INTERIM REPORT OF THE
COMMISSION TO STUDY THE COSTS AND ADMINISTRATION
OF
HEALTH CARE SERVICES
TO
THE GOVERNOR
AND
THE GENERAL ASSEMBLY OF VIRGINIA

Senate Document No. 29

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INTERIM REPORT OF THE

COMMISSION TO STUDY THE COSTS AND ADMINISTRATION OF

HEALTH CARE SERVICES

Richmond, Virginia

February 19, 1976

To: Honorable Mills E. Godwin, Jr., Governor of Virginia

and

The General Assembly of Virginia

The medical malpractice problem which this Commission was directed to study pursuant to Senate Joint Resolution No. 135, House Joint Resolution No. 174 and House Joint Resolution No. 259 of the 1975 Session of the General Assembly is an extremely complex one. There is little question that in the last five years the frequency and severity of malpractice claims have increased dramatically. (See the report of the State Corporation Commission on Medical Malpractice Insurance in Virginia, hereinafter referred to as Exhibit 1, pp. 19-24. Exhibit I is appended hereto.) Some estimate that approximately ninety percent of all malpractice claims in the United States have been reported since 1965. As a result, the annual premium charged by one insurer in Virginia to the lowest risk category of doctor for a policy with $100,000/$300,000 limits has increased 366% since 1967 while the premium charged to a doctor in the highest risk category for a policy with the same limits has increased 786%. (Exhibit I, pp. 13-14). In all likelihood, medical malpractice premium rates will continue to increase.

The increasing number of malpractice claims has stimulated the practice of defensive medicine. The costs of defensive medicine and the skyrocketing costs of medical malpractice insurance are ultimately borne by consumers, both those who are treated and those who purchase medical and hospital insurance. Thus, while physicians, hospitals, and other health care providers are currently most concerned about these costs, the entire public is affected.

Increasing costs is but one facet of the problem. An even more critical problem, at least in the short term, is assuring the availability of malpractice insurance. Because of the rapid rate of change in the frequency and severity of malpractice claims, companies are finding it increasingly difficult to predict the cost of malpractice insurance and are, therefore, reluctant to continue writing this form of coverage. The major exception in this State is the St. Paul Fire and Marine Insurance Company which insures approximately 80% of the physicians engaged in active practice in Virginia.

There is a need to develop permanent solutions; however, the development of such solutions is complicated by the fact that the real underlying causes of the recent increases in frequency and severity of claims include economic, scientific, sociological and psychological factors. Such causes include the growing popularity of litigation to air and resolve real or imagined grievances, unrealistic public expectations regarding what medical science can do, increasing depersonalization in the delivery of health care and more advanced but riskier medical procedures and treatments. Advances in medical science also increase the complexity and thus the cost of resolving medical malpractice claims. In addition, the present high inflation rate, which increases the losses caused by injuries as well as the cost of processing claims, is a contributing factor. Although it is certain these are the primary reasons underlying the increase in claims, the degree to which each contributes to the problem is extremely difficult to quantify with precision. (See Exhibit I, pp. 53-58).

Interim remedial measures can be taken that will alleviate the problem of availability of insurance and provide for the collection of additional data in order to permit informed decision-making on a continuing but gradual basis. An immediate need is to develop a mechanism to assure the continued availability of malpractice insurance coverage. Part I addresses this issue but not the more complex problem of the cost of insurance. The recommendations contained in Parts II and III relate to cost.

I.

Various alternatives designed to assure the continued availability of malpractice insurance have been proposed. The Commission believes that the Joint Underwriting Association (JUA) is the preferred approach. It offers more financial stability than a doctor- or hospital-owned insurance company and avoids the administrative problems and potential drain on general revenues that would accompany a State-run alternative.

The JUA legislation should provide that the JUA be activated by the State Corporation Commission whenever it finds, after a hearing, that any particular class, type or group of health care provider cannot obtain coverage through the voluntary market.

Nor should the JUA be enacted with the usual automatic two-year termination date since no one knows how long this problem will continue to exist. On the other hand, a JUA of unlimited duration might lull one into believing there is no need to rectify the existing situation. Accordingly, the Commission recommends that the JUA remain in existence until July 1, 1980 and that the Commissioner of Insurance be required to report to the General Assembly each year regarding whether or not the JUA should be kept in existence or should be altered in any way to achieve its objectives

The State Corporation Commission should also have discretion

as to whether or not the JUA, when activated, should be the exclusive source of malpractice insurance coverage for the class, type or group of health care providers. This flexibility concerning whether or not the JUA is to be the exclusive source of insurance is necessary because of competing considerations for and against exclusivity. For instance, if it is not exclusive, other insurers may insure only the good risks leaving the JUA with only bad risks. On the other hand, if the JUA is the exclusive source of insurance, private insurers may discontinue offering this line of insurance thus creating problems when the JUA is terminated. These and other factors and conditions should be weighed at the time the JuA is activated to determine the issue of exclusivity.

The Commission should also have discretion regarding the type or types of policies to be issued by the JUA and amounts of coverage. The principle objection of the medical profession to claims-made policies[1]. appears to be that even after a physician dies or retires, it will still be necessary to purchase expensive insurance against possible claims. The expense of insurance is also a problem for doctors just beginning to practice and doctors wishing to taper off their practices as they get older. These doctors may have more limited exposure to claims than established, fully active physicians. Various suggestions have been made to deal with these situations such as guaranteed reporting endorsements,[2]. installment premiums, and premium adjustments for limited exposure. It has also been suggested that physicians be offered policies with deductibles. Deductibles should decrease the cost of policies as well as make physicians financially responsible, in part, for injuries negligently inflicted by them. Each of these suggestions should be explored for policies issued by the JUA as well as the voluntary market. The Commissioner of Insurance has asked the industry to study these suggestions and other possibilities. It is recommended that to the degree practicable the Commisioner of Insurance take all steps necessary to implement these considerations.

This Commission believes that the rates charged by the JUA should be self-supporting and that other policyholders should not subsidize doctors and hospitals. To this end the JUA legislation should make it absolutely clear that the State Corporation Commission make every reasonable effort to insure rate adequacy. In addition, the legislation should establish a rate stabilization fund to provide some cushion in the event that the approved rates are inadequate. If the rates are inadequate and if the rate stabilization funds are not sufficient, the resulting deficit should then be paid for by the providers of health care through a surcharge over a period of years in order to minimize the burden placed upon the providers of health care.

With respect to participating insurers, this Commission believes that participation should be extremely broad so as to provide financial stability and equity with respect to the temporary assessment of losses pending recoupment from the providers of health care. However, a line must be drawn and where it is drawn must by necessity be somewhat arbitrary. Accordingly, the Commission recommends that participation be determined on the basis of third-party liability coverages — both under the traditional tort system and the related workman's compensation system. This

will provide a broad distribution of responsibility that minimizes to the maximum degree practicable the burdening of any one liability insurance carrier merely because of the fortuitous fact that a carrier writes a very large volume of business in one particular line of coverage.

The proposed legislation is attached to this report in Appendix C.

II.

With respect to the tort system, the Commission makes no recommendation with regard to the statute of limitations, the doctrine of res ipsa loquitur, the doctrine of informed consent, the locality rule governing the standard of care which doctors must exercise, contingent fees, and the imposition of a monetary limit on the liability of health care providers. The Commission recognizes that these matters are the subject of consideration by other legislative studies but does recommend tort system changes relative to the ad damnum clause, the collateral source rule and the review of malpractice claims by screening panels.

The ad damnum clause in pleadings in personal injury and wrongful death cases sets forth the amount of damages asserted by a plaintiff. These amounts often are far above the amounts actually recovered by a plaintiff if the plaintiff recovers anything at all. It has been stated that publicity given to huge damage claims in malpractice cases but not to the actual and considerably smaller judgments and settlements or judgments against the plaintiffs encourages additional claims and litigation. Since the ad damnum clause serves no real purpose other than to establish jurisdiction (which could be averred without claiming specific amounts), it is recommended that the ad damnum clause be abolished from motions for judgments in all personal injury and wrongful death cases. Legislation is included in Appendix B.

The collateral source rule, which is followed in Virginia, prohibits the reduction of any damages awarded a plaintiff by the amount of reimbursement for medical expenses and lost wages that the plaintiff has received from sources other than the defendant. The reason for this rule is that a defendant who has negligently injured someone should compensate that person for the injuries he inflicted and should not benefit from, or have this obligation reduced by, insurance or other sources of compensation paid for by the person he injured. On the other hand, it is argued that a jury should have all facts before it in determining the damages to be awarded. The Commission recommends that evidence of collateral sources of compensation be permitted to be introduced in any personal injury or wrongful death action. See Appendix A.

The Commission also recommends that legislation be enacted which would provide for the review of malpractice claims by panels composed of health care providers, lawyers and members of the public. The purposes of such review panels are to weed out

nonmeritorious claims, encourage settlements and provide a speedier and less costly alternative to trial. The Commission's recommended legislation, set forth in Appendix D, does not make a panel review mandatory but would permit any party to demand a panel review when filing a motion for judgment or an answer to a motion for judgment in a medical malpractice case. A panel review is not mandatory since the Commission believes that there will be cases in which a panel review would serve no useful purpose and thus no party would desire such a review. When demanded, the court in which the action was instituted would appoint a panel to hear the claim and render an opinion. The panel would be composed of two health care providers, two lawyers and one person who is neither a health care provider nor an attorney. This membership should afford balance and expertise. The opinion of the panel is not binding and may be rejected by any party. It is admissible into evidence in any subsequent trial of the claim. Costs of the panel review are to be borne equally by each side except that if a defendant demands the panel review, the defendant must pay the reasonable fees of a just number of expert witnesses for the plaintiff. This last provision is intended to equalize the incentive to demand a panel review.

III.

The Commission is impressed by the State Corporation Commission's hospital-based distribution proposal. One reason why medical malpractice premiums are high relative to premiums paid by policy holders in other insurance systems is the fact that the exposure of health care providers is extraordinarily large relative to the number of providers among whom these costs must be distributed. For example, the 100 hospitals in Virginia are exposed to approximately 5,000,000 bed-patient days. (See Exhibit I, pp. 79-93, 96-97). Equally important, the vast majority (anywhere from 75 to 80%) of all malpractice claims against physicians arise from incidents occurring within the confines of a hospital. Furthermore, consumers of hospital-based care often have insurance covering hospital care which permits the cost of malpractice losses to be distributed over a much broader base.

Because of these considerations the Commission believes that the proposal offers more potential than any solution proposed so far to accomplish the following objectives:

1. Provide immediate rate relief to those providers of health care that need it the most (i.e. specialists with hospital-based practices). Hopefully, this will create a less emotional climate for rational decision making. In addition, it will shift the economic burden for these losses onto the entity that is ostensibly in control of the environment in which most of the malpractice incidents occur. This, in turn, should provide incentives for those that control this environment to develop workable long-range solutions.

2. Focus attention upon the area where the vast majority of all malpractice incidents occur. Hopefully, this will also facilitate the

development of workable solutions over time.

3. Facilitate data gathering and other research efforts essential to the development of long-range solutions.

4. Institutionalize a procedure for the development of long-range solutions on a gradual but continued basis as information becomes available.

5. Permit, if not encourage, a subtle shift in attitude by all facets of the hospital medical delivery system so that everyone involved in that system will begin to make a coordinated effort to develop long-range solutions.

Nonetheless, a number of administrative problems remain to be solved and there may be viable alternative ways to achieve the same objectives. It is imperative, therefore, that all interested parties seriously focus on the hospital-based distribution proposal and other alternatives. The Commission has requested the State Corporation Commission to prepare draft legislation designed to implement the hospital-based distribution proposal. This will provide a tangible starting point from which to develop a viable proposal. This Commission will study the proposal and devise specific legislative recommendations for inclusion in its final report to the 1977 General Assembly.

Conclusion

Because of the extreme complexity of the problem of controlling the costs of medical malpractice insurance, there is no immediate, effective solution to the problem. The Commission believes that the hospital-based distribution proposal described in Part III offers the greatest possibility for eventual solution of the problem in a rational and effective manner. In addition, the Commission has recommended in Part I a means of dealing with an immediately critical problem, that of assuring the availability of liability insurance. It has also recommended in Part II some revisions in the tort system which may help to alleviate the cost problem.

Respectfully submitted,

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Adelard L. Brault

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Frank A. Schwalenberg

**James R. Tate

*STATEMENT OF ROBERT CARTER

I disagree with the Commission's decision to recommend no major action in the tort area.

**STATEMENT OF JAMES R. TATE

I cannot agree with the majority recommendation to repeal § 8-628.3 of the Virginia Code and abolish the collateral source rule. Changing the law as recommended will require the plaintiff in a malpractice case to disclose all of the insurance that he carries to pay for the injuries sustained. This recommendation of the Commission is without equity to support it; for why should the plaintiff be required to disclose his insurance if the defendant is not required to disclose his. Further, the proposed repeal would discriminate between plaintiffs, rewarding those who were foolish enough not to buy health insurance while punishing those who have contracted with an insurance company and paid health insurance premiums for years. Nor is there evidence that abolishing the collateral source rule will result in a favorable impact on medical costs paid by the public.

The Commission is to be commended, however, for its forthright report and logical analysis of the medical malpractice insurance problem in Virginia. I am particularly impressed with the very learned report of the Virginia State Corporation Commission on Medical Malpractice Insurance (Exhibit 1). The report, written by Virginia Insurance Commissioner John Day provides the foundation for most of the important recommendations of the majority; i.e., (1) establishment of a Joint Underwriting Association to assure the availability of malpractice insurance - found in Part I of the majority report, and (2) the broadening of the malpractice insurance rate base to bring down unit insurance cost - found in Part III of the majority report. While it is probably true that the overall cost of malpractice insurance to consumers will not decrease initially as a result of implementation of the recommendations in Part III of the majority report, nevertheless hospitals will have a real incentive to improve the quality of medical care provided. Further, cost reductions to individual practitioners who are now forced to pay such high malpractice rates that they can no longer continue to practice after retirement should enable many doctors to continue to provide medical care on a part-time basis - thereby increasing the availability of health care services to the general public.

Part II of the Commission's report attacks the tort system, and

recommends abolishing the ad damnum clause and the collateral source rule, as well as the establishment of a malpractice panel to be required at the insistence of either party—the panel's findings being admissable in evidence at a subsequent trial. In my judgment, a fair reading of the Corporation Commission's report leads to the inevitable conclusion that no basis exists to believe tort system changes will solve the problem faced by this Commission. I have no objection to abolishing the ad damnum clause in tort cases because I believe it causes as many problems for plaintiffs as defendants. Nor do I object to the panel as proposed, because I believe such a panel could prove equally advantageous to either side—depending on the merits of its case. I do, however, strongly object to abolishing the collateral source rule, because to do so would unfairly discriminate against the injured plaintiff who carries hospitalization insurance—and pays for it. I do not expect that any of the proposed changes in the tort system will have a measurable impact on medical costs borne by the public.

Should the General Assembly, in its wisdom, deem it advisable to adopt the recommendation of the majority of this Commission and abolish the collateral source rule, then it will have added another law to that growing list of laws that unfairly discriminate against the middle class who are the backbone of this State and pay most of the bills to keep it running. Most middle class Virginians pay monthly for hospital insurance, and allowing the big defense insurance companies to get the benefit of their hospital insurance premiums is a blatant surrender to the special interests of those companies and I cannot support it.

FOOTNOTES

1. A claims-made policy provides insurance against claims made against an insured during the life of the policy. An occurrence policy provides insurance against liability for acts done during the life of the policy.

2. A guaranteed reporting endorsement is a guarantee by an insurer that it will provide insurance at a stated price following the expiration of the existing policy to a doctor who retires or to his estate if he dies against claims made after his death or retirement.

Appendix A

A Bill to repeal § 8-628.3 of the Code of Virginia, relating to effect of reimbursement for loss of income on damages in certain cases and admissibility of evidence of such reimbursement; and to amend the Code of Virginia by adding a section numbered 8-628.4, permitting evidence of collateral sources of compensation in certain cases.

Be it enacted by the General Assembly of Virginia:

1. That § 8-628.3 of the Code of Virginia is repealed.

2. That the Code of Virginia is amended by adding a section numbered 8-628.4 as follows:

§ 8-628.4. In any action for damages for personal injury or death where it is alleged that the plaintiff or decedent suffered economic loss by reason of such injury or death, including but not limited to the cost of medical care, custodial care or rehabilitation services, loss of services, and loss of earned income, evidence shall be admissible that any such cost or expense was paid for or payable by or any such economic loss was replaced or indemnified, in whole or in part, by insurance or governmental, employment or service benefit programs.

Appendix B

A Bill to amend the Code of Virginia by adding a section numbered 8-628.4, prohibiting the inclusion of a dollar amount or figure in the demand for relief in motions for judgment in certain cases.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 8-628.4 as follows:

§ 8-628.4. No dollar amount or figure shall be included in the demand for relief in any motion for judgment in any action for damages for personal injury or death but the demand shall be for such damages as are reasonable in the premises.

Appendix C

A Bill to amend the Code of Virginia by adding in Title 38.1 a chapter numbered 20, consisting of sections numbered 38.1-775 through 38.1-789, relating to the creation of a medical malpractice joint underwriting association.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 38.1 a chapter numbered 20, consisting of sections numbered 38.1-775 through 38.1-789, as follows:

Chapter 20.

Medical Malpractice Joint Underwriting Association.

§ 38.1-775. Definitions.—As used in this chapter:

1. "Association" means the joint underwriting association established pursuant to the provisions of this chapter.

2. "Medical malpractice insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering or failing to render professional service by any provider of health care.

3. "Commission" means the State Corporation Commission.

4. "Provider of health care" means (a) any of the following deemed by the Commission to be necessary for the delivery of health care: (i) physician and any other individual licensed or certified pursuant to Chapter 12 of Title 54 of the Code; (ii) nurse, dentist, or pharmacist licensed pursuant to Title 54 of the Code and (iii) any health facility licensed or eligible for licensure pursuant to Chapter 16 of Ttitle 32 or Chapter 8 of Title 37.1 of the Code; and (b) any other group, type, or category of individual or health related facility that the Commission finds, after a hearing, to be necessary for the continued delivery of health care.

