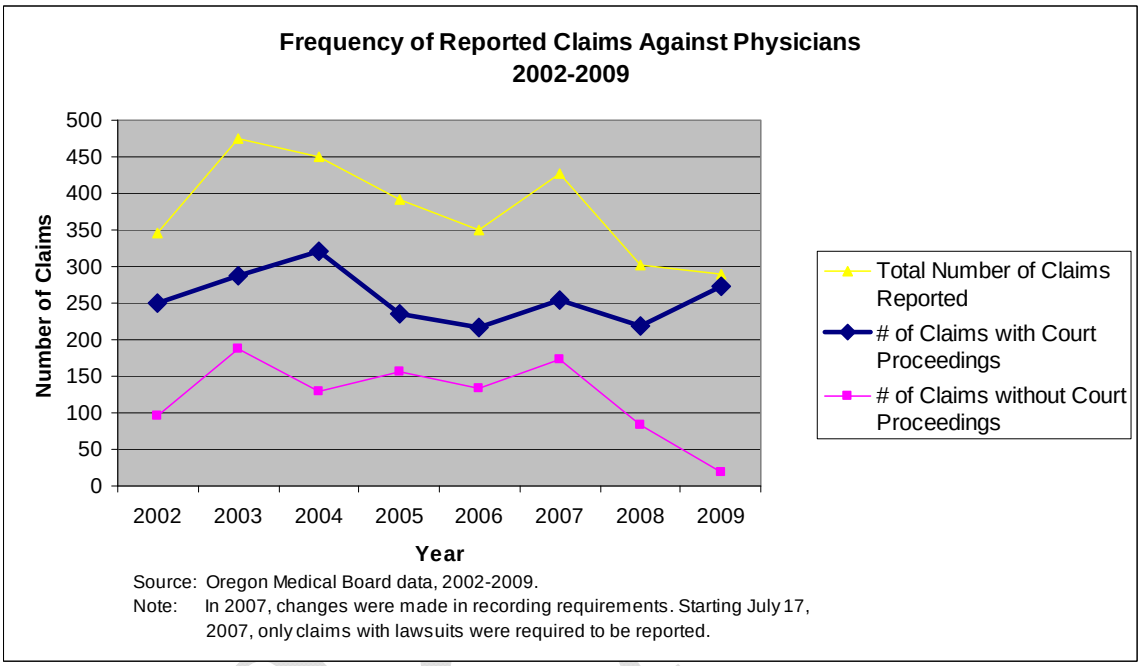
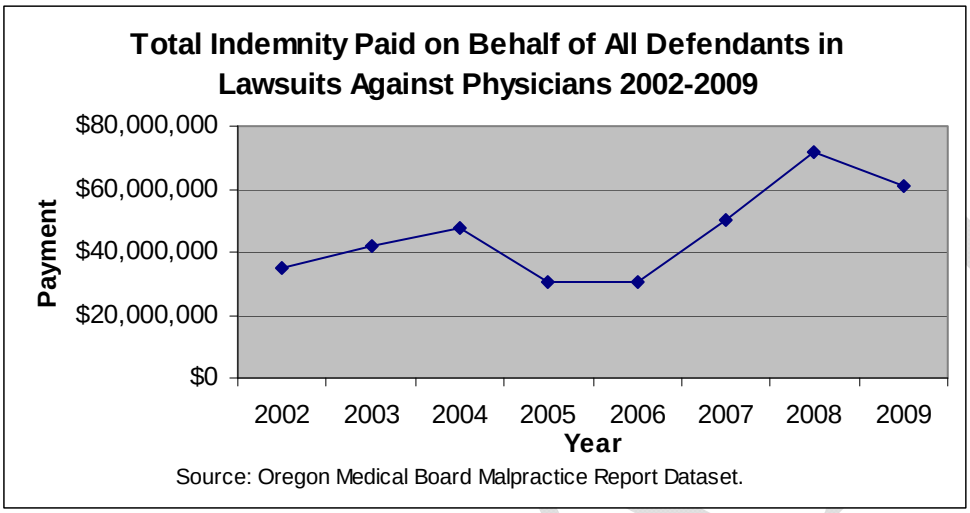
Appendix 1. Liability Cost Trends

The cost of indemnity payments is a function of the frequency of claims and average payment amounts. In Oregon, the frequency of claims filed against physicians in court that have been reported to the Oregon Medical Board has been somewhat volatile in the last few years; on balance, however, although Oregon's population has grown, there has been no apparent upward trend. (See chart below.)



