSURANCE COMMISSIONER MAKES THE ACTUARIAL DETERMINATION THAT A JUA DEFICIT NO LONGER EXISTS, CONSIDERING THE CASH POSITION OF THE JUA AND THE SIZE OF THE STABILIZATION RESERVE FUND.

3. THE INSURANCE DEPARTMENT SHOULD REVISE INS 1702.07 TO CHANGE THE METHOD OF DEFRAYING ANY JUA CASH DEFICIT ON OCCURRENCE POLICIES BEYOND WHAT WOULD BE COVERED BY THE JUA OCCURRENCE FUND AND THE STABILIZATION RESERVE FUND. THE REVISION SHOULD PROVIDE FOR REMAINING DEFICITS TO BE SHARED AMONG ALL LIABILITY INSURANCE CARRIERS WRITING IN THE STATE OF NEW HAMPSHIRE, INCLUDING THOSE WRITING AUTOMOBILE LIABILITY INSURANCE. THE RULE CHANGE ALSO SHOULD INCLUDE A POSITIVE METHOD OF RECOUPMENT, THROUGH IDENTIFIABLE PREMIUM SURCHARGES ON ALL LIABILITY INSURANCE POLICIES WRITTEN IN THE STATE.

4. THE INSURANCE DEPARTMENT SHOULD ADOPT A PUBLICLY STATED POLICY THAT THE MATTER OF APPROVAL OF FUTURE JUA RATES WILL BE UNDERTAKEN WITH EXTREME CARE, IN ORDER TO ASSURE THAT THE RATES TO BE CHARGED BY THE JUA WILL BE NEITHER INADEQUATE, EXCESSIVE, NOR UNFAIRLY DISCRIMINATORY. IN ADDITION, THE DEPARTMENT MUST UNDERTAKE TO REVIEW ANNUALLY, IN PUBLIC HEARING, THE NEED FOR CONTINUATION OF THE STABILIZATION RESERVE FUND SURCHARGE PROVIDED FOR IN THE SECOND RECOMMENDATION.

B. Risk Management Subcommittee

1. THE INSURANCE DEPARTMENT SHOULD MANDATE A NEW RULE THAT ALL MEDICAL LIABILITY INSURERS NOTIFY THE BOARD OF REGISTRATION IN MEDICINE OF ALL CHARGEABLE CLAIMS AND SUITS. (The intent here is to report every chargeable claim and suit, not incidents.)

2. THE BOARD OF REGISTRATION SHOULD NOTIFY THE HOSPITAL CHIEF EXECUTIVE OFFICER FOR REFERRAL TO THEIR RESPECTIVE CREDENTIALS AND QUALITY ASSURANCE COMMITTEES OR EQUIVALENT FORMAL COMMITTEES WITH A TWO-STEP PROCESS. THE BOARD OF REGISTRATION SHALL CONDUCT A REVIEW ON CLAIMS ARISING IN NON-HOSPITAL SETTINGS.

3. THE HOSPITALS' CREDENTIALS AND QUALITY ASSURANCE COMMITTEES OR EQUIVALENT FORMAL COMMISSIONS WITH A TWO-STEP PROCESS SHOULD PERFORM THEIR REVIEWS, ESTABLISH AND CARRY OUT NECESSARY ACTIONS, IF ANY, AND REPORT BACK TO THE NEW HAMPSHIRE BOARD OF REGISTRATION IN MEDICINE. A PROGRESS OR FINAL REPORT SHOULD BE MADE TO THE BOARD WITHIN 45 DAYS. FURTHER DEFINITION OF THE CONTENT OF THE REPORT SHOULD BE ACCOMPLISHED BY THE BOARD OF REGISTRATION THROUGH ITS RULEMAKING AUTHORITY.

4. THE BOARD OF REGISTRATION SHOULD SATISFY ITSELF THAT ACTIONS TAKEN BY THE HOSPITAL ADMINISTRATION AND BOARD ARE APPROPRIATE AND CARRIED OUT. THE BOARD SHOULD TAKE ADDITIONAL ACTION IF IT IS CONSIDERED NECESSARY. SHOULD THE INSURANCE DEPARTMENT HAVE NEED TO REVIEW ANY CLAIM OR SUIT, THE COMMISSIONER SHOULD HAVE FULL ACCESS TO THE BOARD OF REGISTRATION'S DATA.

5. THE BOARD OF REGISTRATION SHOULD ADDITIONALLY MAINTAIN A DATA BASE IN USABLE FORM, AND SHOULD ESTABLISH AND CARRY OUT AN ONGOING EDUCATIONAL PROGRAM FOR PHYSICIANS AND HOSPITALS, UTILIZING CASE INFORMATION WITH NO IDENTIFIERS. IMPROVED EDUCATION ON THE CAUSES OF MEDICAL INJURY AND CHARGEABLE CLAIMS, AS WELL AS ON PHYSICIAN COMMUNICATION WITH PATIENTS, SHOULD HELP TO PREVENT INJURY AND TO AVOID CLAIMS AND SUITS IN CASES OF UNTOWARD OUTCOMES OF QUALITY MEDICAL PRACTICE.

6. RULES GOVERNING THE CONFIDENTIALITY OF DECISIONS MADE BY THE BOARD OF REGISTRATION SHOULD BE LIFTED. CARE MUST BE TAKEN TO INSURE THAT INFORMATION REGARDING A PHYSICIAN IS VERIFIED AND BONA FIDE, NOT FRIVOLOUS, BEFORE IT IS MADE PUBLIC. THIS RECOMMENDATION REQUIRES FURTHER SPECIFIC DEFINITION BY THE BOARD OF REGISTRATION IN MEDICINE THROUGH ITS RULEMAKING AUTHORITY.

C. Tort Reform Subcommittee

1. THE NEW HAMPSHIRE DEPARTMENT OF INSURANCE SHOULD AUTHORIZE, THROUGH ITS RULEMAKING AUTHORITY, A DEMONSTRATION PILOT PROJECT, OF A VOLUNTARY, BINDING ARBITRATION SYSTEM FOR THE RESOLUTION OF MEDICAL LIABILITY CLAIMS. SUBSEQUENT TO POSITIVE EVALUATION OF THIS DEMONSTRATION BY THE N.H. INSURANCE DEPARTMENT, THE NEW HAMPSHIRE GENERAL COURT SHOULD CONSIDER ENABLING LEGISLATION WHICH WOULD SUPPORT AND FUND, IF NECESSARY, A VOLUNTARY, BINDING ARBITRATION SYSTEM IN NEW HAMPSHIRE.

2. THE 1985 NEW HAMPSHIRE GENERAL COURT SHOULD CONSIDER PASSAGE OF A TORT REFORM BILL WHICH WOULD:

   . ELIMINATE THE AD DAMNUM CLAUSE IN FILING A LIABILITY CLAIM.

   . SHORTEN THE NEW HAMPSHIRE STATUTE OF LIMITATIONS IN WHICH AN ADULT COULD BRING SUIT FROM THE CURRENT SIX YEARS TO THREE YEARS FROM OCCURRENCE OF INJURY, OR DISCOVERY OF INJURY (OR WHEN INJURY REASONABLY SHOULD HAVE BEEN DISCOVERED). ALLOW STATUTE OF LIMITATION FOR A MINOR TO RUN UNTIL THREE YEARS AFTER HE/SHE HAS REACHED MAJORITY (18).

   . LIMIT THE APPLICATION OF RES IPSA LOQUITOR TO CERTAIN TYPES OF CASES OR MANDATE THE COURTS TO PROVIDE SPECIAL INSTRUCTIONS TO THE JURY ON THIS USE OF THIS DOCTRINE IN A TRIAL

3. THE NEW HAMPSHIRE BAR ASSOCIATION AND THE COURTS SHOULD ENCOURAGE THE USE OF STRUCTURED PAYMENTS FOR ALL LARGE TORT CASE AWARDS AND AS A NEGOTIATION TOOL IN SETTLEMENT.

4. THE N.H. BAR ASSOCIATION AND THE COURTS SHOULD REVIEW THE CURRENT CONTINGENCY FEE SYSTEM FOR MEDICAL LIABILITY CASES, AND ENSURE AN EQUITABLE CONTINGENCY FEE SYSTEM TO MAXIMIZE THE AMOUNT OF THE AWARD WHICH GOES TO THE INJURED PARTY, WITHOUT JEOPARDIZING HIS/HER ACCESS TO THE LEGAL SYSTEM.

5. THE INSURANCE DEPARTMENT SHOULD EXPLORE THE FOLLOWING AS INNOVATIVE, LONGER-TERM APPROACHES TO MORE EQUITABLY SPREAD THE COST OF THE MEDICAL LIABILITY PROBLEM:

   a. OTHER FORMS OF MEDICAL LIABILITY INSURANCE, INCLUDING FIRST PARTY MEDICAL LIABILITY INSURANCE (E.G. SURGERY INSURANCE), AND DEDUCTIBLES FOR PHYSICIANS ON THEIR MALPRACTICE INSURANCE

   b. CREATION OF MEDICAL INJURY COMPENSATION POOL WHICH WOULD BE SOMEWHAT ANALOGOUS TO WORKERS COMPENSATION.

c. NO-FAULT LEGISLATION FOR MEDICAL INJURY COMPENSATION SIMILAR TO THAT IN AUTOMOBILE INSURANCE.

d. PREMIUMS ADJUSTED PROPORTIONATELY TO THE PRACTICE INTENSITY OF THE PHYSICIAN WHICH MAY VARY BY GEOGRAPHIC LOCATION IN THE STATE.