5. "Incidental coverage" means any other type of liability insurance covering activities directly related to the continued and efficient delivery of health care that: (a) cannot be obtained in the voluntary market because medical malpractice insurance is being provided pursuant to this chapter; and (b) cannot be obtained through other involuntary market mechanisms.

6. "Premiums written" means gross direct premiums charged on all policies less all premiums and dividends returned to policy holders or the unused or unabsorbed portions of premium deposits on liability insurance.

7. "Liability insurance" means (a) personal injury liability insurance as defined in § 38.1-15, (b) property damage liability insurance as defined in § 38.1-16, (c) the liability component of multiple peril package policies, (d) the liability component of motor vehicle

insurance and (e) workmen's compensation and employer's liability insurance as defined in § 38.1-17.

§ 38.1-776. Joint underwriters association.—A. There is hereby created a joint underwriting association which shall be in effect until July one, nineteen hundred eighty, and which shall consist of all insurers authorized to write and engaged in writing, within this State on a direct basis, liability insurance other than those insurers exempted from rate regulation by § 38.1-279.31(c). Each such insurer shall be a member of the association and shall remain a member as a condition of its authority to continue to transact such kind of insurance in this State.

B. The purpose of the association shall be to provide a market for medical malpractice insurance on a self-supporting basis without subsidy from its members. On January one of each year the Commission shall submit to the General Assembly a report recommending whether this legislation should or should not be repealed or whether it should be amended.

C. The association shall not commence underwriting operations for any class, type or group of providers of health care until the Commission, after investigation and a hearing, has determined that medical malpractice insurance cannot be made reasonably available for a significant number of any class, type or group of providers of health care in the voluntary market. Upon such determination, the association shall commence operations in accordance with the provisions of this chapter. Policies issued by the association may be countersigned by an agent licensed by the Commission as an agent of the association for the purposes of this chapter.

If the Commission determines at any time that medical malpractice insurance can be made reasonably available in the voluntary market for any class, type or group of providers of health care, the association shall thereby cease its underwriting operations for such class, type or group of providers of health care.

D. The Commission shall also determine after investigation and a hearing whether the association shall be the exclusive source of medical malpractice insurance for any class, type or group of providers of health care and the type of policy or policies that shall be issued to any class, type or group of providers of health care. The Commission may from time to time after an investigation and hearing reexamine and reconsider any determination made pursuant to this subsection D.

E. The association shall, pursuant to the provisions of this chapter and the plan of operation set forth in § 38.1-778, have the power on behalf of its members: (1) to issue, or to cause to be issued, policies of insurance to applicants, including incidental coverages, subject to limits as specified in the plan of operation but not to exceed one million dollars for each claimant under any one policy and three million dollars for all claimants under one policy in any one year; (2) to underwrite such insurance and to adjust and pay losses with respect thereto; (3) to appoint a service company or companies to perform the functions enumerated in this paragraph; (4) to assume reinsurance from its members; and (5) to cede reinsurance.

§ 38.1-777. Directors.—The association shall be governed by a board of fourteen directors. Two directors shall be appointed by each of the following three insurance industry trade associations: (a) the American Insurance Association; (b) the American Mutual Insurance Alliance; and (c) the National Association of Independent Insurers. The Commission shall appoint two directors to represent unaffiliated insurance companies. One director shall be appointed by each of the following two agent trade associations: (a) the Virginia Association of Insurance Agents; and (b) the Mutual Insurance Agents Association of Virginia and the District of Columbia. Two directors shall be appointed by the Medical

Society of Virginia and two directors shall be appointed by the Virginia Hospital Association.

If any of the foregoing associations fail to appoint a director or directors within a reasonable period of time, the Commission shall have the power to make such appointments.

§ 38.1-778. Plan of operation.—A. Within forty-five days following the effective date of this chapter the directors of the association shall submit to the Commission for review, a proposed plan of operation, consistent with the provisions of this chapter.

B. The plan of operation shall provide for economic, fair and non-discriminatory administration and for the prompt and efficient provision of medical malpractice insurance, and shall contain other provisions including, but not limited to, preliminary assessment of all members for initial expenses necessary to commence operations, establishment of necessary facilities, management of the association, assessment of members to defray losses and expenses, reasonable and objective minimum underwriting standards developed in consultation with the medical and hospital advisory committees provided for in § 38.1-779, acceptance and cession of reinsurance, appointment of servicing carriers or other servicing arrangements, the establishment of premium payment plans, procedures for determining amounts of insurance to be provided by the association, procedures for the recoupment of assessments and temporary contributions by members and any other matters necessary for the efficient and equitable operation and termination of the association.

C. The plan of operation shall be subject to approval by the Commission after consultation with the members of the association and representatives of interested individuals and organizations. If the Commission disapproves all or any part of the proposed plan of operation, the directors shall within fifteen days submit for review an appropriate revised plan of operation or part thereof. If the directors fail to do so, the Commission shall promulgate a plan of operation or part thereof, as the case may be. The plan of operation approved or promulgated by the Commission shall become effective and operational upon order of the Commission.

D. Amendments to the plan of operation may be made by the directors of the association, subject to the approval of the Commission.

§ 38.1-779. Medical and hospital advisory committee.—The Commission shall appoint a medical advisory committee to the association composed of five physicians licensed to practice medicine in this State and a hospital advisory committee composed of five representatives of the hospitals licensed in this State.

§ 38.1-780. Policy forms and rates.—A. All policies issued by the association shall be subject to the group retrospective rating plan and the stabilization reserve fund provided for by this chapter. No policy form shall be used by the association unless it has been filed with the Commission and either (a) the Commission has approved it or (b) thirty days have elapsed and the Commission has not disapproved it as misleading or violative of public policy.

B. Policies shall be issued by the association after receipt of the premium or portion thereof prescribed by the plan of operation only to applicants that (1) meet the minimum underwriting standards, and (2) have no unpaid or uncontested premium due as evidenced by the applicant having failed to make written objection to premium charges within thirty days after billing.

C. Any policy issued by the association may be cancelled during the term of the

policy for any one of the following reasons: (1) nonpayment of premium or portion thereof; (2) the insured's license has been suspended or revoked; (3) the insured fails to meet the minimum underwriting standards; (4) the insured fails to meet minimum standards prescribed by the plan of operation; nonpayment of any stabilization reserve fund charge.

D. The rates, rating plans, rating rules, rating classifications, premium payment plans and territories applicable to the insurance written by the association and statistics relating thereto shall be subject to the provisions of Chapter 6 of this title giving due consideration to the past and prospective loss and expense experience for medical malpractice insurance written and to be written in this State, trends in the frequency and severity of losses, the investment income of the association, and such other information as the Commission may require. All rates shall be on an actuarially sound basis, giving due consideration to the group retrospective rating plan and the stabilization reserve fund, and shall be calculated to be self-supporting. The Commission shall take all appropriate steps to make available to the association the loss and expense experience of insurers writing or having written medical malpractice insurance in this State.

E. All policies issued by the association shall be subject to a non-profit group retrospective rating plan to be approved by the Commission under which the final premium for all policyholders of the association, as a group, will be equal to the administrative expenses, loss and loss adjustment expenses and taxes, plus a reasonable allowance for contingencies and servicing. Policyholders shall be given full credit for all investment income, net of expenses and a reasonable management fee, on policyholder supplied funds. Any additional premium resulting from a retrospective adjustment will first be collected from the stabilization fund set forth in § 38.1-781. If these funds are insufficient to pay the entire amount due, the balance will be collected through surcharges upon policyholders in accordance with a plan approved by the Commission.

F. In the event that sufficient funds are not available for the sound financial operation of the association, pending recoupment as provided in this chapter and the plan of operation, all members shall, on a temporary basis, contribute to the financial requirements of the association in the manner provided in this chapter.

G. The Commission shall examine the business of the association as often as it deems appropriate to make certain that the group retrospective rating plan is being operated in a manner consistent with this section. If the Commission finds that it is not being so operated, it shall issue an order to the association, specifying in what respects its operation is deficient and stating what corrective action shall be taken.

§ 38.1-781. Stabilization reserve fund.—A. There is hereby created a stabilization reserve fund. The fund shall be administered by five directors appointed by the Commission, one of whom shall be a representative of the Commission, two of whom shall be representatives of the association and two of whom shall be representatives of the association's policyholders.

B. The directors shall act by majority vote with three directors constituting a quorum for the transaction of any business or the exercise of any power of the fund. The directors shall serve without salary, but each director shall be reimbursed for actual and necessary expenses incurred in the performance of his official duties as a director of the fund. The directors shall not be subject to any personal liability with respect to the administration of the fund.

C. Each policyholder shall pay to the association a stabilization reserve fund charge equal to one half of the annual premium due for medical malpractice insurance through the association until the fund reaches a level deemed appropriate by the Commission. The means of payment shall be set forth in the plan of operation and such shall be separately

stated in the policy. The association shall cancel the policy of any policyholder who fails to pay the stabilization reserve fund charge.

D. The association shall promptly pay the trustee of the fund all stabilization reserve fund charges which it collects from its policyholders and any retrospective premium refunds payable under the group retrospective rating plan provided for in this chapter.

E. All monies received by the fund shall be held in trust by a corporate trustee selected by the directors. The corporate trustee may invest the monies held in trust, subject to the approval of the directors. All investment income shall be credited to the fund. All expenses of administration of the fund shall be charged against the fund. The monies held in trust shall be used solely for the purpose of discharging when due any restrospective premium charges payable by policyholders of the association under the group retrospective rating plan provided for in this chapter. Payment of retrospective premium charges shall be made by the directors upon certification to them by the association of the amount due.

F. Upon dissolution of the association, all monies remaining in the fund, after final disposition of all claims, expenses and liabilities against the fund including recoupment of temporary assessments made pursuant to § 38.1-780 F., shall be distributed equitably to the policy holders who have contributed to the fund under procedures authorized of the directors.

§ 38.1-782. Participation.—All insurers which are members of the association shall participate in the temporary contributions to finance the operation of the association in the proportion that the premiums written by each such member during the preceding calendar year (excluding that portion of premiums attributable to the operation of the association) bears to the aggregate premiums written in this State by all members of the association. Each insurer's participation in the association shall be determined annually on the basis of such premiums written during the preceding calendar year in the manner set forth in the plan of operation.

§ 38.1-783. Review of association activities.—Any insurer, applicant or other person aggrieved by any action or decision of the association or of any insurer as a result of its participation in the association, may appeal to the board of directors of the association. The decision of the board of directors may be appealed to the Commission within thirty days from the date that the aggrieved person received notice of the board's action.

§ 38.1-784. Annual statements.—The association shall file with the Commission annually on or before the first day of December a statement which shall contain information with respect to its transactions, condition, operations and affairs during the preceding twelve month period ending on September thirty. Such statement shall contain such matters and information as are prescribed, and shall be in such form as is approved, by the Commission. The Commission may, at any time, require the association to furnish additional information with respect to its transactions, condition or any matter connected therewith considered to be material and of assistance in evaluating the scope, operation and experience of the association.

§ 38.1-785. Examinations.—The Commission shall make an examination into the affairs of the association at least annually. Such examination shall be conducted and the report thereon filed in the manner prescribed in §§ 38.1-174 through 38.1-178. The expenses of each such examination shall be borne and paid by the association.

§ 38.1-786. Public officers or employees.—No member of the Commission or board of directors of the stabilization reserve fund who is otherwise a public officer of employee shall suffer a forfeiture of his office or employment or any loss or diminution in the rights

and privileges appertaining thereto, by reason of membership on the Commission or board of directors of the stabilization reserve fund.

§ 38.1-787. Producer's commissions.—With respect to any medical malpractice or incidental coverage policy issued by the association, the commission payable to the licensed producer shall be limited to five percent of the annual premium for such policy or one thousand dollars, whichever is less.

§ 38.1-788. Immunity.—There shall be no liability imposed on the part of, and no civil cause of action of any nature shall arise against, the association, its board of directors, agents or employees, a participating insurer or its employees, any licensed producer, the Commission or its authorized representatives, the medical and hospital advisory committees, their members or employees for any statements or actions made by them in good faith in carrying out the provisions of this chapter.

§ 38.1-789. Severability provision.—If any section or portion of a section of this chapter, or the applicability thereof to any person or circumstance is held invalid by any court for any reason, the remainder of this chapter, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

Appendix D.

A Bill to amend the Code of Virginia by adding in Title 8 a chapter numbered 39 consisting of sections numbered 8-911 through 8-919, relating to review of medical malpractice claims against health care providers by medical review panels.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 8 a chapter numbered 39 consisting of sections numbered 8-911 through 8-919, as follows:

Chapter 39.

Medical Malpractice Review Panels.

§ 8-911. As used in this chapter:

A. "Health care provider" means a person, corporation, facility or institution licensed by this State to provide health care or professional services as a physician, hospital, dentist, registered or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist, physical therapy assistant or clinical psychologist, or an officer, employee or agent thereof acting in the course and scope of his employment.

B. "Physician" means a person licensed to practice medicine or osteopathy in this State pursuant to Chapter 12 of Title 54.

C. "Patient" means a natural person who receives or should have received health care from a licensed health care provider, under a contract, express or implied.

D. "Hospital" means a public or private institution licensed pursuant to Chapter 16 of Title 32 or Chapter 8 of Title 37.1 or subject to the provisions of Chapter 10 of Title 32.

E. "Tort" means any legal wrong, breach of duty, or negligent act or omission proximately causing injury or damage to another.

F. "Malpractice" means any tort or breach of contract based on health care or professional services rendered, or which should have been rendered, by a health care provider, to a patient.

G. "Health care" means any act, or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical diagnosis, care, treatment or confinement.

§ 8-912. Whenever a motion for judgment against a health care provider for malpractice is filed in any court of this State, the plaintiff may include in such motion for judgment a demand for a review by a medical review panel established as provided in § 8-913. If the plaintiff has not demanded such review, any health care provider named as a defendant in such motion for judgment may demand such a review in his answer to the motion for judgment.

§ 8-913. A. When any party to an action against a health care provider for malpractice demands a review by a medical review panel as provided in § 8-912, the court shall appoint a medical review panel composed of five members, two of whom shall be attorneys licensed to practice law in this State, one of whom shall be a member of the public who is neither an attorney nor a health care provider, and two of whom shall be health care providers. At least one of the health care provider members shall be of the same class of health care provider as the defendant, except that if the sole defendant is a hospital, at least one health care provider member of the panel shall be a physician. If there are two or more defendants, the health care provider members shall be of the same classes of provider as two of the defendants. The members of the panel shall elect one of its members to serve as chairman of the panel.

B. Any party, for cause, may object to the appointment of any panel member upon notice to all other parties, and the court, in its discretion, may replace such panel member.

C. Each panel member so appointed shall serve, provided that the court may excuse a panel member upon a showing of cause by such panel member.

§ 8-914. A. The members of the medical review panel shall be sworn to hear the claim and render an opinion faithfully and fairly.

B. The medical review panel shall conduct a hearing on the claim after notifying the parties by means adequate to assure their presence of the time and place of the hearing. The panel may adjourn or postpone the hearing. The court in which the motion for judgment was filed, upon application, may direct the panel to proceed promptly with the hearing.

C. The testimony of the witnesses shall be given under oath. Members of the medical review panel, once sworn, shall have the power to administer oaths.

D. The parties are entitled to be heard, to present evidence, and to cross-examine witnesses, but rules of evidence need not be observed. The medical review panel may proceed with the hearing and render an opinion upon the evidence produced, notwithstanding the failure of a party duly notified to appear.

E. The medical review panel may issue or cause to be issued, on its own motion or on application of any party, subpoenas for the attendance of witnesses and for the production of books, records, documents, and other evidence. Subpoenas so issued shall be served and, upon application by a party or the panel to the court in which the motion for judgment was filed, enforced in the manner provided for the service and enforcement of subpoenas in a civil action. All provisions of law compelling a person under subpoena to testify are applicable.

F. On application of a party and for use as evidence, the medical review panel may permit a deposition to be taken, in the manner and upon the terms designated by the panel, of a witness who cannot be subpoenaed or is unable to attend the hearing.

G. The hearing shall be conducted by all members of the medical review panel but a majority may determine any question and may render an opinion.

§ 8-915. A. The medical review panel shall render an opinion which shall consist of findings of fact, a recommendation, and a statement of the basis for such recommendation. The recommendation shall relate to both liability and damages.

B. The opinion shall be signed by all members of the medical review panel, except that any member of such panel may write a concurring or dissenting opinion giving his

reasons therefor.

C. The panel shall return its opinion together with all the testimony upon which its opinion is based to the court in which the motion for judgment was filed and, on or before the date upon which its opinion is returned, shall give notice thereof in writing to the parties, or to their counsel of record, by mailing the same to their last known addresses.

§ 8-916. A. Within twenty-one days of the return of the opinion of the medical review panel to the court, each party to the panel review shall file with the court a statement of acceptance or rejection of the opinion of the medical review panel. If the parties accept such opinion, the court shall enter judgment accordingly.

B. In the event that any party rejects the opinion of the medical review panel, the matter shall proceed as provided by law for the trial of civil cases.

§ 8-917. A. An opinion of a medical review panel shall be admissible as evidence in any subsequent trial in the case if the court conducts a review of the opinion and any other relevant information submitted by the parties and concludes that:

1. The findings of fact included in such opinion are not clearly erroneous;

2. The opinion is in accordance with the applicable law; and

3. The required procedures were followed in conducting the hearing and rendering the opinion.

B. The opinion shall not be binding upon the court or jury trying the case but shall be accorded such weight as the court or jury chooses to ascribe to it.

§ 8-918. No person who in good faith provides testimony, information, records, documents, reports, proceedings, minutes, or conclusions in any review by a medical review panel shall be liable for civil damages as a result of these acts or statements.