The number of paid claims against professionals reported to the National Practitioner Data Bank surged in 2008; but until data is in for 2009 and 2010, long term trends will not be clear. (See chart below)

The trend is not clear with respect to dollar amount of payments. In a report issued in February 2008, the Oregon Medical Association and CNA HealthPro reported that the average indemnity amount paid in physician claims declined more than 7.5 percent from July 1, 1999 – October 10, 2005 to October 11, 2005 – October 10, 2007. There is some indication in the Oregon Medical Board data, however, that total payments made in cases filed in court against physicians (and others) is rising. See chart below.



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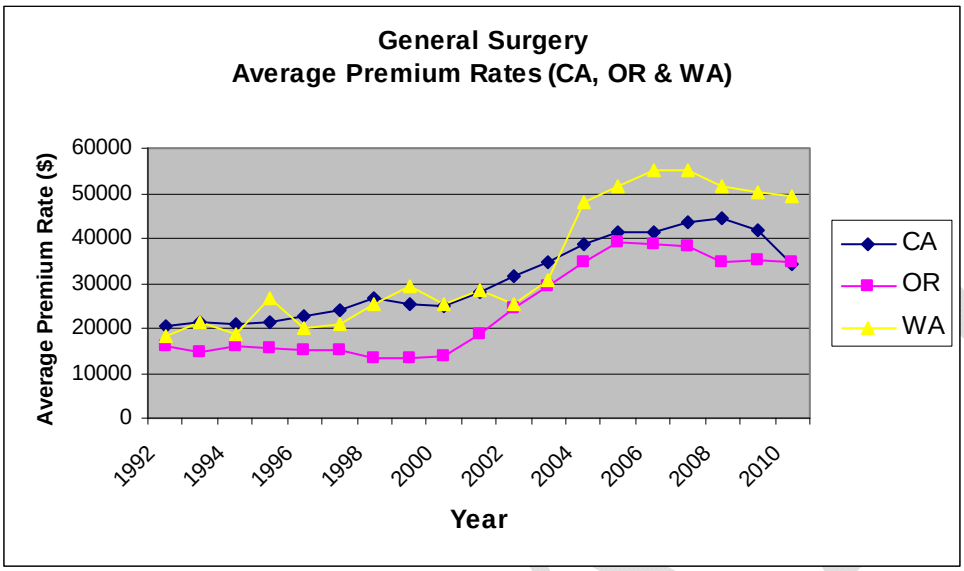
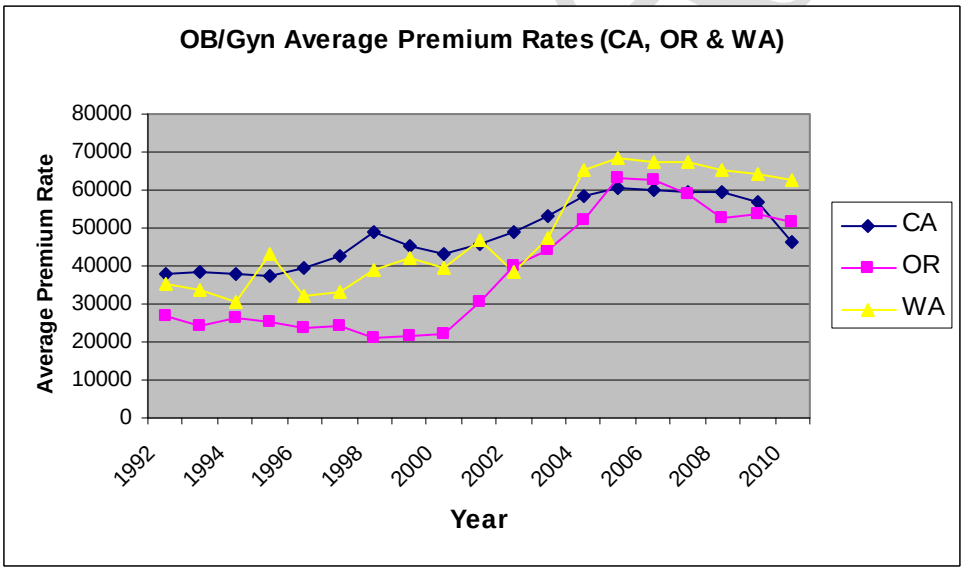
Appendix 2. Trends in Physician Premiums for Medical Liability Insurance