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FINAL REPORT

MEDICAL LIABILITY COMMITTEE/TORT REFORM SUBCOMMITTEE

FINAL REPORT

I. BACKGROUND

Beginning in the mid-70's, physicians throughout the country began to experience difficulty in purchasing medical malpractice insurance. This difficulty had broad implications for the consumer of health services. With health providers holding no medical liability insurance it was possible that an individual, injured through medical malpractice or negligence, would not have an adequate mechanism for receiving compensation. Furthermore, some doctors, understanding the risks inherent in an uninsured medical practice, might be reluctant to continue their practice in the face of possible financial ruin if suit were brought and won. Such an eventuality could put some consumers, particularly those in rural areas, at risk of not receiving adequate medical care. Therefore, the lack of available medical liability coverage had potential impact on both providers and consumers of health care.

Joint Underwriting Association Established

In 1975, in response to this situation, New Hampshire established the Medical Malpractice Joint Underwriting Association (JUA). The JUA is, in essence, a state authorized and regulated medical liability insurance company for the state's health providers. Providers pay premiums to the JUA, which is directed by a Board approved by the N.H. Department of Insurance. The membership of the Board is determined by statute. The JUA Board hires an administrator who actually operates the "insurance company." The Association is regulated by the N.H. Department of Insurance, as are other insurance entities in the state. As such, the JUA premiums are proposed by the JUA, but approved by the Department of Insurance. This solution to the medical liability insurance problem appeared to work well for about six years.

In 1981, however, new problems had surfaced with the JUA. Over the six-year period, the number of claims filed, settled, or awarded in court had increased. In addition, several large medical malpractice decisions had been awarded by the court system.

JUA Deficit

In the early part of 1983, the JUA informed the NH Insurance Department that it faced substantial future deficits in meeting expected claims from the financial resources available to it. In technical terms, the amount of expected claims is referred to as "Incurred But Not Reported" claims (IBNR) and outstanding claim reserves. Because these claims have not

been turned into specific dollar amounts by verdict or settlement, they are actuarially estimated figures. Various actuaries have estimated the JUA IBNR reserve required. These estimates could result in reported deficits ranging from $30 million to $60 million.

Despite the fact that since the early 1980's, JUA premiums had increased dramatically, these rates proved to be inadequate to deal with the estimated amount of future claims.[1]

As a further complication, the number of health care providers insured by the JUA was falling. The voluntary market for medical liability insurance was starting to reappear in New Hampshire, primarily insuring hospitals and medical specialty groups with low loss records. Reduction in the number of JUA insureds portended increasing difficulty for the JUA in dealing with its accumulated deficit because the withdrawals reduced the cash flow available to make settlements and verdicts coming due. It should be emphasized that the projected deficit would not actually be incurred at any one time. Instead, as claims are paid over a period of time, the JUA's cash balance would become less and less, until at some point, the JUA would go into a negative cash position and would not have sufficient funds to continue normal operations or pay claims. At just what point this would occur is difficult to specify because of the many variables and unknowns involved.

Existing NH Department rules governing the JUA make provision for handling JUA deficits. Rule Ins 1702.07(b) and (d) sets up a process whereby assessments would initially be made against each insurer member of the JUA; then insurers would be permitted to recoup the assessments through a surcharge by the JUA against all health care providers not to exceed 100% of each premium for the policy year in which the surcharge was made, and/or a surcharge on future policies of liability insurance other than automobile insurance.

However, an unresolved problem with the JUA deficit affects more than health care providers; it involves New Hampshire health care consumers as well:

- Some NH physicians have threatened to leave practice, feeling they could not financially manage assessments of up to 100% of their premiums for medical liability insurance. Such action could leave some citizens, particularly in rural areas, without adequate access to care.

- The costs of rising premiums are being passed through to consumers in the form of rising health care prices. In essence, all consumers are paying some hidden tax to cover the costs of the existing medical liability system. This situation appears difficult to support when health care costs are expanding rapidly for other reasons as well.[2]

- The increased frequency and severity of medical malpractice claims and awards, nationwide, have intensified the uncertainty inherent in the provision of medical care. To compensate for this uncertainty, doctors often order excessive tests and procedures, and patients do not usually have information to question physicians on this. This practice of "making sure" by excessive use of medical care is often referred to as defensive medicine. Because defensive medicine can lead to excess utilization of health services (more diagnostic procedures, more surgery, etc.) it is expensive and adds to rising health costs for consumers. Although this phenomenon is hard to document statistically, experts in the health care field agree that the medical liability system fuels defensive medicine which in turn drives up the cost of health care for all consumers.[3]

Insurance Department Action

In the Fall of 1983, the NH Insurance Department began action to deal with the problem of potentially mounting JUA deficits. To stabilize the situation, the Insurance Department issued directives effectively restricting the voluntary market for medical liability insurance to renewal of existing coverage for physicians and surgeons. This meant that attrition in the number of JUA assureds was halted temporarily, those health care providers seeking liability insurance in New Hampshire would be required to obtain it from the JUA. This action maintained, at least temporarily, the JUA's premium base.

The Insurance Department also moved to change the assessment formula of Ins 1702.07, proposing a rules change which would assign 20% of the responsibility for JUA deficits to health care providers, 60% of the responsibility for such deficits to insurance companies writing voluntary medical liability insurance in New Hampshire, and the remainder of such responsibility to all insurance companies writing liability insurance in New Hampshire, including automobile insurance.

At a hearing held in December 1983, objections to the department's proposal were raised by certain health care providers who wished to have the continuing opportunity to acquire medical liability insurance in the private market. They believed they could do so at costs lower to themselves than the insurance provided by the JUA. Also, private medical liability insurance carriers protested the proposed rule change on the ground that it would assign to them the risk of covering JUA deficits at a level higher than the premiums they could expect to collect from doing business in New Hampshire. They, therefore, would have no choice but to withdraw from writing voluntary medical liability insurance in the state. Also, at the December 1983 hearing, an alternative proposal was put forward by the American Insurance Association, an insurance trade association, suggesting that a "Stabilization Reserve Fund" be established to deal with impending JUA deficits, to be funded by annual premium surcharges on all policies of medical liability insurance in the state, both in the JUA and in the voluntary market.

Following the December 1983 hearing, in reviewing the available alternatives, the Insurance Department requested an opinion from the Attorney General about (a) the extent of the department's authority under the governing statute which authorizes only "minimum interference" with voluntary insurance markets, and (b) the legality of the Stabilization Reserve Fund proposal. The Attorney General advised the department (a) that meeting the statutory requirement for "minimum interference" is a factual matter to be determined by comparing available alternatives, and (b) that no illegality is perceived specific to the question asked about the Stabilization Reserve Fund (See Appendix A).

Medical Liability Committee Appointed

In the Spring of 1984, Governor John Sununu appointed a Medical Liability Committee, chaired by Senator George Freese, to recommend to him a wide range of solutions to deal with the existing New Hampshire situation. The Governor was particularly mindful of the effect of this situation on rapidly rising health care costs for New Hampshire citizens and businesses who purchase health care coverage for their employees. For efficiency's sake, the Committee was divided into three subcommittees, each dealing with an inter-related but particular aspect of the medical liability situation:

1. The JUA Subcommittee, chaired by Insurance Commissioner, Louis Bergeron
2. The Risk Management Subcommittee, chaired by Frank Jillson, President, New Hampshire Blue Cross/Blue Shield
3. The Tort Reform Subcommittee, chaired by Department of Health and Welfare Commissioner, Sylvio L. Dupuis, O.D.

The Governor charged the Committee with "the development of a cost effective strategy for dealing with the problem of medical liability that will serve the best interests of all the citizens of our state." The three subcommittees were to (1) identify the issues, (2) propose workable solutions, and (3) develop a plan of implementation.

The membership of the Medical Liability Committee and the three subcommittees is listed in Appendix B.

The purpose of this Report is twofold: (a) to report the Committee's recommendations to the Governor for dealing with the underlying problems causing the current medical liability situation in New Hampshire, and (b) to educate the New Hampshire community-at-large on how all participants in the medical liability system contribute to and, therefore, can help solve the current problems.

The report itself is divided into three remaining sections:

II. Exploration of Underlying Causes
III. Problem Definition
IV. Recommendations. (The recommendations are arranged by subcommittee.)

II. EXPLORATION OF UNDERLYING CAUSES

The presenting problem to the Medical Liability Committee was twofold:

- How should the JUA deal with the projected large deficit?
- What could be done to mitigate the further rapid escalation of premiums which physicians were being charged in anticipation of future incurred losses?

The Subcommittees reviewed materials and gathered data in an effort to pinpoint the underlying causes of the large JUA projected deficit and rapidly escalating premiums. Underlying causes fall into two main categories: (a) national trends which are impacting New Hampshire, and (b) specific New Hampshire conditions. National trends are occurring in both the medical and legal systems.

A. National Trends: Medical and Legal

Within the medical system, two major trends impact on medical liability.

1. Rapid technological advance in medicine and increasing utilization of high technology health care have increased the risk for consumers of an unfavorable or unanticipated medical outcome.[4] Untoward outcomes should be expected with state-of-the-art medical care. Unfortunately, both doctors and patients often make health care decisions as if the medical system were perfect, the physician infallible, and the care risk free. This mythology is beginning to change, but it is still operative in our society to a large degree. This mythology often makes people feel that any untoward medical injury should be compensated through a medical liability system.

2. The specialization of health care and the rise of the group practice has contributed to the impersonalization of medical care. The decline of the personal doctor/patient relationship can lead to health care provision being viewed by both doctor and patient as "just a business." This attitude, in turn, can cause lack of sensitivity to the patient by the doctor or willingness to sue the doctor by the patient.