§ 8-919. Each member of the medical review panel shall be paid at the rate of twenty-five dollars per diem, not to exceed a total of two hundred fifty dollars, for work performed as a member of the panel exclusive of time involved if called as a witness to testify in court, and in addition thereto, reasonable travel expenses. Fees of the panel including travel expenses and the costs of the panel review shall be paid one half by the plaintiff or plaintiffs and one half by the defendant or defendants. Each party shall pay the costs and expenses incurred by him in the review by a medical review panel except that if a defendant or defendants demanded such review, such defendant or defendants shall pay the reasonable fees of such number of the plaintiff's or plaintiffs' expert witnesses as may be just.

EXHIBIT I

MEDICAL MALPRACTICE INSURANCE IN VIRGINIA: THE SCOPE AND SEVERITY OF THE PROBLEM AND ALTERNATIVE SOLUTIONS

State Corporation Commission

Bureau of Insurance

Richmond, Virginia

November, 1975

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INTRODUCTION

Since 1960, malpractice insurance premium rates across the United States have increased more than 1000%. Since 1970, the frequency of requests for rate increases has escalated dramatically,and requests for increases ranging anywhere from 100% to 400% are common.

The primary reason for these increases is the rapid and dramatic increase in the number and severity of malpractice claims. In fact, it has been estimated that over 90% of all medical malpractice claims that have ever been made in the United States have been reported since 1965.

In many jurisdictions, the premium rates for certain high risk medical specialists have reached almost prohibitive levels. Other doctors in low risk categories have rightfully become concerned that it will not be long before their premiums will be beyond reach. While many argue that doctors can afford these high premiums, particularly since these costs are passed on to the patient, there is little question that existing malpractice insurance premium levels and their anticipated increases in future years are having an adverse impact upon the availability of health care. New doctors are electing not to practice in high cost jurisdictions,and many doctors are either retiring early, joining hospital staffs as employees or moving to jurisdictions with less adverse experience.

At the same time that insurance companies are charging higher premiums than ever before, they are becoming increasingly

reluctant to continue writing malpractice insurance.[1/] Companies wish to discontinue this line of coverage because they believe they can no longer determine future losses with any accuracy[2/] -- a prerequisite to the establishment of adequate rate levels. In fact, it appears that the industry has consistently underestimated these losses since 1970. As a result, the premiums charged have not been sufficient to cover resulting losses and expenses. The resulting deficit must be shouldered by stockholders and other policyholders. The anxiety generated by unrelated stock and bond market losses, recent underwriting losses in other lines of business and mounting public criticism regarding malpractice rate increases has only reinforced the insurance industry's desire to abandon the "high risk" business of malpractice insurance.

This decline in the malpractice insurance market poses an even greater threat than spiraling premium rates to the continued delivery of health care. This is so because physicians, and to a lesser degree hospitals, will not provide medical services without the protection afforded by malpractice insurance coverage.

1/ In 1965, approximately 70 companies sought new malpractice markets in the United States. Today, no more than a dozen companies are actively writing this business. In addition, most of those companies that are still in the business have either formally or informally notified regulators that they wish to discontinue this line as soon as possible. St. Paul Fire & Marine Insurance Company is a major exception.

2/ The primary reason why traditional actuarial methods cannot accurately estimate future malpractice losses is the recent rapid increase in the number and severity of malpractice claims and the instability of these rates of increase. Actuarial science requires a stable claims pattern which does not exist today.

Virginia has begun to experience similar problems -- though not to the degree experienced in many other jurisdictions. We still have time to institute interim remedial measures to assure continued availability of malpractice insurance and to possibly ease the burden of escalating rates. This will facilitate the development of long range solutions since sound and thoughtful decision making is virtually impossible in a crisis atmosphere.

Equally important is the need to recognize that there is no easy and clear cut long range solution. The development of a permanent solution requires the orderly collection and analysis of data. Such an analysis is difficult at present due to the scarcity of information as to the causes of accelerating malpractice claims. Additionally, more needs to be known about how the existing system for delivering health care and compensation for injured patients really works. Furthermore, any long range solution will necessitate a careful balancing of the many complex and often competing interests of (1) the medical profession; (2) the legal profession; (3) the injured patient and (4) the general public both in its capacity as a future patient who demands readily available high quality health care and as a taxpayer.

The first step in solving any problem is to understand it. Hopefully, this report will facilitate that end. It will begin with a summary of the scope and severity of the problem in Virginia and prospects for the future. The report will then analyze Virginia's malpractice claims experience.

This will be followed by a brief statement of the difficulties encountered in any evaluation of malpractice claims experience and the extent to which Virginia's malpractice insurance rates can and do reflect Virginia experience. The remainder of the report will outline the various "solutions" that have been proposed in this and other jurisdictions with particular emphasis upon what each will and will not do.

The report will conclude with the State Corporation Commission's recommendations.

THE SCOPE AND SEVERITY OF THE MALPRACTICE INSURANCE PROBLEM IN VIRGINIA

Before discussing the availability and rate problems that face Virginia's hospitals and doctors, the various types of malpractice insurance coverage must be defined. Basic limits or primary limits refers to the minimum amount of coverage offered by insurance carriers. Because these limits are low compared to the size of potential claims, doctors and hospitals almost always obtain significantly higher limits. Excess or increased limits refers to coverage for amounts of loss in excess of the primary limits. When an insurance company sells higher limits, it normally purchases insurance for itself to cover all or the higher portions of the possible loss. This is called reinsurance and is designed to distribute the risk for the larger losses as broadly as possible in order

to prevent an unusually large claim from having a severe adverse impact upon any one single company. The availability and cost of excess liability insurance is often dependent upon the availability and price of reinsurance.

A. Hospital Malpractice Insurance in Virginia

There are 129 hospitals in Virginia. Eleven of these are within the federal jurisdiction. Since the Federal Government self-insures, we are concerned primarily with the malpractice insurance problem faced by Virginia's remaining 118 non-federal hospitals.

Prior to July 1, 1974, the exposure of Virginia's hospitals to malpractice claims was limited by the legal doctrine of charitable immunity which prohibited recovery of damages against nonprofit or charitable hospitals. Approximately 70% to 80% of Virginia's hospitals were viewed as non-profit institutions. During 1974, the Virginia General Assembly abolished this immunity. This change in the law had an impact upon rates though not to the degree asserted by many.

1. Rates

Prior to July 1, 1974, when the doctrine of charitable immunity was still in effect, there were two malpractice insurance rates for hospitals: One for profit hospitals and another rate for a not-for-profit institutions. In theory, there was no need for the non-profit hospitals to obtain

coverage because of the immunity. However, in practice, injured patients sued these hospitals and the hospitals often settled with the patient because:

1. it was often unclear whether a particular hospital was solely a nonprofit institution subject to the exemption; and
2. hospitals did not want to test the doctrine of charitable immunity in the courts because the doctrine had been declared unconstitutional in many other jurisdictions.

Generally, the rate for non-profit institutions was less than half that of profit motivated institutions. For example, at the time the doctrine was abolished by the General Assembly, the annual per bed rates for $25,000/75,000 basic limits were $14.50 and $38.50 for nonprofit and profit hospitals, respectively.

Prior to 1970, both rates remained relatively stable. Since then, rates for both have increased dramatically, in part because of increased losses and in part because the basic limits upon which rates were computed were increased from $5,000/15,000 to $25,000/75,000. The following table summarizes the increase in the Insurance Services Office's (ISO)[3/] rates for basic limits converted to a uniform basis since 1970:

3/ The ISO is an organization that pools industry statistics for rate making purposes.

Basic Limit Per Bed Rate[4/]

Date	Rate		Amount of Basic Limits
	For Profit	Not For Profit	
7/22/70	$ 38.50	$ 14.50	$25,000/75,000
9/25/74	$ 112.00	$ 112.00	$25,000/75,000

The 1974 increase in the not-for-profit bed rate of $14.50 to $112.00 is attributable to: (1) the abolition of the doctrine of charitable immunity; and (2) the steady increase in the number of malpractice claims against non-profit hospitals.[5/]

4/ It should be noted that in computing a hospital's malpractice premium, the basic per bed rate is just the starting point. Other factors considered include (1) the number of beds that were occupied during any one year; and (2) the hospital's claims experience under all its various liability insurance coverages since all liability insurance, including malpractice insurance, is usually purchased and sold as a package. Premiums in excess of $200,000 per year would not be unusual for coverage of $1,000,000/1,000,000 for a large hospital.

5/ Had the charitable immunity doctrine remained in effect, it is estimated that the 1973 annual per bed rate of $14.50 for charitable hospitals would now be anywhere from $50 to $75 per bed because of increasing claims. During the same period, the 1973 per bed rate of $38.50 for profit hospitals increased to $112. Since non-profit hospitals now are treated like any other hospital, their present per bed rate is $112 rather than $50 to $75. Consequently, a charitable hospital that obtained a one year insurance policy in June, 1974 -- one month before the immunity was abolished -- was not subjected to a 672% increase ($14.50 to $112.00 per bed) as alleged by many when the policy came up for renewal one year later, but rather a 49% to 124% increase ($50/$75 to $112.00 per bed) since the premium for nonprofit hospitals would have increased to the $50/$75 level in any event.

a. Existing Rates for Hospitals

Even though the present per bed rate for Virginia hospitals is significantly higher than it used to be, ISO's annual per bed rate for basic limits ($25,000/75,000) is $112. The per bed rate for significantly higher limits ($100,000/$300,000) is $69 more or $181 per bed. These rates compare very favorably with the rates charged for similar coverage in other urbanized jurisdictions:

State	Basic Limits ($25,000/75,000)	Increased Limits ($100,000/300,000)
California	$830	$1,345
Michigan	334	541
D. C.	285	396
Ohio	220	356
Oregon	203	329
Washington	196	318
Virginia	112	181

With respect to the Mid-Atlantic and Southeastern United States, Virginia's current ISO rates are in the median range:

State	Basic Limits ($25,000/75,000)	Increased Limits ($100,000/300,000)
Florida	$535	$867
D. C.	285	396
Georgia	149	241
Delaware	132	183
Virginia	112	181
Tennessee	110	153
*Pennsylvania	100	139
Alabama	97	157
Mississippi	83	134
Maryland	72	117
South Carolina	61	85
West Virginia	51.50	71.50
*North Carolina	27.50	33

* These rates do not reflect the recent changes in malpractice experience in these jurisdictions. For example, the proposed rates for Pennsylvania are now $350 for $25,000/75,000 and $567 for $100,000/300,000. The proposed rates for North Carolina are now $218 for $25,000/75,000 and $355 for $100,000/300,000 limits.

Presently, Virginia's rate for basic and excess limits ranks 22nd and 21st in the country. A state-by-state analysis is attached. (Appendix A)

Between now and the end of the year, hospital malpractice rates are expected to increase at least 160% countrywide. A formal request for a 50% increase in Virginia's rates has already been filed by ISO and will be scheduled for a public hearing in the near future.[6/]

2. Availability

There has been and continues to be a number of companies which write hospital malpractice insurance in

6/ On August 25, 1975 the SCC issued an order requiring that any increase in malpractice rates be filed with the SCC along with supporting data at least 30 days prior to the effective date. The SCC took this action after finding that there was no competition with respect to the sale of malpractice insurance. The SCC then notified insurers that any rate in excess of the standard ISO rate -- the rate based on the broadest data base -- would automatically be subject to a hearing. Rates lower than the standard ISO rate would be subject to a hearing in the event the supporting data did not support the proposed rate or the requested increase affected a large number of Virginia's providers of health care.

Virginia.[7/]

Prior to 1975, Virginia hospitals encountered little or no difficulty in obtaining malpractice insurance coverage. However, in recent months there has been a noticeable tightening-up of the market. This became apparent when a number of hospitals notified the SCC that their insurance carrier would not renew their coverage and that they were having difficulty obtaining coverage from other sources. The Virginia Hospital Association also informed the SCC that a number of other hospitals believed that they too would be faced with the same problem when their contracts came up for renewal later this year.

On June 6, 1975, the Bureau of Insurance requested a meeting with all insurance carriers writing malpractice coverage in Virginia. Although the Bureau of Insurance has no power to order insurers to continue writing the malpractice coverage, the industry was asked to maintain the status quo at least through the next session of the General Assembly in order to avoid a crisis and to insure the continued delivery of health care. The industry agreed, and to its credit the June 6, 1975 agreement has worked relatively well. On occasion, a "communication" problem has arisen which has forced the Bureau of Insurance to intervene. Fortunately, these incidents have been few and far between.

7/ Only eleven companies presently cover more than one hospital. In addition, over the last ten years at least 50 companies have provided some type of malpractice insurance coverage.

It should be pointed out that the June 6, 1975 agreement was limited to existing insurance. It did not solve the problem faced by new hospitals in obtaining initial coverage. Nor did it solve that of existing hospitals that wished to obtain limits higher than those that were in effect. In these instances, the Bureau has played an active role in finding new markets -- a difficult task to say the least since the industry does not want to take on new risks and will only do so in an emergency situation.

At the present time, it appears that most Virginia hospitals will be able to maintain essentially the same coverage they had prior to 1975 and at least through the next session of the General Assembly. A few hospitals which have had extremely large limits have had these limits cut back to lower, but reasonably adequate, levels primarily because of a drying up of the reinsurance market countrywide.

Despite this success, there is no assurance that this stability will continue. In fact, the stability which exists is due to a temporary accommodation on the part of the industry and it is almost certain that the availability problem will become a serious matter for hospitals next year in the absence of remedial legislation.

B. Physicians and Surgeons Malpractice Insurance Problems

Virginia has 6,800 licensed physicians and surgeons. Although data is skimpy, the Medical Society of Virginia

estimates that somewhere between 5,000 to 5,500 of these doctors are engaged in active practice. The remainder are either full-time employees of a hospital or industry, are retired or are engaged primarily in research.

Since 1956 the Medical Society has sponsored a malpractice insurance program which is underwritten and administered by a single insurance company -- St. Paul Fire and Marine Insurance Company. Under this program St. Paul presently provides coverage for approximately 4,100 Virginia doctors -- 80% of the total number engaged in active practice. The coverage of the remaining 20% is fairly evenly distributed among six other companies.

Because of the economies realized under the Medical Society's program, St. Paul's rates over the years have generally ranged anywhere from 25% to 35% lower than those charged by the remaining six companies that use the standard ISO rates.

1. Rates

Physician malpractice premium rates vary with a doctor's type of practice. For rating purposes, doctors have been divided into several categories designed to reflect their

exposure to potential medical malpractice claims.[8/] In addition, in 1973 St. Paul divided Virginia into three rating territories to reflect the different malpractice experience in each. The rates in Territory 1 -- northern Virginia -- have generally been 20% higher than the rates for Territory 3, Rural Virginia. The rates for Territory 2 -- which includes the major urban areas outside of northern Virginia -- have usually been 10% lower than the northern Virginia rates.

The following analysis of Virginia's past and present rate levels will be limited to the rates charged for the highest and lowest risk category of non-government doctors in Virginia's highest risk territory.

a. Rates for the Standard Malpractice Policy for Physicians and Surgeons

The annual premium for $100,000/300,000 limits for the lowest risk category of doctor under the Medical Society's program with St. Paul has increased from $93 in 1967 to $433

8/ Prior to 1974 there were five categories: Class 1 (Physicians) - no surgery (other than incision of boils, suturing of skin) or obstetrical procedures; Class 2 (Physicians) - minor surgery or assisting in major surgery on own patients or obstetrical procedures not constituting major surgery; Class 3 (Surgeons) - general practitioners performing or assisting in major surgery other than on own patients, including cardiologists who engage in catheterization but do not perform cardiac surgery; Class 4 (Surgeons) - specialists such as urologists, cardiac surgeons; and Class 5 (Surgeons) - specialists such as anesthesiologists, neurosurgeons, orthopedic surgeons. In 1973 two additional classifications were made: (1) Physicians and surgeons in active military service; and (2) Physicians, surgeons and dentists employed full time by the Federal Government, but not in active military service.

in 1975 -- a 366% increase. The rates for the highest risk category of doctor for $100,000/300,000 limits has increased from $308 in 1967 to $2,728 in 1975 -- an increase of 786%.

Over the years, these rates have been significantly lower than the rates St. Paul charged to doctors in other jurisdictions. For example, in 1975, the annual premium for the minimum $100,000/300,000 coverage under the Medical Society's program for Virginia's lowest risk category of doctor ranked 29th countrywide. The annual premium for the highest risk classification ranked 26th.

With respect to the January 1, 1975 rates in surrounding states, St. Paul's Virginia rates compared favorably:

State	Class 1 (low risk)	Class 5 (high risk)
Florida	$1,217	$7,702 9/
Ohio	922	4,707/7,532/5,648
D. C.	599	3,790 9/
Kentucky	577	2,940/4,704/3,528
Louisiana	469	2,924 9/
West Virginia	467	2,410/3,856/2,892 9/
Delaware	434	2,215/3,543/2,657
Virginia	433	2,728 9/
Tennessee	383	1,955/3,128/2,347
Maryland	360	2,273
Georgia	285	1,530
Alabama	275	1,738
Pennsylvania	206	2,207
North Carolina	175	871
South Carolina	160	1,010

9/ The first rate is for anesthesiologists and otolaryngologists (with plastic surgery); the second rate is for neurosurgeons and orthopedic surgeons; and the third rate is for obstetrics - gynecologists and plastic surgeons.

Doctors who have not taken advantage of the Medical Society's program have obtained coverage from other insurance carriers which, for the most part, charge the standard ISO rates. Over the years, these doctors have consistently paid more for malpractice coverage than the doctors that have been covered by St. Paul.[10/]

Doctors that are not in the Medical Society's program may be subject to a rate increase in the near future. ISO has already filed for a 93.8% increase. This request will be schedule for a public hearing before the SCC in the near future.[11/]

10/ Even so, existing Virginia ISO rates rank between 19th and 21st depending on the classification and limits of coverage. (See Appendix B) With respect to other mid-atlantic and southeastern states, Virginia's ISO rates are high:

State	Class 1		Class 5	
	25/75	100/300	25/75	100/300
Florida	$2,043	$3,555	$16,339	$28,920
Tennessee	925	1,378	7,409	11,262
Pennsylvania	516	769	3,182	4,837
Virginia	509	886	4,069	7,202
D. C.	468	697	3,744	5,691
West Virginia	365	544	2,921	4,440
Georgia	332	578	2,652	4,694
Delaware	291	434	2,331	3,543
Mississippi	283	492	2,268	4,014
South Carolina	145	252	1,161	2,055
Maryland	131	168	804	1,061
Alabama	115	200	703	1,244
North Carolina	95	122	476	628

While it is impossible to determine Virginia's future ISO ranking with precision, it appears that even with ISO's proposed 93.8% increase, Virginia's ranking will range in the 18th to 20th range when compared to existing and proposed ISO rates countrywide.