Medical liability premiums for the three physician specialties are reported in the Medical Liability Monitor, the pre-eminent industry publication. OHPR staff averaged the reported premium rates for each state by year and prepared the graphs below.





Notes: The Medical Liability Monitor surveys major writers of professional liability insurance for physicians each year. The survey includes manual rates for specific mature claims-made specialties with limits of $1 million/$3 million (the most common limits). The Monitor reports on three specialties only to reflect the wide range of rates charged: internal medicine, general surgery and obstetrics/gynecology. The rates are the reported rates unless otherwise noted and should not be interpreted as the actual premiums an individual

physician pays for coverage. They do not reflect credits, debits dividends or other factors that may reduce or increase premiums. Rates reported also do not include other underwriting factors that can increase premiums. It is estimated that the survey represents companies that comprise 65 to 75 percent of the market nationally.

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Appendix 3. Testimony Concerning the Medical Liability Premium Subsidy Program

Before the
Senate and House Interim Committees on Judiciary
May 24, 2010

Testimony of
Cory Stresinger, Director
Department of Consumer Business Services

My name is Cory Stresinger. I am the Director of the Department of Consumer and Business Services. I am here today to update the Committees on the program that subsidizes medical professional liability insurance costs for rural doctors.

The program began with enactment of House Bill 3630 in 2003. The goal of the program was to assist in attracting and retaining doctors in rural Oregon, and particularly doctors who provide obstetric services. The legislation was the result of escalating concern about the availability and affordability of medical professional liability insurance, particularly for rural doctors who provide obstetric services.

House Bill 3630 directed the State Accident Insurance Fund Corporation (SAIF) to establish a reinsurance program for medical professional liability insurance policies issued to rural doctors. The program was successful in providing medical liability insurance rate relief to rural doctors, and in 2007, the legislature enacted Senate Bill 183 to extend and modify the program for an additional four years, through 2011, but within the original funding limit set in 2003.

In recognition of the role played by nurse practitioners in providing medical care in rural Oregon, the program was expanded to include some nurse practitioners who have a rural practice. In addition, the definition of qualifying "rural" area was modified to exclude areas considered "urbanized" by U.S. Census definitions such as Ashland (except for those doctors and nurse practitioners who provide obstetric care). Also, in order to be eligible for the program, doctors and nurse practitioners had to be willing to serve Medicare and Medicaid patients.

The program continues to prioritize obstetric care, and those who practice obstetrics continue to receive the highest subsidies – 80 percent for obstetricians and nurse practitioners certified for obstetric care and 60 percent for family practitioners or general practitioners whose practice includes obstetrics. Doctors and nurse practitioners in specified primary care fields such as pediatrics and family practice receive subsidies up to 40 percent, while subsidies for doctors and nurse practitioners in non-primary care fields decline over the four year period from not more than 35 percent in 2008, to 25 percent in 2009, and to 15 percent in 2010 and 2011, based on available funds.

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Attached are the expenditures by year for the program, as well as data showing the total number of medical providers participating in the program since its inception and the number of providers participating by county. A total of about $29.1 million has been spent through calendar year 2009. Enrollment during 2009 was 881, consisting of 827 doctors and 54 nurse practitioners, and SAIF expended about $3.7 million for calendar year 2009. Enrollment for the first quarter of 2010 is currently 753 doctors and 48 nurse practitioners. The number of doctors and nurse practitioners receiving subsidies in a given year may not equal the enrollment for that year for various reasons. For example, requests for subsidies may not occur in the same calendar year in which the subsidy was provided.