National trends in the legal system affecting medical liability have been identified in a recent ABA Journal Article.[5]

a. A study by Jury Verdict Research, Inc. of Solon, Ohio, reported in the September 1984 issue of the A.B.A. Journal, states "Verdicts of $1 million or more are the headline makers in personal injury litigation, and juries across the country are continuing to award these verdicts in ever-

increasing numbers. . . . In fact, in 1982, verdicts of this magnitude were rendered at a rate of more than four per week. During the 1960's, million dollar verdicts were granted no more than five times each year." ABA Journal goes on to say that in 1982 a total of 251 verdicts of $1 million or more were awarded to individuals in personal injury cases, cases most commonly involving product liability or medical malpractice.

b. "Trial judges and appellate courts are sustaining compensatory damages in more of these giant verdicts, and in higher dollar amounts, according to lawyers for both sides. In New York, a bellweather state, and other jurisdictions, verdict ceilings affirmed on appeal have risen by several million dollars recently, they say. Other states have had a more gradual increase.

c. The concept of "making the plaintiff whole" has expanded, as injured parties live decades longer than before and computer-age technology greatly advances medical treatment. New forms of suffering - psychological distress and lifestyle changes, for example - are being compensated. Rehabilitation is a lifetime effort, requiring frequent hospitalization, outpatient care and therapy, expensive drug therapy and psychological counseling.

d. New legal theories and new applications of old ones allow more plaintiffs to recover larger awards - for example, through the wider application of strict liability and the acceptance of new torts like wrongful birth.

e. Plaintiff lawyers are using new and highly effective techniques to tell their clients' stories and are sharing this knowledge with each other. Well-established techniques include the use of "day-in-the-life of" films to depict a plaintiff's misery and demographic consultants to help pick juries. Experts of every stripe and color are available to testify on every conceivable subject in expensive detail."[6]

These national trends have brought an increasing number of patients to make claims, and for higher awards. National statistics from 1966-1979 analyzed in a Rand Study on the Frequency and Severity of Malpractice Claims, show frequency of claims growing rapidly from 1971-1975, followed by a sharp decrease, due no doubt, in part, to systems reforms enacted by states in 1974, 1975 and 1976. However, partly because of declining frequency eliminating minor claims, the severity of liability has been outpacing the general rate of inflation

throughout the last decade. "In 1971-78, the average incurred cost per claim against physicians and surgeons increased at 12.4% per annum, compared to 18.9% for claims against hospitals."[7]

B. Specific New Hampshire Conditions

Exhibits I - IV (See Appendix C), prepared for the Medical Liabilities Committee by Johnson & Higgins, administrator of the JUA, displays the JUA history of reserves, paid losses, and loss adjustment expense and written premiums by calendar year. These figures reveal a gradual increase in reserves and losses with relatively no increase in premium from 10/75 to 12/79. The years 1980 - 1982 show a dramatic increase in outstanding reported case reserves followed with a two-year lag by a dramatic increase in the IBNR reserve. Paid losses and loss adjustment expense (LAE) also increased dramatically. Note, however, that written premiums had not yet responded to the problem. The 1983 and estimated 1984 outstanding reported case reserves appear to be leveling off, if not declining. The IBNR which lags between one to two years behind the outstanding reported case reserves is still increasing, but the amount of increase between '83 and '84 (estimate) is half that of '82-'83. Paid losses and LAE which have returned to the 1981 level appear to be declining. Note that the written premium, however, is still rising to make up for the inadequate premium increases 1980-1983. What conclusions can be drawn from this data?

1. Frequency and Severity of Claims: Apparently New Hampshire experienced a big rate of increase in frequency and severity of claims, 1980 - 1983. It is difficult to explain why this occurred because New Hampshire statistics are a very small sample and one or two claims can skew the data for a particular year. With this caveat in mind, it is reassuring to note that the rate of increase appears to be declining from 1983 to estimated 1984. Additional data in Appendix C shows that:

   - From 1975-1984 only two claims have been paid at $1 million or over. None are currently in reserve at that level. A total of $23.5 million has been paid on 405 claims.

   - The JUA has incurred 71 claims over $100,000 with a total of $19 million paid or currently in reserve.

   - The bulk of claims fall under $500,000 with a total of 43 claims in the range of $100,000 - $250,000, and $6.5 million has been either paid or currently in reserve.

- The remaining 28 claims range from $250,000 - $1,000,000 with $13.3 million either paid or currently in reserve.

- The average number of new files reported during years 1978-83 (including reportable incidents, written claims, and suits) was about 13 per month; the current average for 1984 is 17.1 per month.

In sum, the data paints a picture of a frequency and severity problem which occurred in the recent past, to which JUA premiums are still adjusting. It must be emphasized that due to the small number of insureds in New Hamshire, one or two large claims could alter this situation.

2. Rapidly Rising Premiums: Frequency and severity of claims are not currently a crisis in New Hampshire, why then are premiums escalating so rapidly? Premiums have increased 405% from 1975 to July 1984 for basic coverage with 248% from 1980 to 1984. For maximum coverage, premiums increased 626% 1975-84 with 401% from 1980-84.[8] In a letter of August 2, 1984, to the Medical Liability Committee, C. Brian Burke, M.D. reported on his analysis of malpractice premiums in relation to gross physician income. This analysis, performed on results of a survey by N.H. Medical Society, broke physicians into three groups: "The lowest group consists of specialists in internal medicine doing a minimum of invasive testing and family practitioners who do not deliver babies. This group pays 4.5% of their income in insurance premiums of this kind. The second, or middle group, consists of family practitioners with hospital privileges who carry out obstetrical deliveries and specialists in obstetrics and gynecology. These physicians pay about 9% of their gross unadjusted income in premiums. The final group, the high risk practitioners, include anesthesiologists, orthopedic surgeons and general surgeons. The majority of these individuals are paying premiums in the range of 14% of their gross income."

National figures available for comparison purposes indicate that the New Hampshire situation is especially severe for New Hampshire physicians. Pat Danzon in 1984 testimony before U.S. Senate hearing stated: "For physicians, malpractice insurance premiums average around 3% of their gross income, ranging from 1-2% for general practitioners, to 5-6% for high-risk surgical specialties. These percentages have increased only slightly since 1970." It is clear New Hampshire physicians are bearing a larger share of the medical liability premium cost than physicians on the average across the U.S. This differential may be due to several factors: one, the salary levels of New Hampshire physicians which may be lower than national averages, and two, the rapid increase in JUA premiums which New Hampshire has experienced has not yet spread to other states.

3. The High IBNR: James Vaccarino, counsel for Johnson & Higgins the JUA Administrator, in testimony before the N.H. Medical Liability Committee indicated that the high JUA premiums are necessary to cover the high IBNR (incurred but not reported) claim estimates made by the actuarial consultants. The IBNR is an estimated future expense an actuary develops based on (a) analysis of national medical liability statistics (New Hampshire statistics are too small a sample for too short a period of time to be used), (b) perceived claims management practice in New Hampshire, (claims management is defined as how successfully the JUA prevents claims through successful risk management, closes claims without indemnity, settles legitimate claims for reasonable indemnity, or successfully fights claims in court), (c) perceived number of New Hampshire claims which will be brought many years after the injury has occurred, and (d) perceived development or growth in New Hampshire in severity plus increased loss adjustment expense of claims on the books currently, as well as claims expected to be filed in the future.[9]

Some individuals who testified before the Committee felt New Hampshire's actuarial estimates of the IBNR were unjustifiably high. However, a second actuarial opinion sought by the JUA produced even higher IBNR estimates. Unfortunately, there is no way of comparing New Hampshire's IBNR with any other state's IBNR, because, as stated above, the IBNR is a subjective estimate based on state-specific factors which vary widely from state to state. Therefore, there can be no objective measure of comparison for New Hampshire's estimates.

III. PROBLEM DEFINITION

The Medical Liability Committee concluded its exploration of the situation facing New Hampshire with the following problem definitions.

A. The JUA deficit remains a reality despite rising premiums for some health care providers in New Hampshire. Evidence indicates this situation will continue. Some physicians in New Hampshire pay premiums at a higher percentage of the income than the national average.

- What steps can be taken to deal with the JUA deficit without imposing excessive costs on any one segment of the health care system?

This problem was largely addressed by the JUA Subcommittee.

B. While frequency and severity of claims are not now rising dramatically, the perception exists that they will continue to rise and, therefore, increase costs. This perception is reflected in the high IBNR estimate.

. What steps can be taken to reduce the frequency and severity of medical liability claims including (1) changes in the medical system which would reduce or prevent the incidence of medical malpractice or medical liability claims, and (2) changes in the tort system.

This problem was largely addressed by (1) the Risk Management Subcommittee, and (2) the Tort Reform Subcommittee.

IV. RECOMMENDATIONS

A. JUA Subcommittee:

In the Subcommittee's view, there were three major questions to be answered:

1. Should the JUA be continued?

2. Should the voluntary market be allowed to re-emerge? and

3. If the answers to the first two questions were in the affirmative, how could the problem of JUA deficits best be handled?

In response to the first question, the Subcommittee quickly concluded that in light of presently expectable conditions in the health care field, a medical JUA would probably be a necessity for the foreseeable future. No voluntary insurers have yet come forward who would agree to insure all health care providers in the state on a long-term basis, and so there would probably remain a problem of availability of medical liability insurance for at least some health care providers. The JUA should continue this necessary function.

In response to the second question, the Subcommittee concluded that allowing the voluntary market to re-emerge would be a desirable long-term objective. Insurance in the voluntary market could offer cost advantages to qualifying health care providers. A voluntary market could support health care cost containment efforts, as well as encourage health care providers to qualify for lower cost voluntary insurance through better risk management techniques, thereby reducing the incidence of medical injury.

In light of the answers to questions 1 and 2, this problem remained: How to deal with the JUA deficit by sustaining the JUA to the extent necessary, without imposing excessive costs on any one segment of the health care field, and without interfering unduly with the potential re-emergence of the voluntary liability insurance market.

After a series of meetings with representatives of various segments of the health care field and extensive consultations, the Subcommittee identified a series of alternatives including retaining present regulations, making the JUA mandatory, adopting the rule changes as proposed by the Insurance Department, establishing a Stabilization Reserve Fund, and broadening the group of entities which would be responsible for supporting JUA deficits. The Subcommittee concluded that no one of these alternatives would be appropriate to deal with the problem of JUA deficits, and to attain the combined objectives stated above.