11/ See footnote 6 on page 9.

b. Rates Under the "Claims Made" Policy

In May, 1975, St. Paul changed to a new type of medical malpractice insurance policy called a "claims made" policy in order to permit more accurate rate making and the greater use of local rather than countrywide data. Under the "claims made" policy, coverage is provided for the claims actually reported each year rather than for all claims arising out of incidents occurring during the year of coverage.

Because of this fact, St. Paul need only estimate the value of known claims and is not required to estimate the number and value of claims that would be reported anywhere from two to five years later under the old type of coverage. Since the rates will be based on reported claims, the premium under the "claims made" policy should be somewhat lower than that charged for the standard malpractice policy for the first few years of coverage. However, in time, the "claims made" premium will increase until it approximates the rate charged for the standard "occurrence" policy. A detailed discussion of the "claims made" policy, the reasons for this change in rate levels and its advantages and disadvantages is set forth in Appendix C.

Although the initial "claims made" rates are lower than the rates that would have been charged for the old "occurrence" policy in Virginia and elsewhere, Virginia's "claims made" rate ranks 10th in the country when compared to St. Paul's "claims made" premium in other jurisdictions. This relatively high ranking is due to the fact that claims in Virginia are reported more rapidly under Virginia's short two-year statute of limitation than are claims in other jurisdictions. However, after a few years of experience and a build-up of reported claims in other states, Virginia's mature "claims made" rate will rank much lower.

2. Availability

Prior to 1975 physicians and surgeons had little or no difficulty in obtaining malpractice coverage even though most carriers were not aggressively seeking new customers. However, it is now clear that with few exceptions, companies other than St. Paul will not accept new doctors. In addition, these same companies are becoming more reluctant to continue writing malpractice insurance coverage for existing doctors. This reluctance has manifested itself in the use of more stringent underwriting practices: Doctors are now finding that their carrier will either not renew their contract or will renew only if they pay a much higher rate. The situation has eased somewhat since the Bureau's June, 1975 meeting with the insurance industry where the industry agreed to maintain the status quo through the next legislative session.

In summary, Virginia doctors do not have an availability problem for basic and normal excess limits if they are willing to be covered under the "claims made" policy. Those wishing to maintain their coverage with other carriers are very likely to encounter problems next year. This reluctance to continue writing malpractice insurance, coupled with the deteriorating experience in other jurisdictions, argues strongly for a standby mechanism to assure continued availability of coverage for doctors in the event that circumstances change.

VIRGINIA'S MALPRACTICE EXPERIENCE

While there is a considerable amount of data regarding the severity and frequency of malpractice claims and other related rate information, there is little uniformity regarding the manner in which insurance companies collect and compile this data. Accordingly, developing data on a uniform basis is extremely difficult. Fortunately, this problem is minimized regarding the experience of Virginia's physicians and surgeons because 80% of Virginia's active practitioners obtain their coverage from a single carrier -- St. Paul. With respect to Virginia's hospitals, the Bureau of Insurance has undertaken its own survey regarding hospital malpractice experience with the aim of developing a uniform data base. Although the Bureau is still in the process of compiling and verifying malpractice data for physicians and

hospitals, the Bureau has prepared frequency and severity tables from the best available information collected to date.

Virginia Malpractice Experience For Physicians and Surgeons

Like other jurisdictions, the frequency and severity of malpractice claims against physicians and surgeons in Virginia has increased dramatically over the last seven years. St. Paul's Virginia experience demonstrates this fact:

VIRGINIA

Reported Year	No. of Claims Reported[12/]	Frequency (No. of claims per 100 doctors)	Severity[12/] (average cost per claim)
1969	89	2.60	$ 4,182.03
1970	114	3.09	5,824.01
1971	137	3.52	7,583.00
1972	190	4.81	5,738.70
1973	223	5.51	7,278.86
1974	269	6.51	9,649.09
1975 (1st half)	151	7.22	10,190.66
Percent of change		178%	144%

The combined experience of the five companies that write most of the remaining doctors not underwritten by St. Paul yields similar results.

12/ The reported claims include those that are ultimately closed without a loss payment. Severity is computed by dividing the total loss and loss expense by all reported claims -- which include paid claims, pending claims and claims closed without payment.

The sort of changes seen in St. Paul's Virginia experience are also seen in St. Paul's countrywide experience -- which excludes that of New York and California because St. Paul does not write medical malpractice insurance in these jurisdictions:

COUNTRYWIDE

Reported Year	No. of Claims Reported[12/]	Frequency (No. of claims per 100 doctors)	Severity[12/] (average cost per claim)
1968	1,267	2.87	$4,855.58
1969	1,280	2.76	5,799.02
1970	1,538	3.16	6,950.85
1971	2,217	4.37	7,012.48
1972	2,679	5.08	7,344.12
1973	2,930	5.38	9,718.34
1974	3,762	6.85	10,558.72
Percent of change		139%	117%

Other neighboring jurisdictions have experienced similar increases either with respect to claims frequency or

12/ See footnote 12 on Page 19.

severity or both:

	1969	1970	1971	1972	1973	1974	Percent of change
				VIRGINIA			
Frequency [12/] (per 100 doctors)	2.6	3.1	3.5	4.8	5.5	6.5	150%
Severity [12/]	$4,182	$5,824	$7,583	$5,738	$7,278	$9,649	131%
				MARYLAND			
Frequency [12/] (per 100 doctors)	2.9	3.5	5.6	6.9	6.7	8.9	207%
Severity [12/]	$6,280	$6,497	$7,399	$8,060	$8,940	$10,116	61%
				NORTH CAROLINA			
Frequency [12/] (per 100 doctors)	1.6	1.5	1.9	2.2	1.9	2.8	75%
Severity [12/]	$3,133	$4,192	$2,992	$6,406	$9,641	$12,115	287%
				TENNESSEE			
Frequency [12/] (per 100 doctors)	2.0	4.3	4.6	3.5	3.6	4.8	140%
Severity [12/]	$4,948	$2,158	$1,503	$5,612	$2,642	$9,950	101%
				D. C.			
Frequency [12/] (per 100 doctors)	3.0	3.9	5.3	7.0	9.0	10.0	233%
Severity [12/]	$11,605	$5,642	$9,216	$9,175	$9,083	$14,087	150% (1970-74)
				SOUTH CAROLINA			
Frequency [12/] (per 100 doctors)	1.0	.5	1.6	2.3	2.7	4.4	340%
Severity [12/]	$22,332	$3,795	$4,582	$2,541	$12,452	$10,400	174% (1970-74)

HOSPITAL MALPRACTICE EXPERIENCE

In evaluating Virginia's hospital malpractice experience, it is important to remember that up until mid 1974 more than 70% of Virginia's hospitals were exempt from malpractice liability because of the doctrine of charitable immunity. As

12/ See footnote 12 on Page 19.

previously pointed out, non-profit hospitals were sued and these hospitals often settled claims.

These considerations are reflected in the following tabulation of Virginia's hospital malpractice experience. While the absolute number of claims against the amounts paid by non-profit and government hospitals was, and is, greater than the number of claims against the amounts paid by the for-profit hospitals, the relative claims experience of non-profit and government hospitals was considerably better when viewed against the number of patients treated by each type of institution. For example, in 1973 Virginia's non-profit and government short-term acute care hospitals had approximately 4.6 million bed patient days while the for-profit hospitals accounted for only .8 million bed patient days.

The Bureau's survey of Virginia's hospital malpractice experience indicates that the number of claims against Virginia's hospitals have steadily increased. While the average severity has been somewhat erratic, its overall

trend is upward:

FREQUENCY/SEVERITY - VIRGINIA HOSPITALS

Not for Profit and State and Local Government Hospitals

	1969	1970	1971	1972	1973	1974	(First three quarters) 1975	Percent of change
No. of Reported Claims	21	32	41	67	74	99	98	366.7%
Frequency 13/ (per 10,000 bed days)	.051	.075	.093	.149	.162	.215	.279	447.1%
Total Loss	$5,515	$78,801	$131,652	$78,866	$166,399	$637,854	$532,107	9,548.4%
Severity (loss divided by no. of claims)	$ 263	$ 2,463	$ 3,211	$ 1,177	$ 2,249	$ 6,443	$ 5,430	1,964.6%

For Profit Hospitals

	1969	1970	1971	1972	1973	1974	(First three quarters) 1975	Percent of change
No. of Reported Claims	11	6	18	31	68	61	68	518.2%
Frequency13/ (per 10,000 bed days)	.186	.093	.277	.459	.907	.763	1.048	463.4%
Total Loss	$1,567	$ 4,351	$ 13,193	$104,212	$138,837	$182,008	$243,834	15,460.6%
Severity (loss divided by number of claims)	$ 142	$ 725	$ 733	$ 3,362	$ 2,042	$ 2,984	$ 3,586	2,425.4%

Combined Experience

	1969	1970	1971	1972	1973	1974	(First three quarters) 1975	Percent of change
No. of Reported Claims	32	38	59	98	142	160	166	418.8%
Frequency 13/ (per 10,000 bed days)	.068	.077	.117	.190	.267	.296	.399	486.8%
Total Loss	$7,082	$83,152	$144,845	$183,078	$305,236	$819,862	$775,941	10,856.5%
Severity (loss divided by number of claims)	$ 221	$ 2,188	$ 2,455	$ 1,868	$ 2,150	$ 5,124	$ 4,674	2,014.9%

While it is still too early to give conclusive estimates regarding the impact of the abolition of the doctrine of charitable immunity, it is reasonable to conclude that the recent relatively large increases in the number of claims during 1974 and 1975 against nonprofit

13/ Frequency levels were computed using the American Hospital Association's annual survey of bed-patient days in Virginia for the years 1969-1974. Utilization estimates for 1975 were computed by applying the average annual change between 1972 and 1974 to the 1974 utilization figures.

hospitals are due in part to the elimination of the doctrine of charitable immunity in 1974. At the same time, these increases are also due to the fact that more claims are being brought against the providers of health care -- both doctors and hospitals -- than ever before.

THE IMPACT OF VIRGINIA'S SHORT STATUTE OF LIMITATIONS

Under Virginia's law, an injured patient must bring suit on his malpractice claim within two years from the date that the act causing injury occurs. The only exceptions to this rule are when the injured patient does not have control over his actions or is a minor. In these instances the two year period starts to run from the date the disability ceases or when the minor reaches 21. Many states -- particularly those having a severe malpractice problem -- afford the claimant a much longer time within which he can bring suit. Many argue that the resulting "lag" only accentuates the difficulty of predicting future trends and, therefore, the setting of an adequate price for malpractice coverage.

The following tables summarize the claims development (when claims are reported and paid) for all negligent acts occurring during a single year. The year 1969 has been selected for claims against physicians and surgeons and 1971 for claims against hospitals because it takes at least four to five years for most, if not all, claims resulting for acts occurring during any one single year to be reported.

With respect to physicians and surgeons, Virginia's short statute of limitations appears to result in a relatively rapid reporting of malpractice claims when compared to the nation as a whole and in particular, other jurisdictions that have a longer statute of limitations:

CLAIMS DEVELOPMENT FOR CLAIMS AGAINST DOCTORS COVERED BY ST. PAUL ARISING FROM 1969 INCIDENTS

End of Year Which Reported	Cumulative Paid Claims[14] Number of Paid Claims	Paid Loss and Loss Expense	Percentage of Total Loss	Cumulative Reported Claims[14] (Both Paid and Pending) Number of Reported Claims	Loss and Loss Expense[15]	Percentage of Total Loss
		COUNTRYWIDE				
12/31/69	73	$ 107,590	0.8%	507	$ 1,935,075	14.5%
12/31/70	413	488,550	3.7	987	5,804,552	43.6
12/31/71	719	2,013,337	15.1	1,391	10,345,704	77.8
12/31/72	1,081	3,977,941	29.9	1,652	12,332,278	92.7
12/31/73	1,327	6,041,211	45.4	1,710	13,128,561	98.7
12/31/74	1,510	8,360,781	62.9	1,741	13,301,423	100.0
		MASSACHUSETTS (3 Year Limitation)				
12/31/69	2	$ 156	0.0%	22	$ 46,549	2.3%
12/31/70	13	6,745	0.3	52	380,188	19.2
12/31/71	30	44,735	2.3	97	1,072,707	54.1
12/31/72	41	76,233	3.8	128	1,722,713	86.9
12/31/73	65	390,394	19.7	133	1,895,525	95.6
12/31/74	86	731,428	36.9	137	1,982,053	100.0
		VIRGINIA (2 Year Limitation)				
12/31/69	6	$ 5,471	0.4%	31	$ 177,355	13.6%
12/31/70	26	64,772	5.0	67	523,658	40.1
12/31/71	51	289,376	22.1	93	1,173,717	89.8
12/31/72	72	545,471	41.7	98	1,236,595	94.6
12/31/73	79	591,680	45.3	99	1,299,397	99.4
12/31/74	90	1,122,368	85.9	102	1,307,243	100.0

14/ Refers to claims paid as of the "Date" in the first column. Dollar amounts are payments as of the same "Date".

15/ Refers to claims reported as of the "Date" in the first column. Dollar amounts are based on actual amounts paid and the latest reserve estimates on claims still pending as of 12/31/74.

The claims development pattern of claims against Virginia's hospitals compiled from the Bureau of Insurance's study indicates that the loss development of Virginia's hospitals is similar to that experienced by physicians and surgeons. However, the speed with which claims are finally settled appears to be slower:

CLAIMS DEVELOPMENT FOR CLAIMS AGAINST HOSPITALS ARISING FROM 1971 INCIDENTS OF MALPRACTICE

	Cumulative Paid Claims [16]			Cumulative Reported Claims (Both Paid and Pending) [16]		
End of Year Which Reported	Number of Paid Claims	Amount Paid and Loss Expense	Percent of Total Loss Reported	Number of Reported Claims	Amount of Loss & Loss Expense [16]	Percent of Total Loss Reported
12/31/71	19	$ 2,209	1.6%	42	$ 13,102	9.6%
12/31/72	42	3,575	2.6%	60	30,320	22.2%
12/31/73	56	6,791	5.0%	80	135,626	99.2%
12/31/74	74	52,381	38.3%	84	136,786	100.0%
9/30/75	77	57,857	42.3%	84	136,786	100.0%

Even though Virginia's short limitation period results in a faster reporting and processing of claims, Virginia is not immune from the "long tail" phenomena, i. e., malpractice claims being reported many years after the malpractice act causing injury takes place. For example, during the last twelve months, St. Paul has had 5 claims involving minors not subject to the two-year limitation reported to it for incidents occurring prior to 1966. In addition, even after claims are reported, it often takes a long time to process

16/ See footnotes 14 and 15 on Page 25.

the claim through the courts:

ST. PAUL'S ACCIDENT YEAR DISTRIBUTION OF CURRENTLY OUTSTANDING CLAIMS AGAINST PHYSICIANS AND SURGEONS ON PRIMARY POLICIES ONLY IN VIRGINIA

Accident Year	No. of Claims Outstanding As of 12/31/74	Loss and Loss Expense Reserve As of 12/31/74
1959	1	$ 7,500
1961	1	3,750
1967	2	39,750
1968	3	78,750
1969	12	184,875
1970	24	446,250
1971	37	356,625
1972	72	964,875
1973	74	1,207,500
1974	84	1,500,375
	310	$4,790,250

NUMBER OF LARGE VERDICTS OR SETTLEMENTS

In recent years, considerable publicity has surrounded the extremely large verdicts or settlements for malpractice claims that have been realized throughout the country. Many argue that these large dispositions are a major factor in the cost of malpractice insurance because of the relatively small number of malpractice claims relative to other types of personal injury claims. (e. g., in 1974, Virginia had approximately 400 malpractice claims and more than 50,000 automobile accident bodily injury claims.)

While extremely large verdicts or settlements may be a severe problem in other jurisdictions, available data indicates

that verdict or settlement size has not yet reached crisis proportions in Virginia:

SIZE OF CLAIMS PAID AGAINST PHYSICIANS, SURGEONS AND HOSPITALS SINCE 1970

Number	Size
29	$ 25,000 - $ 49,999
8	50,000 - 74,999
4	75,000 - 99,999
5	100,000 - 149,999
1	150,000 - 249,999
1	250,000 - 499,999
0	500,000 +

At the same time, there is no assurance that this experience will continue. Presently there are several dozen claims reserved in the $100,000 range and a few have the real possibility of exceeding $500,000.

THE LOCATION OF AND TYPE OF DOCTOR INVOLVED IN MALPRACTICE CLAIMS

The 1973 HEW Malpractice Commission Report concluded that 75% of all malpractice acts of physicians and surgeons occur within the confines of a hospital. More specifically, the Commission's survey indicated that physicians' and surgeons' malpractice occurs in the following areas:

Facility	Percent of Cases Where Known
Hospital	74.6
Office	20.3
Home	1.7
Nursing Home	.6
Outpatient	.1
Other	2.7
	100.0

St. Paul's nationwide experience supports the conclusion that the vast majority of malpractice claims appear to be made against specialists whose practice is hospital oriented and involve medical treatment that is either rendered or culminates in a hospital, e. g., a negligently performed operation or a faulty diagnosis in the doctor's office which ultimately results in the wrong but correctly performed treatment in a hospital.