The funding for the program came from credit against workers' compensation assessments paid by SAIF. These assessments are collected from Oregon employers for administration of Oregon's workers compensation system. Under the law, the program costs were capped at $40 million, based on a one-time surplus in this workers' compensation account. However, that surplus has long since gone and this account is not a sustainable source of funding for this program, although there will be sufficient funds available for the last two years.

The program continues to provide medical professional liability insurance rate relief for both rural doctors and nurse practitioners. It should be noted that the medical professional liability insurance market tends to by cyclical, and rates have been declining in recent years. Rates for Oregon's two largest insurers have gone down an average of 20 percent since 2006:

Year	NPIC/Doctors Company*	CNA
2006	-8.3%	1.9%
2007	-10.2%	-3.2%
2008	-8.9%	-7.6%
2009	0%	-2.5%
2010	-5.1%	0%

*Prior to 2010, coverage was through Northwest Physicians Insurance Company. Beginning in 2009, coverage was through The Doctors Company, Northwest Physicians Insurance Company's parent.

The program is scheduled to sunset at the end of 2011.

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Rural Medical Liability Financial Reinsurance Plan
Plan Results for 2004 - 2009
By Medical Provider Specialty

Program Expenditures by Year							
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**Total**
Obstetricians	$1,114,027	$1,322,013	$1,440,071	$1,269,246	$1,349,518	$1,183,017	$7,677,892
Family Practice with Obstetrics	$591,524	$629,147	$645,169	$602,271	$506,395	$501,134	$3,475,640
40% Specialties	$2,995,327	$3,445,771	$3,575,492	$3,446,355	$1,400,897	$1,271,826	$16,135,668
All Other Providers	N/A	N/A	N/A	N/A	$1,075,669	$728,929	$1,804,598
Total	$4,700,878	$5,396,931	$5,660,732	$5,317,872	$4,332,479	$3,684,906	$29,093,798

Total Number of Medical Providers Participating in Program						
Through Years Ending:	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Obstetricians	49	54	71	77	44	51
Family Practice with Obstetrics	70	71	73	84	64	59
40% Specialties	935	980	1,024	1,136	512	479
All Other Providers	N/A	N/A	N/A	N/A	316	293
Total	1,054	1,105	1,168	1,297	936	882

Notes: 2008 data include 46 nurse practitioners. 2009 data include 54 nurse practitioners. Prior to January 1, 2008, the "40% Specialties" and "All Other Doctors" categories were combined in one "40%" category. 2004 excludes $200,000 for actuarial study.

Subsidy Percentages by County
As of December 31, 2009

% Subsidy	80%	60%	40%	25%	Total by County
Total	51	59	479	293	882
Frontier	3	13	38	19	73
Baker		2	9	2	13
Gilliam	0	0	0	0	0
Grant		1			1
Harney		2	3		5
Lake		4	1		5
Malheur	3		17	16	36
Morrow			2		2
Sherman	0	0	0	0	0
Wallowa		4	6	1	11
Wheeler	0	0	0	0	0
Rural	42	26	379	263	710
Clatsop			16	11	27
Columbia			1		1
Coos	7	2	61	35	105
Crook		2	6		8
Curry			9	1	10
Douglas	6	1	59	44	110
Hood River	3	6	12	14	35
Jefferson		4	2		6
Josephine	7	3	65	34	109
Klamath	5	4	38	28	75
Lincoln	1		19	4	24
Polk		1	10	1	12
Tillamook	2	2	12	8	24
Umatilla	3		31	18	52
Union		1	9	11	21
Wasco	3		4	20	27
Yamhill	5		25	34	64
Mixed	6	20	62	11	99
Benton			1		1
Clackamas		1	11		12
Deschutes		4	24	2	30
Jackson		4	4	1	9
Lane			6	1	7
Linn			1	2	3
Marion	6	11	15	5	37
Washington	0	0	0	0	0
Urban	0	0	0	0	0
Multnomah					0

Appendix 4. Proposed Addition to Oregon's Insurance Code

(1)

(a) "Adverse event" means a negative consequence of patient care that is unanticipated, is usually preventable and results in or presents a significant risk of patient injury.