The Subcommittee concluded that a combination of these alternatives would be most appropriate in addressing the problem:

1. TO STABILIZE THE PRESENT JUA, THE INSURANCE DEPARTMENT SHOULD CONTINUE UNTIL DECEMBER 31, 1985, ITS ADMINISTRATIVE ORDERS OF SEPTEMBER 7 AND NOVEMBER 9, 1983, RESTRICTING THE ISSUANCE OF PRIVATE MEDICAL MALPRACTICE POLICIES TO RENEWAL ONLY. THE INSURANCE DEPARTMENT'S ORDERS SHOULD BE REMOVED ON JANUARY 1, 1986 AND THE VOLUNTARY MARKET WILL THEN BE ALLOWED TO DEVELOP FURTHER.

   This step is designed to allow the JUA's servicing carrier more time to carry out its management reforms, and to improve the economics of the JUA.

2. THE INSURANCE DEPARTMENT SHOULD ADOPT A RULE ESTABLISHING A STABILIZATION RESERVE FUND TO HELP SUPPORT JUA CASH DEFICITS WHICH MAY ARISE IN THE FUTURE. THE STABILIZATION RESERVE FUND WOULD BE FUNDED BY A 15% PREMIUM SURCHARGE ON ALL MEDICAL MALPRACTICE INSURANCE POLICIES WRITTEN OR RENEWED ON OR AFTER MARCH 1, 1985, OR 30 DAYS AFTER THE EFFECTIVE DATE OF THE RULE ESTABLISHING THE FUND, WHICHEVER DATE OCCURS LATER. PREMIUM SURCHARGES WOULD BE DEPOSITED IN THE STABILIZATION RESERVE FUND. THE SURCHARGES WOULD REMAIN IN EFFECT UNTIL THE INSURANCE COMMISSIONER MAKES THE ACTUARIAL DETERMINATION THAT A JUA DEFICIT NO LONGER EXISTS, CONSIDERING THE CASH POSITION OF THE JUA AND THE SIZE OF THE STABILIZATION RESERVE FUND.

Recommendation #2 is made with the understanding that in addition to offering occurrence policies, the JUA will be authorized to offer and will begin offering policies on a "claims-made" basis at a reduction in premium during a five-year transition period. This would help soften the financial impact of Stabilization Reserve Fund surcharges on health care providers. During the five-year period, the JUA would collect amounts to meet its costs and actuarially determined risks, together with the surcharge for the Stabilization Reserve Fund.

3. THE INSURANCE DEPARTMENT SHOULD REVISE INS 1702.07 TO CHANGE THE METHOD OF DEFRAYING ANY JUA CASH DEFICIT ON OCCURRENCE POLICIES BEYOND WHAT WOULD BE COVERED BY THE JUA OCCURRENCE FUND AND THE STABILIZATION RESERVE FUND. THE REVISION SHOULD PROVIDE FOR REMAINING DEFICITS TO BE SHARED AMONG ALL LIABILITY INSURANCE CARRIERS WRITING IN THE STATE OF NEW HAMPSHIRE, INCLUDING THOSE WRITING AUTOMOBILE LIABILITY INSURANCE. THE RULE CHANGE ALSO SHOULD INCLUDE A POSITIVE METHOD OF RECOUPMENT, THROUGH IDENTIFIABLE PREMIUM SURCHARGES ON ALL LIABILITY INSURANCE POLICIES WRITTEN IN THE STATE.

4. THE INSURANCE DEPARTMENT SHOULD ADOPT A PUBLICLY STATED POLICY THAT THE MATTER OF APPROVAL OF FUTURE JUA RATES WILL BE UNDERTAKEN WITH EXTREME CARE, IN ORDER TO ASSURE THAT THE RATES TO BE CHARGED BY THE JUA WILL BE NEITHER INADEQUATE, EXCESSIVE, NOR UNFAIRLY DISCRIMINATORY. IN ADDITION, THE DEPARTMENT MUST UNDERTAKE TO REVIEW ANNUALLY, IN PUBLIC HEARING, THE NEED FOR CONTINUATION OF THE STABILIZATION RESERVE FUND SURCHARGE PROVIDED FOR IN THE SECOND RECOMMENDATION.

The Subcommittee anticipates that this combination of proposals will not be entirely satisfactory to everyone. Nevertheless, it is the Subcommittee's judgement that the recommendations fairly balance competing considerations and distribute burdens equitably among the several interested groups. As such, the recommendations constitute a responsible compromise resolution to an extremely difficult set of problems. Minority opinions are contained in Appendix D.

B. Risk Management Subcommittee:

The basic goals of the Risk Management Subcommittee were (1) to formalize a statewide risk management program which would prevent, as much as possible, medical injury; (2) to centralize a data base on allegations of medical malpractice; (3) to see that all actions necessary to protect health care consumers are carried out; and (4) to provide education to providers of health care. The Risk Management

Subcommittee recognizes that amendments to the law governing the Board of Registration in Medicine will have to be passed to provide additional authority, responsibility, and funding to meet these recommendations.

1. THE INSURANCE DEPARTMENT SHOULD MANDATE A NEW RULE THAT ALL MEDICAL LIABILITY INSURERS NOTIFY THE BOARD OF REGISTRATION IN MEDICINE OF ALL CHARGEABLE CLAIMS AND SUITS. (The intent here is to report every chargeable claim* and suit, not incidents.)

   *"Chargeable Claim" is defined as any allegation of medical professional liability where a reserve has been established.

2. THE BOARD OF REGISTRATION SHOULD NOTIFY THE HOSPITAL CHIEF EXECUTIVE OFFICER FOR REFERRAL TO THEIR RESPECTIVE CREDENTIALS AND QUALITY ASSURANCE COMMITTEES OR EQUIVALENT FORMAL COMMITTEES WITH A TWO-STEP PROCESS. THE BOARD OF REGISTRATION SHALL CONDUCT A REVIEW ON CLAIMS ARISING IN NON-HOSPITAL SETTINGS.

3. THE HOSPITALS' CREDENTIALS AND QUALITY ASSURANCE COMMITTEES OR EQUIVALENT FORMAL COMMISSIONS WITH A TWO-STEP PROCESS SHOULD PERFORM THEIR REVIEWS, ESTABLISH AND CARRY OUT NECESSARY ACTIONS, IF ANY, AND REPORT BACK TO THE NEW HAMPSHIRE BOARD OF REGISTRATION IN MEDICINE. A PROGRESS OR FINAL REPORT SHOULD BE MADE TO THE BOARD WITHIN 45 DAYS. FURTHER DEFINITION OF THE CONTENT OF THE REPORT SHOULD BE ACCOMPLISHED BY THE BOARD OF REGISTRATION THROUGH ITS RULEMAKING AUTHORITY.

4. THE BOARD OF REGISTRATION SHOULD SATISFY ITSELF THAT ACTIONS TAKEN BY THE HOSPITAL ADMINISTRATION AND BOARD ARE APPROPRIATE AND CARRIED OUT. THE BOARD SHOULD TAKE ADDITIONAL ACTION IF IT IS CONSIDERED NECESSARY. SHOULD THE INSURANCE DEPARTMENT HAVE NEED TO REVIEW ANY CLAIM OR SUIT, THE COMMISSIONER SHOULD HAVE FULL ACCESS TO THE BOARD OF REGISTRATION'S DATA.

5. THE BOARD OF REGISTRATION SHOULD ADDITIONALLY MAINTAIN A DATA BASE IN USABLE FORM, AND SHOULD ESTABLISH AND CARRY OUT AN ONGOING EDUCATIONAL PROGRAM FOR PHYSICIANS AND HOSPITALS, UTILIZING CASE INFORMATION WITH NO IDENTIFIERS. IMPROVED EDUCATION ON THE CAUSES OF MEDICAL INJURY AND CHARGEABLE CLAIMS, AS WELL AS ON PHYSICIAN COMMUNICATION WITH PATIENTS, SHOULD HELP TO PREVENT INJURY AND TO AVOID CLAIMS AND SUITS IN CASES OF UNTOWARD OUTCOMES OF QUALITY MEDICAL PRACTICE.

6. RULES GOVERNING THE CONFIDENTIALITY OF DECISIONS MADE BY THE BOARD OF REGISTRATION SHOULD BE LIFTED. CARE MUST BE TAKEN TO INSURE THAT INFORMATION REGARDING A PHYSICIAN IS VERIFIED AND BONA FIDE, NOT FRIVOLOUS, BEFORE IT IS MADE PUBLIC. THIS RECOMMENDATION REQUIRES FURTHER SPECIFIC DEFINITION BY THE BOARD OF REGISTRATION IN MEDICINE THROUGH IT'S RULEMAKING AUTHORITY.

C. Tort Reform Subcommittee:

The Tort Reform Subcommittee identified specific actions which had been taken or proposed by states across the country. It evaluated these actions on the basis of five criteria.

- Affect on severity and/or frequency of medical malpractice claims/awards
- Affect on cost of medical liability insurance premiums
- Affect on total cost of medical care
- Affect on the percentage of the total tort system costs which go to injured party
- Affect on individual rights of redress of victims of medical malpractice

In addition, testimony was gathered and analysis performed on previous attempts at Tort Reform in New Hampshire: (1) RSA 507-C enacted in 1977 which was struck down as unconstitutional by the N.H. Supreme Court in Carson v. Maurer, 120 NH 925 (1980), and (2) a revised proposed 507-C which was sent to Interim Study by the N.H. Legislature in 1981 session. See Appendix C for further details.