For example, St. Paul's countrywide data indicates that presently there is 1 claim pending against every 10.3 general practitioners who engage in little surgery. This claims frequency, however, increases in direct proportion to the degree to which a doctor engages in a hospital-based surgical speciality:

Speciality	Claims Ratio
Pediatrician	1 per 26.2
Internist	1 per 19.5
Hematologist	1 per 10.4
Thoracic Surgeon	1 per 5.9
General Surgeon	1 per 5.5
Plastic Surgeon	1 per 4.4
Orthopedic Surgeon	1 per 3.6
Neurosurgeon	1 per 3.3
Vascular Surgeon	1 per 3.3
Cardiac Surgeon	1 per 2.5

Similarly, a summary of the allegations made against

doctors in malpractice actions displays a hospital emphasis:

Ranking of Frequency of Allegations
(all rating classes combined)

1. Surgical error
2. Post operative problems
3. Improper surgical procedure
4. Failure to diagnose fracture
5. Lack of supervisory control
6. Improper treatment of fracture
7. Improper treatment - infection
8. Birth-related problems
9. Failure to diagnose cancer
10. Drug side effect

Clearly, the vast majority of all medical malpractice occurs within the confines of the hospital. As will be pointed out later, this fact argues strongly for focusing on the hospital in the search for solutions.

THE PROBLEM OF EVALUATING MEDICAL MALPRACTICE EXPERIENCE

Predicting the future is always a difficult task. This is especially so with respect to medical malpractice.

Because of the nature and complexity of medical malpractice, these claims take somewhat longer to be reported and to be finally resolved than other types of personal injury claims. As a result, the most relevant information regarding future developments -- the experience of the last few years -- must, by necessity, involve a considerable amount of judgment regarding the probable number of claims that will be but are not yet reported and the value of pending claims which have not yet been paid.

The only way one can minimize this type of judgment is to look into the past where the lapse of time has permitted more claims to be reported and paid. However, the further one goes into the past in this quest for certainty, the less relevant this data becomes in evaluating what is happening today or what will happen tomorrow -- particularly when the best available evidence indicates that frequency and severity of malpractice claims are increasing at a greater rate today than they were several years ago.

The problem is compounded by the fact that the conditions necessary for actuarial science to make reasonably accurate predictions regarding the future are not present in the medical malpractice context. Since actuarial science predicts the future by looking at past and present experience, it requires a relatively stable trend that is likely to continue into the future. This, in turn, is dependent upon a stable claims environment and a sufficiently large volume of claims each year so that the impact of unusual or random events is minimized.

Neither ingredient is present today. As we have seen, the rate of increase in the frequency and severity of malpractice claims in Virginia and other jurisdictions is significantly greater than the claims experience of other types of personal injury. Equally revealing is the fact that Virginia's rate of change, as well as that of other surrounding jurisdictions, appears to be greater than that in some of the high risk jurisdictions, such as New York

State. This is so probably because most states are just entering a new phase of claims consciousness while the high risk states have already made this transition. In addition, the malpractice claims volume in Virginia and other jurisdictions is very small relative to other types of personal injury claims. As a result, an unusually high verdict or settlement or an abnormal rash of claims can significantly distort our evaluation of what is actually happening.

The problem is an extremely difficult one that does not lend itself to easy solutions. For example, many argue that the only way to predict future trends is to rely on broader-based countrywide data in order to minimize the distortions that invariably accompany a small volume of claims. Once this trend is established, it is then applied to the state's actual claims experience. Many have argued that the partial use of this countrywide data results in Virginia policyholders shouldering part of the burden of other states that have worse experience. While there is some merit in this argument, there is no readily available alternative. The trending of past and present experience is a necessity and we must make use of the best available information we have. The dilemma is particularly acute since the use of Virginia data only for trending and loss development purposes often produces results that are worse than the countrywide experience.[17/] It does this precisely because it is not large enough to

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17/ E.g., using Virginia accident-year data between 1967 and 1975, the average increase in frequency for physicians and surgeons approximates 18%. This is well above the 12.1% annual change projected on the basis of comparable country-wide figures.

project statistically reliable trends.

It is because of these reasons that the "claims made" policy was developed. As previously pointed out, the rate for a "claims made" policy is based on the actual number of claims reported each year rather than on an estimate of the number and value of future claims that may be reported anywhere from 2 to 10 years in the future. While the "claims made" policy does not completely solve the problem, it does eliminate some of the guesswork that exists under the present system and permits the greater use of Virginia statistics.

Obviously, legislators, regulators and the insurance industry are faced with a difficult dilemma: the most relevant data, by necessity, must be based in large part upon judgment -- albeit educated judgment -- which is always subject to error. The more one eliminates judgment in the evaluation of present and future experience, the more one must rely on the fully developed experience of earlier years. The more one relys on this old but certain data, the less relevant this data becomes because the factors that determine the number and size of past claims may not be present today or tomorrow. We are faced with this problem not because of incompetency or a concerted effort to distort the facts but rather because of the very nature of the malpractice claim and how it is processed.

It is important to remember that while there are very real problems associated with the evaluation of this data, it does not mean that we cannot make some reasonable estimates regarding the future. It merely means that we must exercise great caution. This is particularly so since, when viewed from hindsight, it appears that, if anything, the industry, regulators and others who have studied the problem have consistently underestimated the frequency and severity of medical malpractice claims.

SOLUTIONS

Like other jurisdictions, Virginia must develop means to assure the continued availability of malpractice insurance at reasonable premium rates -- that is, rates that are justified by reasonably accurate claims data and which do not unduly burden the providers of health care.

Assuring the availability of malpractice insurance is a relatively easy task. Several alternatives are already in operation elsewhere and appear to be working well. We can draw upon this experience.

Assuring that future premium rates will be based upon accurate claims information is a more difficult task. As will be discussed in more detail, efforts presently underway in Virginia and on a national level should in time cure some of these deficiencies.

Assuring that future premium rates will either be equal to or lower than existing rate levels is easier said than

done. Since malpractice insurance premium rates are directly related to the frequency and severity of malpractice claims, the effectiveness of any proposed solution will depend on its ability to reduce or to contain these claims. Whether any of the proposed solutions will achieve this objective is subject to much doubt primarily because there is little hard data regarding the causes of the recent increases in frequency and severity of malpractice claims.

Equally, if not more important, is the often overlooked fact that malpractice rate levels will always be high relative to other insurance rates because the exposure of doctors and hospitals to malpractice incidents is extremely large when compared to the number of doctors and hospitals that the resulting malpractice losses must be distributed among. For example, each year Virginia's 100 acute-care hospitals handle over 600,000 patients. These patients account for more than five million bed patient days each year. Even if malpractice incidents were reduced to a minimum, this large exposure would still produce a large number of claims and losses which can only be spread among 100 hospitals. If, on the other hand, these losses could be spread over a broader base, the average premium would be lower. For example, motor vehicle accidents in Virginia cause considerably more losses than medical malpractice incidents. However, automobile accident losses are spread among Virginia's 2.7 million motorists -- resulting in a much lower average premium for each policyholder.

Doctors are faced with a similar problem. In 1972 physicians had approximately one billion contacts with their patients countrywide. The resulting losses from this extraordinarily large exposure was distributed initially among 300,000 doctors rather than the one billion units of exposure.

Clearly, the premiums paid by doctors and hospitals will always be much larger than those paid by individuals in an insurance system that distributes losses over a broader base, such as the insurance system applicable to automobile accidents.

The following discussion will begin by outlining the alternative methods for assuring continued availability of malpractice coverage. This will be followed by an analysis of the major proposals designed to reduce the cost of malpractice insurance by reducing the number and cost of handling malpractice claims. Finally, it will outline possible ways to broaden the distribution of malpractice losses so as to ameliorate the adverse impact that malpractice insurance premiums are having and will continue to have upon the delivery of health care.

Solutions To Assure Continued Availability Of Malpractice Insurance

The major solutions fall into three categories:

1. A hospital and/or physician-owned insurance company;

2. A state insurance fund operated by the state itself or by an insurance carrier selected by the state to manage the fund; and
3. A combination of private insurance carriers that are compelled to provide malpractice insurance coverage with provision for the distribution of resulting losses or gains among the participating insurance companies.

Each will be discussed in the above order.

A. A Hospital or Physician-Owned Insurance Company

Under this approach doctors or hospitals would establish their own insurance company. Availability of coverage is assured because doctors and hospitals would have control over the insurance company. Other advantages include: (1) the elimination of the credibility gap that presently exists between the providers of health care and insurance companies since the doctors and hospitals would have control over and access to their own claims experience; (2) assuring that doctors and hospitals would see first-hand which doctors and hospitals cause more claims than others -- which would hopefully provide incentive for the medical profession to police its membership; and (3) the realization of savings through the elimination of certain selling and marketing expenses (e. g., agent's commissions) and centralized claims handling facilities.

This type of company is already in operation in New York and Maryland. Since these companies have only been in operation for several months it is too early to venture an opinion regarding their success.

Such a company could be established in Virginia under the existing insurance law. While current statutes only require an initial capitalization of $300,000 for a reciprocal company and $800,000 for a mutual company, prudence would require substantially greater capitalization. In addition, those experienced in insurance company management and claims handling would have to be hired to manage the day-to-day operations of the company. Lastly, the company can function successfully only if it can get a large number of Virginia's doctors and hospitals to participate.

At the present time a number of doctors are actively pursuing this alternative. They indicate that the company will not go into operation unless approximately 1,200 doctors elect to participate. This level of participation should provide a capital base of approximately $1.5 - $2 million. Nor will the company go into operation unless it can obtain reinsurance for claims in excess of $100,000. The proposed company will issue a "claims made" policy only and its rates would be subject to review by the State Corporation Commission.

While the proposed company would result in the advantages previously discussed, there are also disadvantages. A new company with limited capital will be less able than a joint underwriting association (discussed on p.p. 41-52) or a large established company to withstand unexpected adverse claims experience -- which may or may not result after sufficient time has elapsed for claims to develop. If the new company were to become insolvent, Virginia's Property and Casualty Guaranty Association[18/] would only cover those claims that have been reported under the "claims made" policies in force at the time of the insolvency. Claims reported 30 days after the date of the insolvency would not be covered by the Guaranty Association. In the event this happens doctors would be personally responsible for these claims if they could not obtain insurance from another company for incurred but not yet reported claims.

Because no one is certain that a doctor or hospital owned company will continue in operation or will avoid the financial difficulties that have beset many of the companies that have specialized in this type of insurance, a standby back-up system -- either a state fund or private sector pooling arrangement -- should be established to assure continued availability of malpractice coverage. This conclusion is

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18/ The Guaranty Association legislation provides for an association composed of property and casualty insurers. The association is required to defend and, when appropriate, to pay any successful claim that was covered by an insurance policy issued by an insurance company that subsequently became insolvent. The association is responsible only for losses up to the limits of the policy issued or $300,000, whichever is less.

supported by the fact that back-up systems have been established in those jurisdictions where this type of company is doing business.[19/]

B. State Fund

This would involve the creation of a state authority that would provide malpractice insurance coverage. The agency could be staffed by state employees or administered by an independent risk and claims manager selected and paid for by the state. While the premiums charged to the providers of health care would be designed to pay all losses and administrative expenses, the use of a state fund increases the risk that any deficits would be paid for out of general state revenues.

Those that favor a government fund make the following arguments: (1) Cost savings would be realized by avoiding the payment of agent's commissions and the elimination of duplicative management and claims handling personnel and facilities; (2) Service would be better than that provided through the private sector because the industry is less than enthusiastic regarding the provision of malpractice coverage either individually or through a combination of companies; and (3) To the extent there are losses, these losses should be spread among the entire population through the tax base rather than among other policyholders or stockholders as would happen

19/ E. g., New York has a joint underwriting association supplemented by a State Fund. Maryland has a joint underwriting association.

under the private sector alternatives.

Arguments against a state fund are as follows: (1) a state fund greatly increases the risk of using badly needed general revenues for administrative costs and the subsidization of malpractice insurance rates; (2) almost without exception government-run operations are less efficient than those run by the private sector; and (3) the potential cost savings resulting from centralized marketing and claims handling procedures can be realized under the private sector alternatives. On balance, a state fund has many potential disadvantages with few or no advantages.

Because of these considerations only four states have adopted the state fund approach. In New York, it will come into operation only if all assets of the private sector pooling arrangement are exhausted or it is declared unconstitutional. In Michigan, a state fund is in operation which is funded by premiums and assessments on health providers. Louisiana and Indiana also have state funds but only for those doctors that cannot obtain insurance in the voluntary market. While the rates charged for insurance issued by the Indiana fund are designed to be self-supporting, the initial capitalization of the fund comes from the general tax revenue.

C. Private Sector Alternatives

These proposals take the form of either a Joint Underwriting Association (JUA) or a reinsurance facility.

Under the JUA alternative, insurance companies writing certain lines of business would be required to form an association that would issue malpractice insurance coverage to all health care providers in accordance with underwriting standards established by legislation or the Commissioner of Insurance. All losses or profits would be distributed among participating insurance companies in accordance with an equitable formula that is usually based on the premium volume that each company writes in the state. This standby mechanism would be activated by the Commissioner of Insurance whenever he finds after a hearing that malpractice insurance is not readily available through the voluntary market. The JUA would be managed by a single carrier with malpractice experience selected by the participating insurance companies in accordance with a plan of operation approved by the Commissioner of Insurance.

Under the reinsurance facility approach, each insurance company that is required to participate must offer malpractice insurance coverage to anyone that asks for this coverage in accordance with underwriting standards established by legislation or the Commissioner of Insurance. Unlike a JUA, each insurance company would issue its own policy to the requesting hospital or doctor. In addition, each company would handle and process all claims covered by the policy. Once an insurance company issues a policy, it can, at its option, reinsure the risk with the reinsurance facility -- an assocation composed of all insurance companies required to write this

coverage. Only losses and profits of reinsured risks would be distributed among the members of the facility. Gains or losses on a policy that is not reinsured would be shouldered by the company issuing that policy.

The vast majority of jurisdictions have opted for the JUA alternative rather than the reinsurance facility for a number of reasons. Under a reinsurance facility, all companies required to write malpractice insurance must service the policy sold by them even though the risk is reinsured with the facility. Since the vast majority of companies have no expertise in the malpractice area, each company would be required to either obtain staff with this expertise or to rely on independent claim adjusters. This results in an unnecessary duplication of expense -- particularly since the volume of malpractice claims in any single state can be efficiently managed by a single carrier. In addition, many believe that participating companies will tend to "cream-skim" the good risks and will put only bad risks into the reinsurance facility. It is argued that this can result in an inequitable distribution of losses among participating insurance companies. Because of these considerations, several of the states that have reinsurance facilities have approved a plan of operation that resembles that of a JUA.

While there is virtual unanimity of opinion that a JUA is the preferred alternative, there is a sharp difference of opinion regarding the specific provisions that should be made part of a JUA solution.

If the legislature determines that a JUA is the best way to assure availability, it must also decide several important questions regarding the scope and operation of the JUA. The following section will outline the major issues that must be decided and the various considerations that must be weighed in reaching a decision.

D. The Policy Issues Involved in the Establishment of a Joint Underwriting Association

1. Should the JUA be a permanent institution or should it be set up for a specific period of time?

Most states have established JUA's for a two to four year period.[20/] One rationale for a specific termination date is to keep pressure on the state to take action on the underlying causes of the present crisis, i. e., the increasing frequency and severity of malpractice claims. To this end, JUA enabling legislation often provides for a Study Commission to review the problem and to make specific legislative recommendations that can be put into effect on or before the termination date. Implicit in this rationale is the belief that the Study Commission will be able to develop recommendations in a two to three year period that will cure the underlying

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20/ E. g., California - until March 1, 1978; Florida - not to exceed three years; Idaho - June 1, 1977; Maine - July 1, 1977; Maryland - July 1, 1977; Massachusetts - December 31, 1977; New York - not to exceed 6 years; South Carolina - December 31, 1977; Tennessee - July 1, 1977; Texas - December 31,1977 (no new policies issued after this date); Hawaii - 3 years from date of operation; Iowa - July 1, 1977 or earlier based on availability; Ohio - December 31, 1978; Rhode Island - July 1, 1977;

cost pressures and, therefore, the availability problem. Others argue that a definite termination date is desirable because remedial programs like a JUA tend to continue in existence after they are no longer needed. The latter argument has more merit than the former. Probably the best alternative is to provide for periodic review by the Commissioner of Insurance to determine whether or not the JUA is still needed. Alabama, Georgia, Pennsylvania and Nevada have taken this approach.

2. Which insurance companies should be required to participate in the JUA?

Many segments of the insurance industry want the required participation base to be as narrow as possible. They argue that it is not fair for all policyholders to shoulder losses sustained by a limited number of policyholders, i. e., the doctors and hospitals. This argument assumes that malpractice coverage cannot be priced on a self-sustaining basis and that losses will have to be distributed among participating insurance carriers. Accordingly, in some jurisdictions the JUA includes all liability carriers licensed to do business in the State except to the extent that they write automobile insurance.[21/] Other jurisdictions exclude other types of insurance, such as

21/ E. g., Arkansas; Florida; Nevada; New Hampshire; North Carolina; South Carolina and Tennessee.

workmen's compensation.[22/]

However, many argue that the malpractice insurance problem is a social rather than insurance problem because the continued availability of malpractice insurance is directly related to the continued delivery of health care. This being so, the entire population will benefit. This, coupled with the fact that the burden placed on each company will decrease as the distribution base increases, argues for the conclusion that the JUA base should be as broad as possible. Accordingly, many states have required every insurance carrier writing most types of liability insurance to participate in the JUA.[23/] One state - Ohio - has even gone further and required "prepaid" hospital health insurers to participate in the plan because of the direct relationship between malpractice insurance and the cost of health care. This does not mean that the hospital health insurers will be required to write malpractice insurance, but rather that they will participate in the sharing of losses and gains resulting from the coverage offered by the JUA.

3. Should the JUA be the exclusive source of malpractice coverage or should it be available only for those doctors, hospitals and other providers of health care that cannot obtain insurance from an insurance company?

Many argue that once it is determined that there is an

22/ E. g., Arkansas - homeowners and farmowners insurance; Idaho - workmen's compensation; Maryland - workmen's compensation; New York - workmen's compensation; Maine - companies with assets less than five million; Texas - mutuals and county mutuals.