(b) "Claim" means a written demand for restitution for an injury alleged to have been caused by the medical negligence of a health practitioner or licensed health care facility.

(c) "Health practitioner" means a person described in ORS 31.740 (1).

(2) An insurer may not decline or refuse to defend a health practitioner or a health care facility against a claim arising from an adverse event for any reason that is based on the disclosure to the patient or the patient's family by the health practitioner or facility of the adverse event or information relating to the cause of the adverse event.

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Appendix 5. State Medical Error Disclosure Laws

State	Oregon	Pennsylvania
Covered entities	hospitals, ASCs, dialysis centers, nursing homes, and pharmacies (voluntary)	Hospitals, ASCs, and birth centers (mandatory)
What must be reported?	Serious adverse events specified by rule--e.g., in the case of hospitals, "any unanticipated, usually preventable consequence of patient care that results in patient death or serious physical injury, including the events described in Appendix A"	Serious events, incidents, and infrastructure failures. A serious event is "an event, occurrence or situation involving the clinical care of a patient…that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient." An incident--like a serious event--compromises patient safety, but it does not result in unanticipated injury or require the delivery of additional health services. An infrastructure failure is "an undesirable or unintended event, occurrence or situation involving the infrastructure of a medical facility or the discontinuation or significant disruption of a service which could seriously compromise patient safety."
What must be disclosed?	Reportable events [See reporting requirement.]	Serious events [For definition see reporting requirement.]
How?	in writing	In writing
When?	in a timely way	Within 7 days of the event
Who is responsible?	the facility	The facility is responsible for disclosure; health care workers (includes facility employees and physicians authorized to practice in the facility) must report.

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State	New Jersey	California	Florida
Covered entities	all health facilities including outpatient clinics, labs, and pharmacies	Hospitals (mandatory)	Hospitals, ASCs, mobile surgery facilities, and licensed health care practitioners (mandatory)
What must be reported?	Serious preventable adverse events. A serious preventable adverse events is "an event that is a negative consequence of care that results in unintended injury or illness" AND "could have been anticipated and prepared against, but occurs because of an error or other system failure" AND "results in death or loss of a body part, or disability of loss of bodily function lasting more than seven days or still present at the time of discharge from a health care facility"	Adverse events (multipage definition which tends toward events resulting in death or serious (but not necessarily permanent) disability.	"Adverse incidents that result in serious harm to the patient." Adverse incident means "an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred" AND which had one of a laundry list of rather serious consequences.
What must be disclosed?	Serious preventable adverse events and allergic reactions. [For definition see reporting requirement.] OR An adverse event defined as "an event that is a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable" that involves an allergic reaction.	Adverse events [For definition see reporting requirement.]	"Serious adverse incidents" [Undefined, but see definition of adverse incident in reporting section.]
How?	In person if patient in facility; by telephone if patient is no longer in the facility and a face-to-face meeting cannot be arranged; by certified mail if facility cannot contact the patient by phone. Contents of the notification must be documented in the patient's medical record.	"inform"	"inform"
When?	No later than the end of the episode of care	By the time the report is due (within 5 days after the error was detected)	"as soon as practicable"
Who is responsible?	the facility	The facility	Facilities and licensed providers

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State	Vermont	Washington
Covered entities	Hospitals (mandatory)	Hospitals (mandatory)
What must be reported?	"Adverse events" that by rule must be reported. (Rule adopts NQF list) "Adverse event" is defined as "any untoward incident, therapeutic misadventure, iatrogenic injury, or other undesirable occurrence directly associated with care or services provided by a health care provider or health facility"	?
What must be disclosed?	"Adverse events" that cause "death or serious bodily injury."	Only requirement is for hospital to have a policy in place to assure that "when appropriate, Information about unanticipated outcomes is provided"
How?	"disclose"	unspecified
When?	unspecified	unspecified
Who is responsible?	The hospital	The hospital

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Appendix 6. Recommended Study.

The feasibility study should address the following design issues, among others. It should identify alternative design choices and evaluate their impact on objectives identified in the Task Force's framework for medical liability reform:

- Compensability standard: What options are there for defining the injuries to be covered by the system?