1. THE NEW HAMPSHIRE DEPARTMENT OF INSURANCE SHOULD AUTHORIZE, THROUGH ITS RULEMAKING AUTHORITY, A DEMONSTRATION PILOT PROJECT, OF A VOLUNTARY, BINDING ARBITRATION SYSTEM FOR THE RESOLUTION OF MEDICAL LIABILITY CLAIMS. SUBSEQUENT TO POSITIVE EVALUATION OF THIS DEMONSTRATION BY THE N.H. INSURANCE DEPARTMENT, THE NEW HAMPSHIRE GENERAL COURT SHOULD CONSIDER ENABLING LEGISLATION WHICH WOULD SUPPORT AND FUND, IF NECESSARY, A VOLUNTARY, BINDING ARBITRATION SYSTEM IN NEW HAMPSHIRE.

   The New Hampshire Medical Society (NHMS) has taken a leadership role in commissioning a study of various arbitration systems being proposed and tried for the resolution of medical liability claims. The study makes specific design recommendations and is available from the NHMS. The Committee agreed unanimously that a well-designed, voluntary, binding arbitration system would significantly reduce total costs of the medical liability system

over the long-term. In addition, arbitration could shorten the time between the filing of a claim and its settlement. Voluntary binding arbitration does not interfere with the individual's right of redress if the system is appropriately designed and thoughtfully implemented.

Key to successful implementation is the resolution of issues such as (1) the timing of agreement to binding arbitration: pre-treatment or post-treatment; and (2) the design of a back-out period during which either party can back away from their agreement to arbitrate should a claim arise. The Committee believes that design of a voluntary, binding system will be a challenge, and its implementation will require careful, committed effort. For these reasons, joint involvement of the medical and legal systems, as well as state executive branch, is critical. Adequate funding, which the Committee believes will be minimal, and an objective evaluation component are also critical to the success of the demonstration. The Committee believes such an approach can yield the positive outcomes desired.

2. THE 1985 NEW HAMPSHIRE GENERAL COURT SHOULD CONSIDER PASSAGE OF A TORT REFORM BILL WHICH WOULD:

- ELIMINATE THE AD DAMNUM CLAUSE IN FILING A LIABILITY CLAIM.

  Eliminating the ad damnum clause would have the affect of prohibiting mention in a filed claim the dollar amount demanded in damage. Large claims may encourage prejudicial pre-trial publicity, harm the reputations of defendants who are later vindicated, and distract the jury from basing its award solely on the evidence presented at trial. Furthermore, elimination of the clause could positively affect actuarial perceptions of how New Hampshire claims are managed and, therefore, reduce the IBNR estimate.

- SHORTEN THE NEW HAMPSHIRE STATUTE OF LIMITATIONS IN WHICH AN ADULT COULD BRING SUIT FROM THE CURRENT SIX YEARS TO THREE YEARS FROM OCCURRENCE OF INJURY, OR DISCOVERY OF INJURY (OR WHEN INJURY REASONABLY SHOULD HAVE BEEN DISCOVERED). ALLOW STATUTE OF LIMITATION FOR A MINOR TO RUN UNTIL THREE YEARS AFTER HE/SHE HAS REACHED MAJORITY (18).

  New Hampshire has one of the longest Statutes of Limitations in the United States. A shortened Statute of Limitations supports the perception of a more reasonable "tail" on the part of plaintiffs, lawyers and actuaries. If it can be demonstrated that such perception would lead to a significantly lower IBNR estimate, the Committee feels that taking this action is worth the time and attention of the legislature.

A shorter "tail" can have the affect of reducing the severity of claims. This is so because the longer time elapses between occurrence and the bringing of a claim, the harder it is to reconstruct the facts of a case. Records are harder to find; memories are vaguer; personnel involved have moved to other areas. Some feel this lack of clear documentation leads to larger settlements and verdicts in favor of the plaintiff. In general, the committee believes shortening the Statute of Limitations does not limit individual right to seek redress of wrong if the "discovery rule" is applied broadly as recommended. Note that such a change must be written to apply to all tort cases, or it could be struck down by N.H. Supreme Court as a violation of equal protection considerations.

. LIMIT THE APPLICATION OF RES IPSA LOQUITOR TO CERTAIN TYPES OF CASES OR MANDATE THE COURTS TO PROVIDE SPECIAL INSTRUCTIONS TO THE JURY ON THIS USE OF THIS DOCTRINE IN A TRIAL

Res Ipsa Loquitor means "the thing speaks for itself" it is a legal doctrine which places the burden on the defendant to prove he did not malpractice as opposed to the more usual situation in which the plaintiff has the burden of proving that malpractice actually occurred and was the cause of injury. Some states have limited the application of Res Ipsa Loquitor to particular types of cases, such as those in which a sponge was left in the body during surgery.

Although the doctrine is not currently being misused in the N.H. court system, the Committee believes such action to be important as it reinforces the concept of clearly compensable injury. If the limitation is narrowly applied to a few types of cases, such action does not affect individual rights.

3. THE NEW HAMPSHIRE BAR ASSOCIATION AND THE COURTS SHOULD ENCOURAGE THE USE OF STRUCTURED PAYMENTS FOR ALL LARGE TORT CASE AWARDS AND AS A NEGOTIATION TOOL IN SETTLEMENT:

Such action allows payment of awards, usually in excess of $100,000, to be made by installment at the discretion of the court, or request of one of the parties. Structured payments can help a victim better handle large sums of money. In addition, structured payments are useful as a negotiation tool in settlement. An annuity can be purchased which will earn the dollar difference between the amounts on which the plaintiff and defendent are willing to settle.

4. THE N.H. BAR ASSOCIATION AND THE COURTS SHOULD REVIEW THE CURRENT CONTINGENCY FEE SYSTEM FOR MEDICAL LIABILITY CASES, AND ENSURE AN EQUITABLE CONTINGENCY FEE SYSTEM TO MAXIMIZE THE AMOUNT OF THE AWARD WHICH GOES TO THE INJURED PARTY, WITHOUT JEOPARDIZING HIS/HER ACCESS TO THE LEGAL SYSTEM.

5. THE INSURANCE DEPARTMENT SHOULD EXPLORE THE FOLLOWING AS INNOVATIVE, LONGER-TERM APPROACHES TO MORE EQUITABLY SPREAD THE COST OF THE MEDICAL LIABILITY PROBLEM:

   a. OTHER FORMS OF MEDICAL LIABILITY INSURANCE, INCLUDING FIRST PARTY MEDICAL LIABILITY INSURANCE (E.G. SURGERY INSURANCE), AND DEDUCTIBLES FOR PHYSICIANS ON THEIR MALPRACTICE INSURANCE

   b. CREATION OF MEDICAL INJURY COMPENSATION POOL WHICH WOULD BE SOMEWHAT ANALOGOUS TO WORKERS COMPENSATION.

   c. NO-FAULT LEGISLATION FOR MEDICAL INJURY COMPENSATION SIMILAR TO THAT IN AUTOMOBILE INSURANCE.

   d. PREMIUMS ADJUSTED PROPORTIONATELY TO THE PRACTICE INTENSITY OF THE PHYSICIAN WHICH MAY VARY BY GEOGRAPHIC LOCATION IN THE STATE.

   The above ideas were discussed briefly by the Committee and considered worthy of further investigation by the executive department having appropriate jurisdiction. They were judged too new and unproven to merit consideration for implementation at this time.

FOOTNOTES

1 Between 1975 - 1979, the JUA premiums for basic coverage ($100,000 per claim; $300,000 per aggregate claim) for a Class I physician (e.g. general practitioner with no surgery) and Class VII physician (e.g. cardio-vascular or neurosurgeon) were $310 and $2,580 respectively. In July 1984, the premiums were $1,569 and $12,813 respectively for basic coverage. For maximum coverage ($1 million per claim; $3 million per aggregate claim) in between 1975-1979 premiums for Class I were $462 and for Class VII, $3,810. As of July 1984, for Class I maximum coverage the premium was $3,311, and for Class VII maximum $27,676. (Source: Johnson & Higgins, November 1984)

2 There is some evidence indicating that while malpractice premiums do affect health care costs, this affect may be exaggerated. Patricia Danzon in testimony before Comm. on Labor and Human Resources, U.S. Senate, is quoted as saying: "The allegation that malpractice insurance is a major factor driving the high and rising cost of health care is exaggerated. Between 1975 and 1982, malpractice insurance premiums rose roughly 73%, while the cost of physicians' services rose 92% and the cost of a hospital room rose 130%. Overall, malpractice insurance premiums account for around 1% of the $350 billion health care bill."

3 "Payment Systems, Cost Management, and Malpractice" by James E. Ludlam, Hospitals (November 1, 1984) p 102.

4 Medical liability language calls an unanticipated, unfavorable medical outcome an "untoward" outcome. This nomenclature specifically avoids the implication of negligence or malpractice by the provider.

5 A.B.A. Journal (American Bar Assoc., Chicago, Ill.) Sept. 1984, pgs 52-53

6 A.B.A Journal (American Bar Assoc., Chicago, Ill.) Sept. 1984, pg. 53

7 The Frequency and Severity of Medical Malpractice Claims, a Rand Study by Patricia Munch Danzon, pg. 6-7

8 Source: Johnson & Higgins, current administrators of the NH JUA.

9 In insurance language, the length of time after injury during which a claim can be brought is called a "tail." Studies have shown the longer the tail the more severe the claim and greater likelihood of a case being won.

0563D

G L O S S A R Y

JUA	Joint Underwriting Association
IBNR	Incurred But Not Reported
ABA	American Bar Association
LAE	Loss Adjustment Expense
ORCR	Outstanding Reported Case Reserves
NHMS	N. H. Medical Society

APPENDIX A

THE STATE OF NEW HAMPSHIRE

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ASSISTANT ATTORNEYS GENERAL
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October 17, 1984

Mr. Louis Bergeron
Commissioner
New Hampshire Insurance Department
Concord, New Hampshire 03301

Dear Mr. Bergeron:

You requested our advice on two proposed regulations which would alter the New Hampshire Medical Malpractice Joint Underwriting Association's (JUA) assessment mechanism. First, you asked whether the proposal offered by the American Insurance Association (AIA) could be applied legally to premiums paid on policies issued prior to the adoption of that regulation. Second, you asked whether proposed regulation Ins. 1702.C71 constitutes a "minimum interference with the voluntary market" as required by RSA 404-C:2.