23/ E. g., Alabama, Georgia; Florida; Hawaii; Illinois; Nevada; Rhode Island; Pennsylvania; Texas; Wisconsin.

availability problem requiring the activation of the JUA, the JUA should be the exclusive source of malpractice coverage. This argument is premised on the belief that if the JUA is not exclusive, there will be a tendency for individual insurance companies to write only the low risk doctors and hospitals while leaving the so-called high risks providers for the JUA -- that is providers that engage in certain specialties that entail high risks even when the treatment is performed correctly, such as anesthesiologists; cardiovascular surgeons, orthopedic surgeons and neurosurgeons. It is argued that this "cream-skimming" almost assures that the JUA premium level would be extraordinarily high for the JUA high risk policyholders who are now the very providers most in need of relief. It is also argued that in order to determine accurate adequate malpractice insurance rates, a broad data base is essential. If companies can pick what risks they will or will not insure, the data base will be fragmented and, therefore, it will be more difficult to make accurate actuarial projections.

Those opposed to an exclusive JUA argue that it will stifle competition and, thereby, will discourage innovation in the malpractice area. They also argue that under an exclusive JUA those few companies presently writing malpractice insurance coverage will disband their specialized malpractice staff (e. g., claims adjusters). Once this is done, it will be very difficult for companies to re-enter the field in the event that the present problems are eliminated.

The states are divided on the issue. Some provide only for exclusivity.[24] Others emphasize exclusivity, but provide for a number of exceptions.[25] Approximately, 12 states have provided for non-exclusivity.[26] Still others give the Commissioner of Insurance discretion to determine whether exclusivity or non-exclusivity is desirable for any class of provider.[27] On balance, the last alternative is preferable since the factors that must be considered are complex and are constantly in a state of flux.

4. Should the rates for the malpractice coverage provided by the JUA be self-supporting or should these rates be subsidized?

There is almost universal agreement that malpractice rates should not be subsidized either by the state or by policyholders other than the doctors, hospitals and other providers of health care. It is also argued that if rates are to be subsidized

24/ E.g., Hawaii; South Carolina

25/ E. G., California - exclusive by region. Private insurers can renew existing policies as long as this does not result in adverse selection, i. e., "cream-skimming"; Idaho - exclusive for physicians and other providers of health care but non-exclusive for hospitals; Maine - exclusive for physicians and other providers but need not be for hospitals; Rhode Island - exclusive for physicians but need not be for hospitals and other providers; South Carolina - exclusive for each class provided for which the JUA program is involved.

26/ Non-exclusive states include: Arkansas, Florida, Massachusetts, Michigan, Nevada, North Carolina, North Dakota, Ohio, Texas and Wisconsin. Maryland and New York have a non-exclusive JUA so that doctors that do not wish to obtain insurance from the doctor's mutual company will be able to obtain it from the JUA.

27/ E. g., New Hampshire; Iowa

because of public policy reasons, it should be done through the tax base rather than the private sector.

At the very same time it is widely believed and with some justification that self-supporting rates will be very difficult to realize in the absence of specific measures designed to assure the availability of funds sufficient to meet future losses. More specifically, many states have provided safeguards, such as a rate stabilization reserve funded by a surcharge paid by doctors and hospitals in addition to their malpractice insurance premium.[28/] This fund would be used to pay for any losses that remain after the premiums have been exhausted. In the event that all or part of the fund is not needed, the remaining money would be returned to the doctors and hospitals. Some states provide

28/ E. g., Idaho - a rate stabilization fund funded by a surcharge equal to 1/3 of the annual premium. Maine - stabilization reserve fund funded by a 2% surcharge on future motor vehicle and malpractice premiums; New York - stabilization fund funded by a surcharge equal to 20% of the standard premium until the fund exceeds fifty million dollars; Rhode Island - stabilization fund funded by surcharge equal to 1/3 of first annual premium; Tennessee - stabilization fund funded by a 12% surcharge on future liability policies; Iowa - a stabilization fund funded by a surcharge not to exceed one annual premium: Ohio - stabilization reserve fund funded by a surcharge on primary and excess coverages for all physicians and hospitals. A further surcharge is authorized if losses exceed one million dollars.

for additional assessments on the providers of health care[29/] or provide that losses paid by individual companies through the JUA may be used to offset the premium tax that must be paid by the participating companies.[30/] Still other states provide for a surcharge upon policyholders other than doctors and hospitals.[31/]

5. What type of policy should the JUA offer: "occurrence" or "claims made" policy?

In most jurisdictions the legislation setting up the JUA provides that the JUA may offer either an "occurrence" or "claims made" policy. This does not mean that the JUA

29/ E. g., California - 10% of occurrence rider rate; Florida - first year assessment no greater than 1/3 of annual premium and additional losses reflected in future rates; Hawaii - assessment against policyholders and/or prospective increases in rates; Idaho - group retrospective rating; Iowa - group retrospective rating; Maine - group retrospective rating; Massachusetts - assessment against all physicians and hospitals regardless of whether they had JUA coverage; Michigan - assessment of eligible providers; Ohio - increase premiums to policyholders other than malpractice coverage policyholders; Rhode Island - group retrospective rating; South Carolina - assessment on policyholders not to exceed a single annual premium and/or prospective increases in future rates; Texas - policyholder assessment and rate increase; Wisconsin - prospective rate increases.

30/ E. g., Idaho - past or future premium tax; Iowa - past or future premium tax; Nevada - up to a 20% premium tax credit for 5 years after termination of the JUA; Rhode Island - past or future premium tax; Tennessee - past or future premium tax up 20% a year for five years or longer.

31/ E. g., Idaho - a 2% surcharge on future auto and malpractice premiums; Maine - a 2% surcharge on auto and malpractice premiums; Rhode Island - 7% surcharge on all personal injury and motor vehicle policies; Tennessee - a 2% surcharge on future liability policies.

must offer both types of policies depending upon the desire of each individual hospital or doctor. It merely means that the JUA has a choice regarding which type of policy it will write for every provider of health care. Usually the Commissioner of Insurance is given the authority to make the choice -- either directly or through his power to approve or disapprove the plan of operation.[32/]

Even though the "claims made" policy avoids much of the guesswork involved in pricing malpractice coverage, two states have mandated the "occurrence" policy because of the concerns that many doctors have regarding the claims made policy.[33/] Only two states have mandated some form of "claims made" policy.[34/]

On balance, the arguments favor the use of the "claims made" policy -- particularly since it facilitates more accurate rate making and the use of Virginia experience. In addition, the concerns of the doctors regarding subsequent claims can be easily remedied. Accordingly, the legislation establishing a JUA should mandate a "claims made" policy or at a minimum give the Commissioner of Insurance authority to make this determination after considering all relevant factors

32/ E.g., Arkansas; Hawaii; Idaho; Iowa; Massachusetts; Nevada; Rhode Island; South Carolina; Tennessee and Wisconsin.

33/ E.g., Florida and Texas

34/ E.g., Ohio - a "claims made" policy with a tail provision endorsement; California - provides that an occurrence rider can be purchased from the JUA or private carrier.

existing at the time that the JUA is invoked.

6. What limits of coverage should the JUA offer?

Today, the major availability problem exists with respect to basic and excess limits coverage up to one million dollars per claim. The voluntary market is still providing coverage for limits above this amount. Accordingly, most JUA's provide coverage up to one million dollars for any one claim and a three million dollar aggregate limit for all claims resulting in any one year.[35/]

PROPOSALS DESIGNED TO REDUCE MALPRACTICE PREMIUMS BY REDUCING THE NUMBER AND SEVERITY OF MALPRACTICE CLAIMS AND THE COST OF PROCESSING THESE CLAIMS

Generally, these proposals are designed to accomplish one or more of the following:

- reduce the number of negligent acts caused by the providers of health care;
- reduce the number of so-called "nuisance" claims that are brought against the providers of health care;
- reduce the amounts paid for injuries caused by malpractice acts; and
- reduce the cost of processing malpractice claims.

35/ E. g., California; Hawaii; Idaho; Maine; Massachusetts; Rhode Island and South Carolina; Iowa (including incidental coverage.)

Before discussing these proposals, it is important to stress that it is extremely difficult today to determine the degree to which these proposals will realize their objective of reducing costs because there is very little hard data regarding: (1) the causes underlying the recent increase in the number and size of malpractice claims; and (2) how the existing legal system processes these claims.

Existing Data Deficiencies and the Degree to Which These Deficiencies Hinder the Development of Long-Range Solutions.

While there is unanimity of opinion that malpractice claims are increasing rapidly and the country is faced with a real problem, there is little agreement regarding the underlying causes of the increase in claims or the efficiency with which the present legal system processes these claims. Opinions are seldom accompanied by supporting evidence. In fact, one's position appears to be more a function of the interest group he or she belongs to rather than solid information. For example, doctors tend to blame the lawyers -- whom the doctors accuse of encouraging unmeritorious claims. Lawyers, on the other hand, tend to argue that doctors and hospitals are more negligent than they have been in the past and that the medical profession does not do a good job of policing its membership. While there may be some merit in both positions, these explanations grossly oversimplify the problem. In all probability, the recent increase in the

number and size of malpractice claims is due to the complex interaction of many diverse factors such as:

- an increasingly sophisticated medical science that can accomplish wonders but only with increased risks;
- unrealistic expectations on the part of the public as to what medical science can and cannot do;
- an increasingly impersonal health care delivery system;
- a greater willingness of patients to resort to the courts to air their grievances -- both real and fancied;
- the erosion of traditional legal defenses which often reflect a change of values on the part of society regarding the fundamental purposes of the reparation system;
- increasing litigation costs resulting from the fact that the increasing complexity of medical science makes the resolution of a malpractice claim infinitely more difficult than it was before; and
- a high rate of inflation which inflates both the losses sustained by injured patients and the cost of processing the patient's claim.

Unfortunately, there is little information regarding the degree to which each is a contributing factor. Nor is there complete and statistically reliable information regarding the processing of malpractice claims. The absence of this information is due to several factors:

- The awareness of the malpractice problem is a relatively recent one. Consequently, there has been little incentive for the industry to develop a uniform industry-wide system for the collection of claims and related rate information;
- malpractice incidents by their very nature are difficult to quantify. For example, when one is in an automobile accident, it is relatively easy, in most instances, to determine whether one's adverse physical or mental condition is a result of the accident. On the other hand, it is far more difficult to tell whether the failure of one to recuperate after an operation is due to negligent medical treatment or due to the patient's below average recuperative powers; and
- many of the underlying causes of the adverse malpractice experience are intimately related to a change in public attitudes regarding what one is entitled to and how to obtain it. These

attitudes are constantly in a state of flux and even when stable do not lend themselves to precise measurement.

Only in recent years have efforts been undertaken to collect the required information. In the early 1970's the Secretary of Health, Education and Welfare's Commission on Medical Malpractice completed a series of studies on various aspects of the problem. While the Report of the Commission is helpful, the study did not collect countrywide experience on a comprehensive and statistically reliable basis similar to that undertaken by the U. S. Department of Transportation with respect to automobile accident losses.

In a number of states, including Virginia, insurance regulators have begun to collect more accurate rate information. And in June, 1975, the National Association of Insurance Commissioners (NAIC) instituted the following three-point data gathering program:

- the annual and quarterly statement form that must be filed by every insurance company with state insurance departments was amended to provide for the collection of detailed malpractice insurance information on a state-by-state and countrywide basis. This information will begin to be forwarded to the Bureau in 1976.
- the NAIC is working with the industry to develop a uniform statistical plan so that

all rate information can be collected and evaluated on a uniform basis. ISO has finalized a uniform plan to be effective January 1, 1976, but a number of issues still must be resolved, such as the number and nature of the reports that ISO will compile from the data and which insurance companies must participate in this effort. Even after the plan goes into operation, it will take approximately three years before meaningful data is available; and

- the NAIC has directed the industry to collect extensive claims information on all claims closed after July 1, 1975. While this study should provide some useful information late this year, the fact that the study is limited to closed, as opposed to reported claims, means that the collected information will provide very little insight regarding future trends.

While these efforts should provide better information than exists today, it is evident that both the evaluation of existing proposals and the development of long-range solutions will require much more information. This information can only be collected through (1) a comprehensive effort similar to that undertaken by the U. S. Department of Transportation with respect to automobile accident losses; or (2) a system that

will permit the collection of the required information on a prospective day-by-day basis. Several possible ways to accomplish the latter are discussed later in this report.

Proposals Designed to Upgrade the Delivery of Health Care

In most jurisdictions, the state has authority to censure, reprimand or revoke the license of a physician if he practices in a manner detrimental to the public welfare. Similarly, most states license hospitals and other health care institutions and require that these institutions meet certain minimum standards. Often, these institutions are subjected to periodic inspection.

There is almost universal agreement that existing state regulatory bodies should and can be strengthened. In addition, most states have not in the past required that malpractice incidents be reported to appropriate state officials for review and appropriate disciplinary action.

Because of the recent malpractice crisis, a number of states have re-evaluated their existing regulation of health care providers and as a result of that review, have enacted legislation that provides for one or more of the following: (1) requires the reporting of all malpractice claims to appropriate state regulatory authorities; (2) spells out in more detail the grounds for disciplinary action; (3) places a public representative on disciplinary boards; and (4) requires a certain amount of continuing medical education as a condition to the retention of one's license to practice. Because of the volume of these changes,

a summary of enacted legislation in the various states is set forth in Appendix D.

In Virginia the State Board of Medicine may reprimand, suspend or revoke the license of a physician if it finds that a physician is "conducting his practice in such a manner as to make his practice detrimental to the health and welfare of his patient or the public." In addition, hospitals and other health institutions licensed by the Department of Health must meet certain minimum standards established by the Department and are subject to periodic inspections by the Department. Under both regulatory schemes, there is no requirement that any alleged act of malpractice be reported and reviewed by these state regulatory bodies.

In twenty-seven jurisdictions, steps have also been taken to broaden the immunity of providers of health care from civil suit when they participate on peer or medical review committees.[36/] Proponents of immunity argue that this will encourage more effective state regulation and peer review -- which is becoming more prevalent pursuant to state and federal regulation.

Virginia has already moved in this direction. In 1975

36/ Again because of the volume of legislation, a summary of the changes in various states is set forth in Appendix E.

the Virginia General Assembly enacted legislation that eliminated civil liability for any statement, act or decision of a physician made in performance of his duty as a member of any committee, board, group or other entity which functions primarily to review the adequacy or quality of professional services, provided that such entity has been established pursuant to a federal or state law, or has been established and duly constituted by one or more public or licensed private hospitals, or a medical or dental society or association affiliated with the American Medical Association or the American Dental Association. However, some feel that the 1975 legislation is not broad enough. They argue that there would be more cooperation and effective enforcement if the immunity were broadened to include any person who is not a member of such a board or committee and who reports to and/or testifies before the board or committee with regard to an alleged incident of malpractice. Michigan, Montana, Maryland, Nevada, Ohio, Oregon, Tennessee, and West Virginia have enacted such legislation.

Proposed Changes in Way the Present Legal System Processes Malpractice Claims

1. Shortening the Statute of Limitations

Under the law, injured claimants must bring a lawsuit for losses caused by negligence within a prescribed period of time. This time period varies from state-to-state and usually ranges anywhere from one to six years from the time of the occurrence. This limitation is designed to (1) prevent stale claims from being made long after the negligence occurs

when necessary records and other evidence may or may not be available; and (2) provide certainty in our daily affairs by setting an outside limit regarding when a suit may be brought against one for some past act. Usually, an exception is made for injuries sustained by a minor. Here, the limitation period does not begin to run until the minor reaches an age where he is legally an adult.

Often the strict application of this limitation can produce inequitable results. For example, the effect of a negligent act may not manifest itself until after the limitation period has expired. This is particularly true in malpractice cases. Because of this fact, courts in several jurisdictions have developed a number of devices to ameliorate the harshness of the rule such as holding that the limitation period does not begin to run until the patient discovers that he has suffered injury or with the exercise of reasonable diligence should have discovered it.

As a result of this liberalization, particularly in jurisdictions that have a relatively long limitation period to begin with, numerous doctors and hospitals have had malpractice suits brought against them anywhere from five to fifteen years after the alleged malpractice took place. As previously indicated elsewhere in this report, this delay makes the pricing of a standard liability policy extremely difficult. In addition, it adds to the cost of processing malpractice claims since relevant evidence becomes more difficult to

locate as time passes.

Because of these considerations many argue that the statute of limitations should be shortened -- even for minors -- and that the limitation should be measured from the date that the malpractice event occurs rather than the date of discovery. Others argue that a liberal limitation should be retained. They argue that it is unfair to have an innocent patient foreclosed from pressing his claim against a negligent doctor or hospital merely because of the fortuitous fact that the nature of his injury precluded discovery within the prescribed time period.

Throughout the United States legislatures have been required to balance these competing considerations and a number have opted for a more restricted limitation

period.[37/]

Unlike many other jurisdictions, Virginia already has a two-year limitation period. In addition, Virginia courts strictly interpret the limitation, i. e., it begins to run from the date that the malpractice act occurs rather than

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37/ E. g., Florida - 2 years from the date of the negligent act or 2 years from reasonable discovery with a maximum limit of 4 years. This may be extended to 7 years if discovery is hindered by fraud or concealment on the part of the defendant; Illinois - 2 years from reasonable knowledge with an outside limit of 5 years, whichever occurs first; Indiana - 2 years from the date of the negligent act except for minors under six years. Here, the minor has until 8 years of age to file; Iowa - 2 years from reasonable discovery with an outside limit of 6 years from the act, except where a foreign object is unintentionally left in one's body; Louisiana - 1 year from act or discovery with outside limits of 3 years; Maryland - the shorter of 5 years from the negligent act or 3 years after reasonable discovery; Massachusetts - 3 years from act except if one is under 6 years, one has until his 9th birthday; Nevada - 4 years after the injury or 2 years after reasonable discovery -- whichever is shorter; New York - 2 years, 6 months from act or last continuous treatment; foreign object one year from discovery; North Dakota - 2 years from accrual with an outside limit of 6 years from the act; Ohio - 1 year from accrual with outside limitation of 4 years from act; a minor under 10 years has until his 14th birthday; Oregon - 2 years from reasonable discovery with outside limit of 5 years from treatment or operation except in the case of fraud, deceit, or misrepresentation. Here the limit is 2 years from reasonable discovery; South Dakota - 2 years from accrual with an outside limit of 6 years from the act; Tennessee - 1 year from accrual of the cause of action; 1 year from a reasonable discovery of foreign objects. Texas - 2 years from breach or tort or last treatment; a minor under 6 years has until 8th birthday.

when the injury is discovered by the patient.