- Filing of claims: Should claims be considered only if filed by the injured patient or her representative or family? Should providers be required to affirmatively advise the patient of any medical event that meets the threshold for a claim for benefits and direct her to the agency that processes claims as in other systems? Should providers be required to file such claims on behalf of the injured patient as in the workers compensation system?

- Economic Losses: What losses will be reimbursed?
    - Medical Costs: Will compensable losses include medical costs as they do in the workers' compensation system or should all financial responsibility for medical costs related to the injury be borne by the health insurer and/or the injured patient? If medical costs are compensable, how will responsibility for those costs be apportioned and determined? Should responsibility be apportioned in the administrative proceeding, with the collateral source rule abolished? Or should it be the responsibility of the fund to collect from a health insurer without involving the injured patient?
    - Death benefits: Should death benefits be payable? Is the workers compensation system a good model?
    - Lump sum payment or ongoing responsibility for losses: Will losses—such as predicted costs of medical care, non-medical care such as home care or skilled nursing care, and lost wages—be paid in a lump sum or will losses be paid by the administrative system on an on-going basis? If on an ongoing basis, who will decide what needs are related to the injury and determine what services are necessary and what will be paid for them? Will expenses be reimbursed to the patient or paid directly by the system?

- Non-economic Losses: Should non-economic damages be paid according to a schedule? How will schedules be established and updated?

- Responsibility: How will the administrative system interface with the tort system in cases in which someone other than a professional or a healthcare institution bears some responsibility for the injury (e.g., defective medical device)?

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- Administration: Will there still be insurance carriers that accept or deny and pay claims? Will there be a single state fund out of which claims are paid?

- Financing: Who will pay for the administrative/adjudicative apparatus? Who will pay for the cost of claims?

- Attorney fees: How will injured patients' lawyers be paid? (By the system? Out of the injured patients' recovery?

- Appeals: Who may appeal an adverse determination by the administrative adjudicator? Should the appeal be taken to the court of appeals in the same manner and reviewed under the same standard as decisions in contested cases? Who should pay costs on appeal?

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The study should address the specific questions listed below:

- Patient Safety
  - What is the likely effect of replacing the medical liability system with an administrative compensation system on patient safety?
  - Will it create more or less incentive for health care providers and facilities to invest in prevention of medical errors?
  - Will the effect on safety incentives depend on how the system is financed?
  - Will the proposed change support the safety improvement infrastructure more or less effectively?
  - Will some administrative system designs support patient safety improvement more effectively than others?

- Access to and adequacy of payment
  - What is its likely effect on access to and amounts of compensation for patient injury?
  - How would the choice of compensability standard and other design choices affect numbers of injured individuals compensated or amounts of recovery?
  - Who will suffer as a consequence of any payment reductions?

- Relationship to the health care system and health insurance costs
  - How will an administrative program affect health insurance costs?
  - How will it affect the practice of defensive medicine?

- Federal issues
  - Is ERISA implicated by an administrative program?
  - How would federal payers interact with it?
  - Would they have liens against recoveries?

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- State constitutional issues (right to jury trial and right to remedy)
  - Can an administrative program be implemented to replace the tort system without statutory or constitutional changes?
  - If not, what changes are necessary?
  - Will some system designs pass constitutional muster and others not?

- Financial feasibility
  - What are the anticipated total costs of the program?
  - How do those costs compare to those of the current system?

- Political feasibility
  - Are health care providers and institutions that currently take direct responsibility for paying for the current liability system in the form of premiums willing to finance the new administrative system? If not, who is?
  - Who can be expected to support or oppose the concept?[34]

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[34] Replacing the current system with an administrative one would both eliminate jury trials and limit damages to the extent that compensation is scheduled in some way. Although the ultimate reaction of any group to the results of a study cannot be predicted with certainty, it can be anticipated that trial lawyers who represent injured Oregonians and other groups who have opposed previous efforts to impose caps on damages may view an administrative substitute for the right to a jury trial for negligence as an assault on fundamental rights and vigorously oppose it.

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