For the reasons stated below, the answer to your first question is "yes," and the answer to your second question will depend on the resolution of factual issues which must be determined by your office.

By letter dated January 16, 1984 from Martin Gross to you, the AIA proposed a regulation which would manage any JUA deficits by establishing a Stabilization Reserve Fund. As proposed, the Stabilization Reserve Fund would be funded by an annual premium surcharge to all medical malpractice insureds in the State of New Hampshire, regardless of whether the policy was written through the JUA. You asked whether that surcharge can be applied to premiums paid on policies which were written prior to the adoption of the regulation without running afoul of the prohibition against retrospective laws. In our opinion, the proposed regulation does not alter the existing contracts

of insurance; it merely imposes a surcharge on premiums paid which will be used to manage any potential JUA deficits. That surcharge will be levied on only those premiums paid after the effective date of the regulations. The time honored test of retrospectivity for a civil law is to determine whether a vested right would be impaired, or a new obligation created, or a new disability attached for some past transaction or consideration. Woart v. Winnick, 3 N.H. 473, 479 (1826). The proposed surcharge will apply only to premiums paid for future insurance coverage, and hence, the regulation in fact does not have a retrospective application.

In the unlikely event the regulation is determined to be retrospective, it could be upheld on the basis that the public benefit outweighs the injury which results from the retrospective application. State v. Ballou, __ N.H. __ (Decided July 31, 1984) (Souter, J., dissenting). In the case of Hayes v. LeBlanc, 114 N.H. 141 (1974) the New Hampshire Court decided that an amendment to the minimum insurance requirements in the motor vehicle financial responsibility law could be applied retroactively to policies written before the effective date of the amendment. The amendment increased the coverage limits required by law in cases where a driver after an accident is ordered to obtain insurance as evidence of financial responsibility. The Court applied the new coverage limits to a policy written before the amendment, which provided the old, lower limits. That application does not violate either the Contract Clause (United State Constitution, Article I, §10) or the New Hampshire prohibition against retrospective laws (New Hampshire Constitution, Part I, Article 23) because those "limitations must yield where it is reasonable for State government to regulate activities in the exercise of the police power." 114 N.H. at 145 (citing El Paso v. Simmons, 379 U.S. 497, 508-09 (1965); Home Building and Loan Association v. Blaisdell, 290 U.S. 398, 428 (1934); 2A. Sutherland, Statutory Construction 41.07 (4th Ed. C. Sands 1973)). The court further noted these prohibitions "were not intended to prevent the Legislature from amending laws which regulate contracts in the public interest where such laws have proven inadequate to accomplish their task." Id.

The Legislature, pursuant to its police power authority to regulate insurance activities, gave your office the power to establish a mandatory risk sharing plan where "any form of liability insurance is not readily available in the voluntary market." RSA 404-C:1. Under the rule enunciated in LeBlanc v.

Hayes, supra, you may amend the regulations where necessary to make the plan adequate to accomplish its task and to protect the public interest provided that interest outweighs any resulting private injury, even if that amendment has a retrospective application. For those reasons, it is our opinion that the regulation proposed by the AIA may be applied to policies written prior to its effective date.

A second regulation was proposed by the staff of the Insurance Department as a possible solution to the potential underfunding of the JUA. That proposal was numbered Ins. 1701.071 and filed with the Administrative Procedures Division of the Office of Legislative Services as required by RSA 541-A, but has not been formally adopted by your office. Amongst other requirements, any mandatory risk sharing plan implemented under 404-C must "establish procedures that will create minimum interference with the voluntary market." RSA 404-C:2, II. You asked whether the proposed regulation would satisfy that criterion.

The only New Hampshire Supreme Court case which discusses the minimum interference requirement is State Farm Mutual Automobile Insurance Co. v. Whaland, 121 N.H. 400 (1981). The court in that case upheld the plan establishing the New Hampshire Reinsurance Facility for automobile liability insurance partly on the basis that it satisfied the minimum interference requirement. The Court noted that some interference with the voluntary market is to be expected and is implicitly authorized by the Legislature in RSA 404-C. In that particular case, the court upheld the finding of the trial court "that the involuntary market interferes with the voluntary market and the voluntary market subsidizes the involuntary market." 121 N.H. at 406. In agreeing with the trial court that the plan creates a minimum interference, the Supreme Court reviewed the facts established by the evidence below. Likewise, the decision of whether proposed Ins. 1702.071 creates only a minimum interference can be made only after the relevant facts are known and reviewed. That decision was entrusted by the Legislature to your office as the agency possessing the necessary experience and expertise. Because the Legislature's use of the term "minimum" requires a relative inquiry, you should determine whether any alternative mechanisms will satisfy the purposes of RSA 404-C and create less interference with the voluntary market than the regulation in question. If there are not such alternatives, then the proposed regulation will satisfy the minimum interference standard.

For those reasons, the answer to your second question will depend on facts not known to us, such as the existence of alternative proposals and the relative effect of those proposals on the voluntary market. The gathering and evaluation of those facts and the ultimate determination of minimum interference is uniquely within the province of your office. We are available to review your decision and its factual basis for compliance with RSA 404-C at your convenience.

Please let me know if you have any further questions concerning this matter.

Sincerely yours,

Ronald F. Rodgers
Assistant Attorney General
Division of Legal Counel

RFR/clp
84-46-I

APPENDIX B

Medical Liability Committee

For a number of years, the issues around medical liability have become more and more of a problem affecting the ultimate cost of health care. As the number of suits against physicians, and other health services providers, have steadily increased, and as the dollar amounts of settlements have increased even more so, there have been two basic results. Physicians have tended to order more and more diagnostic and treatment services as a hedge against such suits; and the cost of medical malpractice insurance has increased in staggering amounts.

There have been attempts at solutions to the problems, including legislation which passed and was overturned by the Courts, and a Joint Underwriting Association which is in a difficult financial situation. However, the basic problem continues unabated.

The Medical Liability Committee, under the Chairmanship of State Senator George Freese, is being constituted to identify positive practical solutions to the troubling issue of medical liability costs. These costs to society are measured both in terms of economics and human suffering. The Committee will explore three broad areas of concern, namely:

(1) Joint Underwriting Authority/private insurance coverage;
(2) Tort Reform;
(3) Risk Management.

The primary mission of the Medical Liability Study Committee will be the development of a cost effective strategy for dealing with the problem of medical liability that will serve the best interests of all the citizens of our State.

The three subcommittees will be charged with identifying the issues and proposing workable solutions as well as a plan of implementation. It is planned that the activities of the working groups will be coordinated into a single comprehensive and achievable strategy. It is anticipated that the solutions will involve the executive branch, the legislative branch, and the private sector. The workplan completion dates will be focused to permit legislative priorities to be recommended to the 1985 legislative session.

It is also intended that the work groups be supplemented by additional persons on an ad hoc basis through the chairperson of the respective groups. Testimony and input will be sought from affected and interested parties in both the public and private sector. Many new and creative solutions have been advanced in other states and jurisdictions. These areas of interest will also be examined as a part of the workplan of the individual subcommittees.

J.U.A./Private Insurance Coverage Subcommittee

The J.U.A./Private Insurance Coverage subcommittee will be chaired by Insurance Commissioner Louis Bergeron.

It will examine the original N.H.M.M.J.U.A. enabling legislation as well as its record of accomplishments to date. The committee will explore projective deficits and possible solutions, as well as examining the role of the private insurance market in New Hampshire. The committee will be charged with developing short range as well as mid range and long term solutions. Staff support will be provided by the New Hampshire Insurance Department.

Tort Reform Subcommittee

The Tort Reform Subcommittee will be chaired by Dr. Sylvio L. Dupuis, Commissioner of Health and Welfare for the State of New Hampshire. It will review previous attempts at state legislative tort reform, as well as the position of the courts regarding these proposals. It will also review efforts of other states in the area of Tort Reform, as well as the potential for developing National Legislative standards. The committee will be staffed through the Office of Policy and Planning of the Department of Health and Welfare.

Committee on Risk Management

The Committee on Risk Management will be chaired by Frank Jillson, President of the New Hampshire Blue Cross/Blue Shield. This committee will explore the issue of risk management from both the institutional and individual practitioner viewpoint. The coimmittee will examine peer review, current licensure authority, incident reporting, risk management strategies and medical records development in all its aspects. It will also examine institutions, physician and patient behavior relative to the challenges posed by the practice of defensive medicine. Staffing will be provided by Mr. Jillson's organization.

The final recommendations and the implementation timetable will be developed as a single unified strategy for consideration and approval by the full committee. Staff of the participating agencies will be assigned to draft final recommendations for approval.

Medical Liability Committee

Major Membership

Senator George Freese, General Chairman
Chairman, Senate Insurance Committee

Nancy Baybutt
Office of the Governor

Louis Bergeron
Commissioner, Insurance Department

Dr. Merwyn Bagan
Past President, N. H. Medical Society

Representative Harold W. Burns
Vice Chairman, Committee on Commerce and Consumer Affairs

John Collins
C.E.O., Hitchcock Clinic

Representative Elizabeth Crory
Member, Committee on Commerce and Consumer Affairs

Sylvio L. Dupuis, O.D.,
Commissioner, Department of Health and Welfare

Frank Jillson
President, Blue Cross/Blue Shield

Kennett Kendall
Kendall Insurance Agency

Les McLeod
President, Huggins Hospital

Elizabeth Natti
Former Executive Director, Health Careers Council

Harvey Hill, Chief Executive Officer, CPM Products
Chair, Health Cost Containment Subcommittee of Business & Industry Assoc.