2. Preclude the Use of the Breach of Warranty Doctrine in Malpractice Cases

Generally, the statute of limitations for contract claims is longer than that for claims based on negligence. Because of this fact, courts in some jurisdictions have permitted injured patients to avail themselves of the longer limitation period by allowing their claim to be based on a breach of contract rather than negligence. Under this approach, it is argued that when the doctor or hospital renders negligent treatment, they have breached their implied promise or warranty that the treatment they render will meet high medical standards.

The use of the breach of warranty doctrine is not applicable in Virginia. The Virginia Supreme Court has held that an action to recover damages for personal injuries based on a breach of warranty is essentially an action for personal injuries and that the applicable limitation period is the shorter two-year period provided for personal injuries.

3. Limit the Amount that Would be Received by Injured Patients

In many jurisdictions, there has been a startling increase in the number of large awards during the last five years. Many argue that these large awards contribute significantly to the overall cost of malpractice insurance -- particularly in view of the small base over which malpractice

losses must be distributed. Accordingly, some have suggested that a limit be placed on the amount that injured patients can recover. For example, Indiana and Louisiana have enacted a law which limits the total recovery for any one act of malpractice to $500,000, i. e., the first $100,000 to be paid by the physician's insurance company and the remaining $400,000 to be paid from a state "patient's compensation fund" funded by a surcharge on the malpractice insurance premiums paid by physicians and hospitals. The Medical Society of Virginia has endorsed this approach. Still other jurisdictions have placed limitations on the recoverable damages without the use of a patient's compensation fund.[38/]

Serious questions arise regarding the efficacy of these types of limits both from a constitutional and cost reduction standpoint. Constitutional questions arise because the limitations usually take something away from the injured patient without conferring some benefit. In fact, the injured patient usually will have a tougher job of recovering than he had prior to the enactment of these laws since these laws also eliminate some of the more liberal negligent doctrines. The presence of a quid pro quo is essential and

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38/ E. g., Idaho limits recovery against each physician and hospital to $150,000 if the providers of health care provide requisite proof of financial responsibility. Illinois limits recovery to $500,000. Ohio and California have limited damages for pain and suffering to $200,000 and $250,000 respectively.

in other contexts has made the difference between the law being declared constitutional or unconstitutional. For example, workmen's compensation and no-fault laws have been declared constitutional because the restrictions these systems place upon recoverable damages are accompanied by a guarantee that the injured patient will be entitled to some benefit without proving negligence. This benefit has been deemed to be a reasonably adequate substitute for what has been taken away.

Furthermore, many doubt that the Indiana type limitation -- a set upper limit around $500,000 -- will have any beneficial cost impact in the state like Virginia where settlements in excess of $200,000 are a rarity. Proponents of a limitation, on the other hand, argue that while such limitations may not have an immediate impact, they would prevent future increase in verdicts that have been experienced in other jurisdictions.

While it appears that limits on the amount of damages recoverable for pain and suffering is more apt to have a beneficial cost impact, this result is by no means certain. This is so because of the amorphous nature of these damages and the absence of conclusive data regarding the degree to which these damages unduly inflate verdicts or settlements.

4. Elimination of the Collateral Source Rule

Under the Collateral Source Rule, a doctor or hospital cannot introduce evidence in a malpractice suit showing that

the injured patient was reimbursed for all or part of his medical expense or lost wages from other insurance programs or sources, e. g., Blue Cross, Blue Shield, sick leave, and Social Security.

Virginia follows this rule. In fact, in 1974 the Virginia General Assembly enacted legislation providing that in any claim for personal injuries or death, proven damages for loss of income shall not be diminished because the injured claimant has received compensation for his losses from other sources. The legislation also precludes the introduction of such reimbursement into evidence.

Even though a patient may recover from all sources more than he has lost, proponents justify this result on the theory that a negligent wrongdoer should not be relieved of his responsibility merely because of the fortuitous fact that the injured patient was entitled to other insurance coverage. They argue that this is particularly so when an injured patient has paid for this coverage either through outright purchase or taxes.

Opponents argue that the elimination of this wasteful duplication would significantly reduce the cost of malpractice insurance.

While the elimination of the Collateral Source Rule would realize significant savings, these savings must be balanced against the inequity of having the negligent provider of health care benefit from insurance coverages

that are usually paid for out of the injured patient's own pocket. In balancing these competing considerations, most states have sided with the injured patient. To date, only five states have eliminated the rule and two of these made an exception for benefits received from insurance purchased by the injured person or his employer.[39/]

5. Regulation of Contingent Fee Contracts

Most personal injury claims -- including those caused by a doctor's or hospital's negligence -- are handled by lawyers on a contingent fee basis. Under this arrangement the attorney is paid a fee only if the suit is successful or if an out-of-court settlement is realized. Generally, the attorney receives one-third of the amount recovered plus expenses. The contingent fee system is justified by many on the theory that it affords quality legal representation to those least able to afford it and at a time when legal advice is desperately needed.

Others, on the other hand, assert that the contingent fee system encourages nuisance suits and, therefore, contributes to the spiraling cost of malpractice insurance.

39/ Idaho - elimination of the Collateral Source Rule; Iowa - eliminated except for assets of the claimant or members of the immediate family; New York - eliminated except for those having liens against the amounts recovered by the plaintiff; Ohio - eliminated except with respect to claims against the state or with respect to amounts paid by the injured person or his employer. Subrogation was also eliminated except where subrogation was expressly provided for by statute; and Tennessee - eliminated except for assets and insurance purchased by the claimant.

Accordingly, these individuals advocate the regulation of these fees. Generally, these proposals would limit an attorney's fee to a lower fixed percentage or to a sliding scale, with the percentage decreasing as the award increases A sliding scale fee arrangement is presently in use in New number of states.[40/] Others either direct the courts to devise a reasonable limit or legislatively establish some outside limit.[41/]

The elimination of contingent fees in their entirety would probably result in a dramatic reduction of malpractice suits because most individuals could not afford to obtain legal representation. Since this extreme approach would indiscriminately preclude both legitimate and unmeritorious claims, it has not received serious consideration in most jurisdictions. At the same time, it is questionable that the more limited proposals discussed previously will have a beneficial cost impact. In fact, it is forcefully argued that the contingent fee arrangement acts as a screening device in that lawyers will not accept cases where success is unlikely. Accordingly, proposals aimed at regulating

40/ E.g., New Jersey, Indiana, Pennsylvania and California.

41/ Idaho -- fees in excess of forty percent including disbursements are deemed unreasonable; Tennessee - the fee is set by the Court but in no event shall exceed one-third; Iowa - reasonableness of fee determined by the court; Ohio - legislature requested the Supreme Court to establish a contingent fee schedule not to exceed one-third; Oregon - not more than one-third; Wisconsin - contingency fee calculated after deducting from amount recovered past medical and future medical expense in excess of $25,000.

contingent fees are more apt to assure that the injured patient receives more benefits than he might otherwise receive rather than significantly reducing the cost of malpractice insurance.

6. Increased Use of Arbitration

Many have suggested that the resolution of medical malpractice claims can be more efficiently, economically and rationally handled through arbitration rather than the traditional court procedures with a jury. These individuals argue that an arbitration panel composed of doctors and lawyers is in a better position to evaluate exceedingly complex expert medical testimony than a lay jury. They also argue that less formal arbitration procedures would reduce the cost and delay inherent in the processing of these claims through the courts.

The various arbitration proposals fall into three basic categories:

- Voluntary but not binding arbitration: Here the injured patient would voluntarily submit his claim to arbitration but would not be bound by the results of the arbitration panel, i. e., he can take his claim to court if he disagrees with the arbitration panel. Often, this type of proposal provides that the findings of the arbitration panel can be introduced in evidence at the subsequent trial;

- Voluntary and binding arbitration: Here the injured patient consents to have all malpractice claims submitted to arbitration and consents to be bound by the findings of the arbitration tribunal. Under this approach the injured patient could not institute a lawsuit in the courts. Usually, the findings of the arbitration panel would be subject to some form of limited judicial review to make sure that the arbitration panel properly applied state law and that their findings were supported by the evidence submitted to the tribunal;

- Mandatory and non-binding arbitration: Under this approach all malpractice claims would be required to be submitted to an arbitration panel whose findings would be admissible in any subsequent trial.

While there is almost universal agreement that arbitration should be emphasized in the resolution of malpractice claims, there is considerable opposition to making arbitration the exclusive tribunal since the injured patient would be denied his constitutional right to a jury trial.

Because of these considerations most states that have enacted legislation to encourage arbitration have stressed

voluntary or mandatory arbitration whose findings are not binding but can be introduced into evidence at any subsequent trial of the claim. The latter approach is often referred to as pre-trial screening.

For example, in Arkansas the patient may submit his claim to an informal panel composed of medical and legal practitioners. This procedure is not binding except by agreement and the findings of the tribunal are not admissible at trial. Several other states mandate a hearing before a panel composed of medical and legal experts. Here the findings of the tribunal regarding liability are admissible at the subsequent trial. Other states permit the findings of the panel on liability and damages to be admitted at the trial. At least one state -- Michigan -- has required that a patient be afforded an opportunity to consent to binding arbitration. Because of the volume of legislation that has been enacted, the state-by-state summary is attached as an Appendix F.

In Virginia, the Medical Society and the State Bar Association have jointly sponsored since the early 1960's a voluntary arbitration system in which three physicians and three attorneys may make findings of either a probability or no probability that a doctor or hospital has been negligent in the rendering of treatment. If the panel finds that there was no probability of negligence, the plaintiff's attorney is precluded from pursuing the matter in

the courts. However, this finding is not binding on the injured patient, and he may secure the services of another attorney if he wishes to institute a lawsuit. Since its inception, the panel has heard approximately fifteen to twenty cases per year. It has been suggested that the fact that one's attorney may not continue to represent him if there is an adverse finding, may deter attorneys from recommending the use of the panel to their clients.

Clearly, the legislature should explore the various means by which arbitration can play a greater role in the resolution of malpractice claims because arbitration holds the promise of processing these complicated claims in a more efficient and prompt manner.

7. Abolition of the Doctrine of Informed Consent

Under the present law doctors are charged with the duty of making a reasonable disclosure to patients of risks accompanying any medical diagnosis and treatment. It has been charged that in some jurisdictions the rule has been used to hold a physician liable where the patient's injury is severe and the evidence is insufficient to show any negligence on the part of the physician by requiring disclosure of almost every conceivable risk attendant upon a medical or surgical procedure.

The use of this doctrine, however, does not appear to be a problem in Virginia. In Virginia, the duty of disclosure

must be established by expert medical testimony regarding what is usually and customarily disclosed by doctors in the community in which the treatment was rendered. Nor have there been any reported cases in Virginia where the injured patient has recovered damages solely on the basis that the physician did not sufficiently inform the patient of the risks involved in a particular treatment.

8. Provide for the Strict Application of the Local Standard Rule.

In determining whether a doctor or hospital has acted in a negligent fashion, the injured person must prove that the doctor's or hospital's actions were unreasonable when viewed against the normal standards and procedures applied by doctors and hospitals in the surrounding area. In a number of jurisdictions the courts have permitted the injured patient to introduce testimony from expert witnesses from far distant communities where the standards of care may be much higher. Where such evidence is admitted, the jury is much more apt to find for the injured patient.

Opponents of the use of outside experts argue that the standards of medical care vary from jurisdiction to jurisdiction and are often a function of the resources available to the particular community in question. Consequently, it is unfair to require local practitioners, particularly in smaller towns and cities, to adhere to standards of care adopted in other more sophisticated communities that have

greater financial and medical resources.

Many, on the other hand, argue that injured patients often have no choice but to use outside experts since doctors and other practitioners are extremely reluctant to testify against their colleagues or medical institutions that are located in the area in which they practice. It is also argued that local practitioners should always strive to meet the highest possible standards and that the use of outside experts will provide incentive for local physicians and institutions to upgrade the quality of care they deliver to patients.

In Virginia, the locality rule is strictly enforced. Here, the courts have held that a physician or institution is not held to the highest standard of care known to the profession. Instead, providers of health care must exhibit only that degree of skill employed by the ordinary prudent practitioner in the community or in similar communities at the time that the alleged act of negligence took place.

9. Elimination of the Ad Damnum Clause

In most jurisdictions the injured patient institutes a lawsuit by filing with the court a statement of his claim. In this statement he must set forth the specific dollar amount of his claim. Usually, the injured patient cannot receive more than this amount. In legal terminology this statement of the dollar amount is called the Ad Damnum Clause.

Since a patient never is sure of the extent of damages that he has sustained, he usually requests an amount that is often much higher than the actual losses he believes he has incurred.

Many argue that inflated dollar amounts tend to attract sensational newspaper coverage which only accelerates the claims consciousness of the general public. This, coupled with the fact that the dollar amount serves little or no useful function other than to establish a particular court's jurisdiction, has prompted a number of jurisdictions to prohibit its use.[42/] In these jurisdictions, the injured patient merely claims that he is requesting all reasonable damages to which he is entitled.

While the elimination of the Ad Damnum Clause would not undermine the patient's claim for damages, it is doubtful that its elimination will have a measurable impact upon the cost of malpractice claims.

10. Elimination of the Doctrine of Res Ipsa Loquitur

One of the most often suggested changes aimed at reducing the cost of malpractice insurance is the limitation of the legal doctrine of Res Ipsa Loquitur.

Under the law the injured patient has the burden of establishing a doctor's or hospital's negligence. In certain

42/ E. g., Florida, Iowa, Indiana, Louisiana, Massachusetts, Ohio, Tennessee and Wisconsin.

specific instances, the injured patient's burden is made immeasurably easier by the doctrine of Res Ipsa Loquitur. Under this doctrine, the injured patient will have produced enough evidence to enable his case to be determined by a jury, if the injured patient shows that: (1) the thing or individual that caused the patient's injury was under the control or management of the doctor or hospital; and (2) the resulting injury was of such a nature that it probably would not have happened in the absence of negligence. In practical terms, the defendant doctor or hospital must then show that they were not negligent. The rule is justified because (1) a jury could reasonably infer negligence from the facts that must be proven by the injured patient in order to obtain the benefit of the rule; and (2) the defendant is in the best position to obtain relevant evidence bearing upon the issue.

Many argue that this doctrine has been abused with respect to malpractice claims. They argue that in many jurisdictions the courts have resorted to this doctrine to permit the injured patient to recover when injuries are severe and the evidence is insufficient to show any negligence on the part of the hospital or physician.

Only two states have directly addressed the issue and have enacted legislation that is apparently designed to restrict the expansion of the rule.[43/]

43/ E.g., Nevada and Tennessee have enacted legislation that appears to codify the traditional common law rule.

A review of Virginia's law indicates that the doctrine is not abused here. Virginia courts have repeatedly held that a doctor does not guarantee a cure and that a bad result by itself does not warrant the imposition of the doctrine since (1) the result may be attributable to causes beyond a doctor's control (e. g., a patient's below average recuperative power); and (2) the bad result might have happened even with the exercise of the highest degree of care and skill. Virginia courts permit use of the doctrine only in extreme cases, such as when a foreign object (e. g., forceps or a surgical pad or sponge) is left in the body of a patient. In these extreme instances, the Virginia courts have correctly held that such acts are so far beyond the pale of normal medical practice that a layman may infer negligence without the aid of expert testimony.

After analyzing all of the various alternatives set forth above, it appears that Virginia already has many of the legal doctrines that many believe will have a beneficial cost impact. Even so, the number and severity of malpractice claims has and continues to increase. It also appears that many of the other suggested changes -- other than the elimination of the Collateral Source Rule and the greater use of arbitration -- will have little or no impact upon the number and severity of these claims. This does not mean that the present system cannot be improved. It merely means that there may be a tendency to expect too much from many of the proposed changes in the existing legal system.

BROADENING THE DISTRIBUTION BASE

Throughout this report it has been repeatedly stressed that the high level of malpractice insurance premiums is due in large part to the fact that doctors and hospitals have an extraordinarily large exposure relative to the small number of hospitals and doctors that malpractice losses must be distributed among. Although the cost of malpractice insurance is eventually passed on to the patient, the large lump sum premiums that must be paid each year are beginning to strain the financial resources of many providers of health care -- particularly those individual practitioners that have a heavy hospital-oriented type of practice, e. g., anesthesiologists, neurosurgeons and orthopedic surgeons.

A number of suggestions have been made to alleviate this growing burden upon individual practitioners. These include:

- changing the existing rate structure so that general practitioners shoulder more of the cost resulting from the activities of the various hospital-based specialists. Many argue that this is justified because (1) the general practitioner's interest in affording high quality medical care to his patients is dependent upon the general practitioner's ability to refer his patients

to specialists; (2) most of a specialist's patients are, in fact, referred to them by general practitioners; and (3) it is unfair to have needed specialists shoulder the entire cost of claims that may result more from modern, but risky medical, procedures rather than negligence.

- institute a new malpractice premium billing procedure so that doctors are billed on an installment, rather than single lump sum, basis. It is argued that this will minimize the burden presently placed upon the doctor and will facilitate the distribution of the premium cost among the doctor's patients through the doctor's normal patient billing procedure.

- establish procedures so that the cost of malpractice premiums is immediately recognized as a reimbursable cost by Blue Shield. Although these costs are eventually paid by Blue Shield, reimbursement is sometimes delayed under existing methods of computing the amount Blue Shield pays to each physician.

These and related suggestions have some merit. However, they continue to utilize the individual practitioner as the principle conduit for the distribution of malpractice losses.