Attorney James Vaccarino
Counsel for Johnson and Higgins, Managers of the Joint Underwriting Authority for the State of New Hampshire

Subcommittee Membership	Additional Subcommittee Members
Risk Management	
Frank Jillson, Chairman	Vincent Denobile
Les McLeod	
Elizabeth Natti	
Merwyn Bagan, M.D.	
Tort Reform	
Sylvio L. Dupuis, O.D., Chairman	Attny. Michael P. Hall
Rep. Harold W. Burns	Hamilton Putnam
Nancy Baybutt	F.B. Dibble, Jr. M.D.
Harvey Hill	Mike Hill
John Collins	
J.U.A./Private Insurance Coverage	
Commissioner Louis Bergeron, Chairman	
Attorney James Vaccarino	
Elizabeth Crory	
Kennett Kendall	
Staff People	
Judy Chynoweth, Director, OPPD Dept. Health & Welfare	David Kearns, Ass't. Comm. Dept. of Insurance
Nancy Lilly, Admin. Ass't. to President Blue Cross/Blue Shield	

Leo Fraser, Jr.
Ass't. to Gen. Chmn.
Leo Fraser & Associates
PO Box 1364
Concord, NH 03301

APPENDIX C

N.H.M.M.J.U.A.

Financial History

Period Ending	Outstanding Reported Case Reserves	IBNR Reserve	Total Reserve	Paid Loss & Adjustment Expense	Written Premium
10/75-12/76	Not Available	Not Available	$ 1,452,055	$ 3,159	$2,193,211
12/77	Not Available	Not Available	3,304,923	13,377	2,660,860
12/78	$ 1,190,151	$ 5,227,917	6,418,068	76,309	2,638,896
12/79	1,980,800	5,844,501	7,825,301	302,743	2,795,709
12/80	8,962,963	5,426,094	14,389,057	1,704,347	3,661,911
12/81	7,856,850	7,363,476	15,220,326	4,890,749	4,614,454
12/82	13,965,179	28,835,570	42,800,749	7,042,290	6,896,377
12/83	11,555,252	38,999,710*	50,554,962	4,456,579	6,156,741
Est. 12/84	@ 8,000,000	45,110,075*	@ 53,110,075	@ 5,000,000	@ 9,000,000
				$23,489,553	$40,618,189

*$10,000,000 reinsurance purchased in 1983 has not been deducted from the reserves shown.

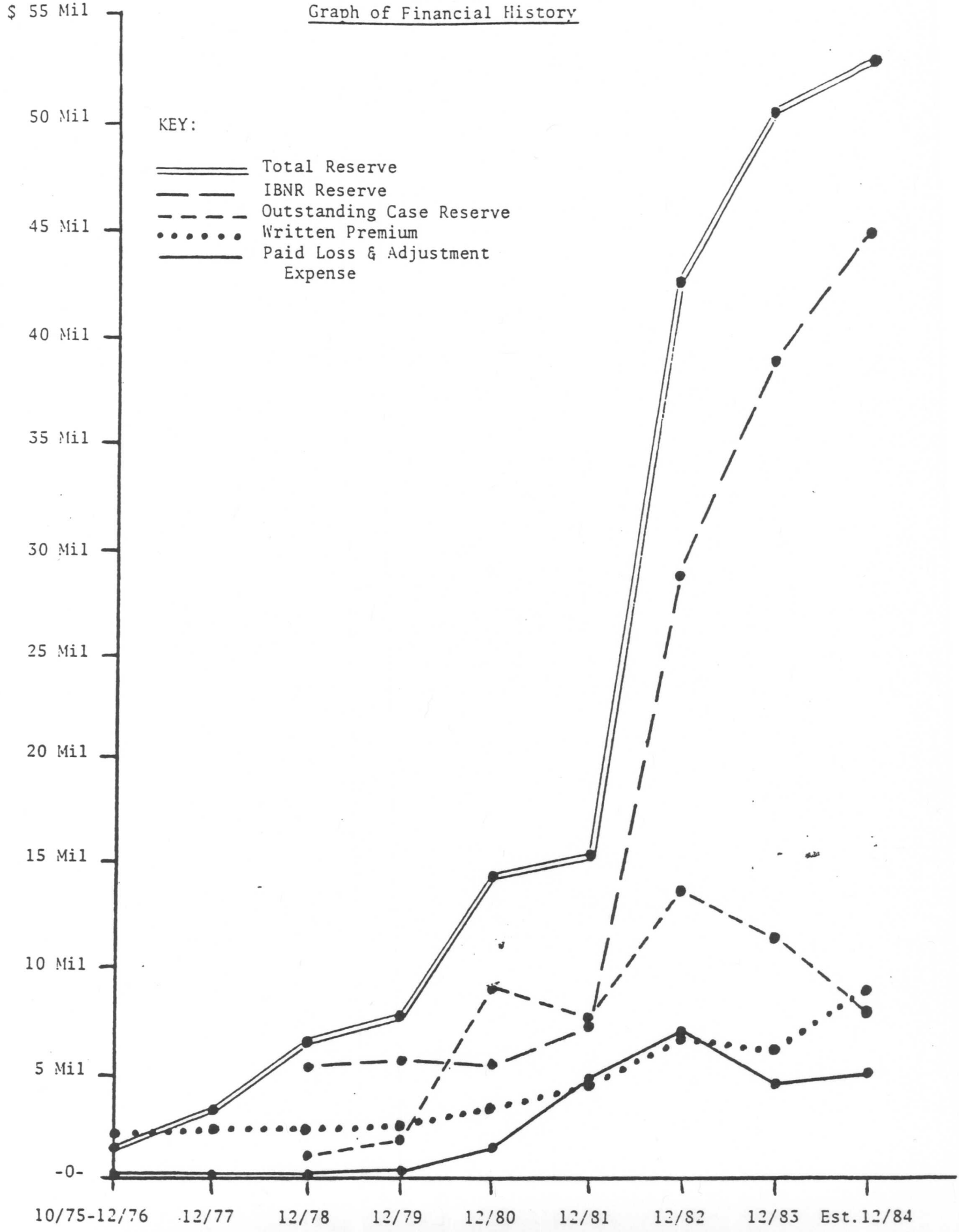
NOTE: All figures through year1983 have been taken directly from the J.U.A. audited financial statements at the close of each calendar year. 1984 year end estimates are calculated by the servicing carrier from third quarter 1984 data. 1984 IBNR reserve is as calculated by the actuary at the end of the third quarter of 1984.

DATA FOR NEW HAMPSHIRE MEDICAL MALPRACTICE J.U.A. ONLY

12/10/84

Exhibit I

N.H.M.M.J.U.A.
Graph of Financial History



12/10/84

Exhibit II

N.H.M.M.J.U.A.

Frequency of Claims

A. Accident Year (claim count by year in which incidents occurred)

1. Claims closed with indemnity payment plus currently open claims:

	75-76	1977	1978	1979	1980	1981	1982	1983	9/84		Total
	32	72	103	105	128	130	96	59	15	335 Open 405 Closed	740

2. Claims closed without indemnity payment:

	36	68	137	108	69	61	57	16	2	554 Closed	554
TOTAL	68	140	240	213	197	191	153	75	17		1,294 + 165* 1,459

B. Report Year (claim count by year in which incidents were reported)

1. Claims closed with indemnity payment plus currently open claims:

	3	30	49	75	98	116	136	105	128	335 Open 405 Closed	740

2. Claims closed without indemnity payment:

	4	41	116	96	96	71	62	60	8	554 Closed	554
TOTAL	7	71	165	171	194	187	198	165	155		1,294 + 165 1,459

*165 closed incident files, no indemnity or expense payment, purged from loss run, not allocated to specific accident or report years.

NOTE: These statistics were taken from the 9/84 quarterly loss run, and represent accurate claim counts as of that date. The 1984 counts given are for 9 months only. For the purpose of this report a "claim" is any incident for which a file is opened and which is added to the loss run (including lawsuits, written claims, and incidents for which no indemnity is paid).

DATA FOR NEW HAMPSHIRE MEDICAL MALPRACTICE J.U.A. ONLY.

N.H.M.M.J.U.A.

Losses Over $100,000

	Claim Count* O	C	T	Paid Indemnity	Reserve Indemnity	Paid Expense	Reserve Expense	Total Incurred Loss
$ 100,001- $ 250,000	16	27	43	$ 4,004,470	$2,070,001	$283,841	$124,471	$ 6,482,783
$ 250,001- $ 500,000	4	13	17	4,725,792	1,220,001	228,803	53,239	6,227,835
$ 500,001- $ 750,000	3	6	9	3,734,713	1,030,553	87,526	20,552	4,873,344
$ 750,001- $1,000,000	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
$1,000,001+	-0-	2	2	2,349,064	-0-	27,158	-0-	2,376,222
TOTAL	23	48	71	$14,814,039	$4,320,555	$627,328	$198,262	$19,960,184

NOTE: These statistics were taken from the 9/84 quarterly loss run and represent current claim counts and values as of that date. The claim count shown is per insured defendant (which is the criteria for opening a claim file and adding to the loss run). It therefore does not represent a completely accurate picture of the size of losses from the standpoint of total payment to any one claimant (i.e. if one claimant filed two suits for $200,000 each, the loss run would show two claims at $200,000 rather than one claim at $400,000). However, research of all settled claims in the last five years indicates that only three claims would change size band if grouped by claimant, and that the above is essentially a true picture of the numbers and sizes of large J.U.A. losses.

*Claim Count: O = Open, C = Closed, T = Total

DATA FOR NEW HAMPSHIRE MEDICAL MALPRACTICE J.U.A. ONLY.

Exhibit IV

12/10/84

APPENDIX D

State of New Hampshire

HOUSE OF REPRESENTATIVES

CONCORD

December 13, 1984

Dear Committee Member:

Enclosed please find my minority report to the JUA subcommittee's full report. As my minority position was not included in the full report, I feel your awareness of my position is important before the meeting on December 18.

Sincerely,

Elizabeth L. Crory

Elizabeth L. Crory
Grafton, District 13

ELC/sg
Enclosure

Minority Report on Joint Underwriters Association (JUA)

Stabilization Reserve Fund

Three of the four proposals of the JUA subcommittee are either an artificial manipulation of the insurance market place or a shifting of the responsibility for the anticipated JUA deficit. Before a governing body endorses such proposals, the severity of the anticipated deficit and the equity of the proposed solution must be resolved.

For the past fifteen months the Insurance Department's directive effectively restricting the voluntary market has resulted in forcing about one hundred new persons desiring medical liability insurance in New Hampshire to purchase their insurance at non-competitive rates from the JUA. Their level of premium resulting to the JUA is about $500,000. Those previously in the JUA were also "frozen" to keep the JUA populated.

The extension of the freeze will be open to challenge if power granted in RSA 404:C 1 and 404:C 2 has been exceeded. The Attorney General's office has advised the Insurance Department it must prove this plan is minimum interference.

This freeze is also connected to the Stabilization Reserve Fund. In 1985 the JUA will sell "claims made" policies to accommodate (soften) the implementation of the 15 percent premium surcharge. Claims made policies have a short run financial appeal which disappears when an insured wants to leave and has to purchase "tail coverage". If claims made policies are purchased in 1985, an expensive impediment to leave the JUA will exist.

The JUA committee report emphasizes all physicians and hospitals who entered into contracts with the JUA from 1975 until 1984 agreed in their insurance contracts to their obligation for the financial burden of any deficit. Nurses, dentists, medical technicians, the Hitchcock Clinic, the Mary Hitchcock Hospital, the Valley Regional Hospital and over 15 classes of health providers who have never purchased medical liability insurance from the JUA will now be forced to cover a deficit currently the responsibility of those insured by the JUA.

The JUA currently has about fourteen million dollars in their account. In 1983 the JUA purchased reinsurance at a cost of 1.5 million dollars to cover all losses arising by June 30, 1983, in excess of thirty million to forty million dollars. Testimony regarding better claims management, case settlements, and operation of the JUA, plus the stabilizing effect of the freeze, support my belief that the deficit is no longer as severe as anticipated in 1983. Before all are surcharged 15 percent of premium should we begin by surcharging only those in the JUA?

The mechanism for a Stabilization Reserve Fund could be established and triggered only if the JUA fund reaches a low of about five million dollars clearly defined as reserved. Cases are finalized for payment on a staggered basis with lead time for planning.

The current regulation allows the Insurance Department to assess one hundred dollars from about 336 insurance companies if a deficit is anticipated. In 1983 this assessment was made for years of licensing by each company at $100 per year and realized $213,700. This mechanism to meet a deficit was not used in 1984 and will be discarded in the new regulation. A higher assessment for the next few years, coupled with the triggering device approach, should be considered.

Before the Stabilization Fund is endorsed tighter controls and clearer language must be developed. In the final report new language appears never discussed in our committee; "an additional amount for deficit control" and "JUA Occurrence Fund". Additional concerns are:

- Will the 15 percent surcharge be exempt from the insurance broker's commission?

- A level between fourteen million and thirty million should be set now as adequate to cover the deficit for the eight years of JUA operation. The open ended allowance for the Insurance Department to decide an adequate level is a temptation for a continual Stabilization Reserve Fund. Agreement was reached in committee that the Insurance Department must conduct an annual hearing to justify extension of the surcharge. The report uses the permissive "should".

- The JUA has maximum coverage limits. Many institutions and individuals buy higher maximums outside the JUA. Should the higher limits be penalized by the 15 percent surcharge?

Proposal #3 will be levied when the JUA fund cannot meet its quarterly obligations and will spread the deficit even further. All persons purchasing homeowners, auto, or any type of liability insurance will be surcharged. These proposals are anticipated to become effective through the rule making powers of the insurance department.

The results of the proposal are:

The insurance companies will be the collector of revenues and the JUA will manage the fund. The unpopular task of collecting higher premiums will fall to companies who will find the JUA firmly entrenched in the market when the freeze is lifted. Companies will no longer be liable for a one hundred dollar annual assessment.

The medical community who benefited from the JUA from 1975-1984 will have a greatly reduced obligation for the deficit and will have paid lower premiums than others for about five years. The medical

community who have never participated in the JUA will pay a portion of the deficit and will continue to pay full premiums to their insurers. These insurers will not have the luxury of a state provided deficit offset.

These proposals will not decrease health costs, for if a deficit arises, the costs will be passed along. As a legislator representing the citizens of New Hampshire, I urge consideration of a more equitable Stabilization Reserve Fund and a triggering mechanism if the anticipated deficit becomes more concrete.

Elizabeth L. Crory
Representative, Grafton 13

THE HITCHCOCK CLINIC
Dartmouth-Hitchcock Medical Center
Hanover, New Hampshire 03756
603/646-5326

December 14, 1984

HAND DELIVERED

Honorable Louis Bergeron
Commissioner
New Hampshire Insurance Department
Concord, New Hampshire 03301

Dear Commissioner Bergeron:

I have received the draft report prepared by the JUA/Private Insurance Subcommittee and wish to offer several observations. For the reasons stated below, I believe that the Subcommittee's recommendations warrant further study and discussion before they can be approved and submitted to the Governor.

1. Administrative Orders Restricting Issuance of Private Insurance. If the administrative orders of September 7, 1983 and November 9, 1983 restricting the issuance of private medical malpractice policies to renewals only are to be removed on January 1, 1986, it is essential that the New Hampshire JUA be specifically authorized to market "claims made" insurance. Since the premiums during the early years of a "claims made" policy are relatively low and therefore attractive, the JUA must be able to market "claims made" policies if it is to compete successfully with private insurers once the administrative restrictions have been lifted. If the JUA were not permitted to offer "claims made" policies, the private insurance market would continue to dilute the JUA. If the voluntary market were to return, the JUA must be in a position to compete effectively.

2. Stabilization Reserve Fund. A draconian measure such as the Stabilization Reserve Fund ("SRF") should be pursued only in pressing and truly dire circumstances. As yet no reliable data has demonstrated that such circumstances actually exist and, therefore, I question whether a SRF is justified. In fact, the $1.5 million cost of reinsurance for the $30 million to $40 million loss corridor suggests only minimal exposure at this loss layer. Perhaps with another year of JUA management by Johnson and Higgins, the need for a SRF could be more readily ascertained.

If a need could be demonstrated accurately, however, I still question several fundamental features of the proposed SRF. For example, the recommendation does not take into account the fact that the Dartmouth-Hitchcock Medical Center ("DHMC") and the individual physicians working there did not contribute to the JUA's present financial difficulties. The costs imposed on the DHMC by the SRF would be extraordinary. Indeed, it would be

fundamentally unfair to impose a 15% premium surcharge on any individual health care provider that has been insured outside the JUA during the years the problems developed. If the JUA were to assess the DHMC and other privately insured health care providers, I fail to understand why these insureds could not, in turn, assess the JUA.

Furthermore, even if the SRF proposal were acceptable in principle, its current form lacks the precision necessary to understand its actual application. For instance, it is unclear whether the 15% surcharge is intended to apply to the cost of just excess coverage, just primary coverage or both. Would the regulation apply to required assessment under restrospective rate schemes? Would the regulation be applied to the total premiums paid regardless of the policy limits? The answers to these fundamental questions will have a material impact on the cost of non-JUA coverage; answers should be provided by the Insurance Commission and not by the drafters of the regulation.

I also believe that the criteria by which the Commissioner would decide that a JUA deficit no longer existed should be explicit and written. Given the competing interest groups affected directly and indirectly by the SRF, all parties would benefit by a considered articulation of the SRF termination conditions.

3. "Claims Made" Policies Offered by JUA. The proposal to include "claims made" policies should stand as a separate recommendation since the implications of the shift to a "claims made" program are considerable. Once a physician or health care provider purchases a "claims made" policy from the JUA, the cost of "tail" coverage from a private insurer is so great that these insureds essentially cannot go elsewhere for their insurance needs. Great care should be taken to inform fully individual physicians and health care institutions about the nature of "claims made" policies, and explicit provisions should be developed for the insureds to obtain "tail" coverage at a price that can be ascertained today. To ignore the "tail" question could mean that the JUA indirectly could become the mandatory insurer of all those who purchase "claims made" policies. The Subcommittee has previously discussed the merits of a mandatory state-wide JUA and if attention is not devoted to the "tail" issue a mandatory JUA might be created inadvertently for a select group.

4. Additional Assessments to Defray Cash Deficits. The relationship between the SRF and the change in the assessment formula is vague. As mentioned above, the duration of the SRF is unclear and, therefore, it is equally unclear when the assessment formula would be imposed on all liability insurance carriers in New Hampshire.

Furthermore, I question the order for the proposed surcharges. The proposed recommendation provides for deficit reduction by first assessing health care providers and then, if a deficit still exists, by assessing all liability insurance carriers in New Hampshire. Why not impose a surcharge on carriers first and then, to the extent a deficit remains, assess care providers.

It is also unclear what monies would be channeled into the JUA Occurrence Fund ("Fund"). Would the Fund be supported just by the premiums from the occurrence policies issued prior to the JUA offering "claims made" policies or would the Fund be supported by occurrence policies issued both before and after such an offering by the JUA? Would the premiums collected on "claims made" policies also go into the Fund? These questions warrant further discussion and analysis.

I have more specific comments on each of the recommendations and hope that I might meet with you prior to the Subcommittee meeting scheduled for December 18, 1984. I appreciate your courtesy in allowing me to set forth my views on these important matters.

Sincerely,

John C. Collins /TDR

John C. Collins
Chief Executive Officer

mjb