Many argue that a much broader and efficient distribution system could be realized by emphasizing the hospital rather than the individual practitioner because:

- hospitals are better able to absorb this cost without straining their total financial resources or their day-to-day cash flow. This is so because the annual revenue of any one hospital is many times larger than the gross revenues of any individual practitioner or group of practitioners;
- a hospital's distribution base (e. g., bed patient days and outpatient visits) is much broader than that of most, if not all, individual practitioners;
- hospital billing procedures are usually more sophisticated and computerized than are the billing procedures of individual practitioners;
- a hospital can further distribute malpractice costs through an extensive private and government (Medicare; Medicaid) insurance system that is much more comprehensive than that applicable to treatments in a physician's office. For example, in 1972, 87.6% of the nation's population was covered by some form of hospital insurance coverage, and approximately 74% of

the population was covered for treatment by a physician in a hospital. At the same time, only 48.2% of the population was covered for outpatient treatment by doctors in their offices;

- distributing malpractice insurance premiums through the hospitals would facilitate the monitoring of the cost pass through to make sure that patients are not being charged for other hidden expenses, e. g., expansion of hospital facilities, specialized medical equipment, etc. This is so because (1) it is much easier to monitor 100 hospitals rather than 5,000 doctors in Virginia; and (2) the sophisticated and centralized accounting procedures of hospitals facilitate expeditious examinations and audits.

These advantages coupled with the fact that the best available evidence indicates that 75% of all physician's malpractice occurs within the confines of a hospital have led some to conclude that it would be worthwhile to explore the feasibility of interim solutions that would channel most of today's malpractice costs through the hospital rather than the individual practitioner.

Under one approach, the hospital would be responsible for any losses caused by any malpractice incident occurring within the confines of a hospital irrespective of whether the

doctor is or is not an employee of the hospital. This approach would provide immediate relief for those doctors most in need of it, i. e., the specialists with a heavily hospital-oriented practice. Of course, these doctors would still be required to have coverage for potential claims arising from incidents outside the hospitals. However, this coverage would cost much less than it does today since much of the malpractice cost under the proposal would be channeled through the hospital.

Nor does it appear that this proposed cost distribution would place a prohibitive financial burden on hospitals. Although hospitals would pay a significantly higher premium under the proposal than they do today, the resulting increase would not materially increase the daily rate that hospitals charge to each of their patients. For example, if it is assumed that an adequate annual malpractice premium for the limits presently applicable to all doctors in Virginia would approximate $16,000,000 in 1976 and that 75% of this premium was distributed among the total bed-patient days of Virginia's hospitals -- including physiatric and custodial institutions -- the daily hospital rate for each bed patient would be increased by $1.20. If the cost was spread among the annual bed days of Virginia's 100 short term acute care hospitals only,

the annual daily rate would increase by only $2.40. Both of these increases would be reduced if the cost was also distributed over the three million outpatient visits that are made to Virginia's hospitals each year.[44/]

The advantages of the hospital distribution approach are as follows:

1. It would broaden the distribution base: Approximately 75% of the cost of all physician malpractice in Virginia would be spread over five to ten million bed patient days and three million outpatient visits rather than Virginia's 5,100 doctors. This, in turn, would be distributed through a comprehensive private and government health insurance system.

2. Reduction of the cost of processing malpractice claims:

   Under the present law, a physician having privileges at a hospital is viewed as an independent agent. As such, the hospital is not responsible for his negligence. Instead, a hospital is responsible only for its own negligence or that

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44/ It should be noted that the above estimates treat all hospitals in the same fashion. Of course, under the proposed system, hospital rates would be designed to place a greater portion of the cost on those hospitals that produce the most claims -- that is those hospitals where most of the more specialized surgical procedures are performed as opposed to the small rural community hospitals.

of its employees, e. g., doctors, interns, nurses, and others that are permanently on its staff. However, in actual practice whenever one sues the independent physician for his negligence occurring in a hospital, the hospital and its employees are almost always named as co-defendants. This is a precautionary measure designed to assure that all parties that could even be remotely responsible for the injury are included in the suit. At the same time, the doctor and the hospital are generally covered by different insurance companies. Accordingly, the hospital and the doctor must obtain separate legal counsel; this results in a duplication of legal expenses -- which in the malpractice setting represents a significant factor in the high cost of medical malpractice insurance. For example, it is estimated that the legal expenses of defense account anywhere from 15% to 25% of the total amount paid for malpractice claims. These legal expenses are high relative to the toal payout because: (1) only 1/3 of the patients that bring a malpractice claim recover anything; (2) these legal expenses must be incurred irrespective of whether the patient recovers or not; and (3) malpractice claims are much more complicated than the average personal injury claim. In addition, they often take much longer to resolve.

If, on the other hand, the hospital is responsible for all incidents occurring within the confines of the hospital, the doctor and hospital would be covered by the same insurance company and would, therefore, have the same counsel. The elimination of this duplicative legal expense could result in a substantial savings.

3. A more equitable rate structure:

Even though a general practitioner's rate today is considerably lower than that of the hospital-based specialist, the general practitioner does pick up some of the cost resulting from claims against the high risk specialists. This occurs because the existing distribution base for medical malpractice losses is exceedingly small. Under the hospital distribution proposal, the cost incurred by the high risk specialist would be channeled through the hospitals and would remove the need for the general practitioner to subsidize the high risk specialist. In addition, the hospital distribution proposal would afford relief to those practitioners that are most in need of relief, e. g., anesthesiologists and various types of surgeons.

4. Reduction of malpractice claims:

In recent years many have questioned whether or not the existing system for disciplining medical practitioners has been effective. Many also question whether the present system for compensating injured victims has acted as an effective deterrent. These critics argue that malpractice could be minimized by upgrading the environment in which most of the negligence occurs before the fact. Under this approach the responsibility for losses is placed upon the entity that is in the best position to take preventive measures. It is also argued that if the hospital is responsible for all negligent acts occurring within the confines of a hospital, the hospital, its trustees, its Board of Directors and the physicians that have privileges in that hospital would have greater incentive to make sure that those entitled to have privileges at the hospital would be of the highest possible caliber and that the hospital is run in the most efficient manner from a risk management standpoint.

5. Collection of hard information regarding the causes of malpractice claims:

As previously indicated, there is very little accurate information regarding the underlying

causes of the recent increases in malpractice claims. Nor is there much information regarding how the existing legal system is processing these claims. It is argued that if the hospitals were responsible for all incidents occurring within the hospital environment, the hospital could easily collect extensive information on a prospective basis regarding all aspects of the activities that give rise to a malpractice claim, how the claim is being processed and the cost of these claims. In fact, Virginia Blue Cross has a pilot information gathering program underway in three hospitals and the results to date look promising. In time, this data would provide detailed information regarding the who, when, what and why of the malpractice problem. Armed with this information, the hospital would be able to develop a meaningful loss prevention program. For example, if the statewide data shows that claims arise with respect to certain procedures as opposed to others, the hospital and doctors associated with hospitals could re-examine these procedures and, to the degree possible, corrective measures could be taken. In addition, the data would enable legislators to develop meaningful and workable changes in the way health care is delivered and the way malpractice claims are processed.

6. Facilitates more accurate malpractice insurance rate making:

As previously pointed out, a "claims made" policy minimizes the guesswork inherent in the present method of determining malpractice rates. At the same time, this type of policy creates some problems for the individual practitioner since (1) claims will continue to be reported after he retires or dies; and (2) it is difficult to predict the cost of insurance to cover these claims. This has been a particular concern to the hospital-based specialist since the larger and more costly claims are against these practitioners. A hospital, on the other hand, continues in existence and would not be subject to these problems. Accordingly, the hospital distribution solution would permit the use of a "claims made" policy with its inherent advantages and would eliminate the disadvantages for those physicians that are most concerned about it.

7. Implementation does not require the creation of a large bureaucracy:

The only portion of the proposal that would have to be implemented by the state is the providing of means for the collection of uniform data and the

monitoring of the cost pass-through. This can be done with little effort with existing personnel of the Bureau of Insurance.

The suggested proposal has a number of potential problems, such as:

1. It would relieve doctors of responsibility for their negligent acts:

Many argue that if the hospital is responsible for all malpractice acts occurring within the confines of a hospital, independent physicians that practice within the hospital will be relieved of responsiblity for their wrongdoing. It is argued that this is not only unfair, but may encourage these physicians to take a more cavalier attitude towards the quality of treatment they render to patients.

While the argument has some merit, it is not as convincing as it first appears. First, there is considerable doubt that the present system has been an effective deterrent. In fact, malpractice appears to be increasing rather than decreasing in direct proportion to the degree that injured patients resort to the courts to make sure that doctors pay for the losses they cause. In addition, many argue that the best way to prevent malpractice is to upgrade the overall environment within which most of the acts

occur (a risk management program) rather than relying upon the imperfect and amorphous deterrent that may or may not result from the existing methods of compensating injured patients or disciplining the providers of health care.

Equally important is the fact that provision can be made under the hospital distribution proposal so that physicians shoulder this responsibility in a much more direct manner than they do today. This can be done by making physicians pay for the first $2-4,000 of any claim successfully brought against the hospital as a result of the doctor's negligent act. This approach would also have the benefit of penalizing only those doctors that were actually found guilty of wrongdoing.

2. <u>The proposal camouflages rather than remedies the underlying causes of the malpractice problem:</u>

Many will argue that the hospital distribution solution will do nothing to cure the underlying causes of the recent increases in the number of malpractice claims. They will also argue that it will hinder the development of fundamental solutions because it will relieve some of the present pressure that is forcing people to come to grips with the problem. While these arguments have some merit, they tend to

oversimplify what the proposal does and does not do relative to other solutions. As previously pointed out, there is no hard information regarding why malpractice claims have been increasing in recent years. Nor is there any solid information regarding the degree to which many of the proposed solutions will remedy the problem. In fact, existing evidence indicates that several of the more popular solutions (e. g., a $500,000 limit on the amount recovered) will not reduce the cost of malpractice premiums in a jurisdiction like Virginia where awards or settlements seldom exceed $250,000. Clearly, more information is needed before fundamental changes are made in the present system. The hospital distribution proposal provides an effective means by which to collect this information.

The arguments also overlook the fact that the narrow distribution base is an important part of the malpractice problem and the hospital base solution will go a long way to remedying it. In addition, there is little question that the existing and proposed malpractice premiums are adversely affecting the delivery of health care -- particularly for those practitioners that engage in needed specialities. The hospital distribution solution would provide immediate relief for these practitioners.

Finally, the hospital distribution solution provides

a framework that is best suited for preventing future malpractice acts because those responsible for the environment in which most of these acts occur will be responsible for the losses resulting from these acts.

Accordingly, the hospital distribution proposal is much more than camouflage. It represents a first step in the development of long-range workable solutions on a gradual but continued basis and only after sufficient information is available upon which legislators and administrators can make an informed judgment.

RECOMMENDATIONS OF THE STATE CORPORATION COMMISSION

The State Corporation Commission's study of malpractice insurance demonstrates that while Virginia has a problem, it has not reached crisis proportions and that Virginia still has time to take corrective measures.

The most urgent need is to devise means to assure the continued availability of malpractice insurance coverage. After reviewing all of the various alternatives, the State Corporation Commission believes that a Joint Underwriting Association is best suited to fulfill this function. If the legislature decides on this alternative, the SCC recommends that the legislation provide for:

(1) specific safeguards to assure that the JUA be self-supporting, such as a rate stabilization fund and possibly a premium tax offset;

(2) broad-based participation by insurance companies licensed to do business in Virginia in order to distribute unanticipated but possible losses in a manner that does not unduly burden any one group of companies or policyholders; and

(3) SCC discretion after a hearing with respect to when the JUA should be placed in operation for any class of provider of health care, the type of insurance policy that should be offered by the JUA and whether the JUA will be the exclusive source of malpractice insurance for those providers that cannot obtain insurance through the private sector.

With respect to the reduction of malpractice claims, emphasis should be placed upon the strengthening of medical disciplinary proceedings. More specifically, all malpractice claims should be reported to appropriate state agencies for review and individuals who provide information to any state or private disciplinary or risk management committee or board

should be immune from civil liability. While there are, no doubt, other areas where improvement can be realized, the SCC recommends caution until more detailed information has been developed regarding all aspects of the malpractice problem.

Caution is also warranted with respect to changes in the existing system for the compensation of injured patients. This is so for several reasons. First, most of the legal doctrines complained of elsewhere are virtually non-existent in Virginia. In fact, many of Virginia's existing legal doctrines are more restrictive than the changes that have been made in other jurisdictions to remedy the problem. Second, even with this conservative legal climate, malpractice claims have escalated and in all probability, will continue to increase. Consequently, one cannot help but wonder whether the changes in the legal system that many advocate will have their intended effect. And third, it should be recognized that many of the proposed changes in the legal system would adversely affect the existing remedies of injured patients. This coupled with the fact that there is considerable doubt as to whether any of the proposed changes would have their intended impact argues strongly for restraint.

Of course, this does not mean that the existing legal system cannot be improved. For example, the increased use of arbitration appears to have great potential for speeding

up and reducing the cost of processing these claims. Accordingly, the SCC recommends that the legislature carefully explore the various arbitration alternatives and seriously consider enacting legislation that will require that injured claimants be given the option of having their claims resolved through arbitration or the courts.

Finally, the SCC is intrigued by the possibilities of providing immediate relief through changes in the methods by which malpractice premium costs are distributed. The hospital based distribution proposal set forth in the Report merits serious consideration. While this proposal was developed primarily as a means to create a broader distribution base, the SCC has become increasingly optimistic regarding its potential for the development of a more objective and effective risk management approach towards the malpractice incidents. The suggested approach also has another advantage: it provides the basis by which comprehensive information can be collected with a minimum of effort and provides a vehicle for continuing but gradual change as information becomes available. In an area as complex as medical malpractice and a medical delivery system that is in the throes change, cautious but steadily progressive remedial action is required.

It cannot be emphasized too strongly that the hospital based distribution proposal is not without its problems. Nor have we deceived ourselves into believing that the

proposal as presented provides all the answers. However, we do believe that it provides a useful starting point to stimulate thought regarding possible solutions that focus on the hospital where the vast majortiy of all malpractice incidents occur.

In this and other jurisdictions, the search for solutions has been inhibited by the natural tendency to spend immense time and energy trying to place the blame for the problem on someone else. Such efforts are counter-productive. Clearly, the time has come to direct our energies towards the development of long-range solutions that will, no doubt, require give and take by all interested parties.

Appendix A

STATE BY STATE COMPARISON OF EXISTING ISO RATES FOR HOSPITALS MALPRACTICE COVERAGE AS OF OCTOBER 1, 1975*

State	Rates	
	25/75	100/300
Ala.	97.00	157.00
Ariz.	186.00	301.00
Ark.	86.00	139.00
Calif.	830.00	1,345.00
Colo.	-	-
Conn.	107.00	173.00
Dela.	132.00	183.00
D.C.	285.00	396.00
Fla.	535.00	867.00
Ga.	149.00	241.00
Ida.	110.00	178.00
Ill.	-	-
Ind.	121.00	196.00
Iowa	118.00	164.00
Kans.	75.00	104.00
Ky.	163.00	264.00
La.	188.00	261.00
Me.	83.00	115.00
Md.	72.00	117.00
Mass.	131.00	182.00
Mich.	334.00	541.00
Minn.	147.00	238.00
Miss.	83.00	134.00
Mo.	109.00	177.00
Mont.	345.00	559.00
Neb.	109.00	177.00
Nev.	94.50	134.00
N.H.	90.00	125.00
N.J.	54.50	72.00
N.M.	147.00	238.00
N.Y.	256.00	415.00
N.C.	27.50	33.00
N.D.	83.00	134.00
Ohio	220.00	356.00
Okla.	111.00	154.00
Ore.	203.00	329.00
Pa.	100.00	139.00
R.I.	20.50	28.50
S.C.	61.00	85.00
S.D.	62.50	101.00
Tenn.	110.00	153.00
Tex.	-	-
Utah	142.00	230.00
Vt.	39.50	55.00
Va.	112.00	181.00
Wash.	196.00	318.00
W. Va.	51.50	71.50
Wisc.	58.00	94.00
Wyo.	82.00	133.00
Haw.	-	-
Alas.	144.00	233.00
P.R.	72.00	95.00
Virginia's National Ranking	22th	21th

*Source: Insurance Services Office

STATE BY STATE COMPARISON OF EXISTING ISO RATES FOR PHYSICIANS AND SURGEONS MALPRACTICE COVERAGE AS OF OCTOBER 1, 1975*

	Rates			
	Class 1		Class 5	
States	25/75	100/300	27/75	100/300
Ala.	115.	200.	703.	1,244.
Ariz.	2,128.	3,703.	17,039.	30,159.
Ark.	260.	452.	2,080.	3,682.
Cal.	3,491.	6,074.	27,919.	49,417.
Colo.	-	-	-	-
Conn.	517.	900.	4,137.	7,322.
Dela.	291.	434.	2,331.	3,543.
D.C.	468.	697.	3,744.	5,691.
Fla.**	2,043.	3,555.	16,339.	28,920.
Ga.	332.	578.	2,652.	4,695
Ida.	786.	1,368.	6,296.	11,144
Ill.	-	-	-	-
Ind.	468.	814.	3,743.	6,625
Iowa	483.	720.	3,863.	5,872.
Kan.	238.	355.	1,905.	2,896.
Ky.	387.	673.	3,095.	5,478.
Lo.	482.	718.	3,856.	5,861.
Me.	336.	501.	2,686.	4,083.
Md.	131.	168.	804.	1,061.
Mass.	337.	502.	2,699.	4,102.
Mich.	2,464.	4,287.	19,708.	34,883.
Minn.	734.	1,277.	5,873.	10,395.
Miss.	283.	492.	2,268.	4,014.
Mo.	822.	1,430.	6,574.	11,636.
Mont.	1,125.	1,958.	9,012.	15,951
Neb.	730.	1,270.	5,838.	10,333.
Nev.	732.	1,091	5,859.	8,906.
NH	78.	116.	389.	591.
NJ	564.	722.	4,515.	5,960.
NM	440.	766.	3,518.	6,227.
NY**	1,183.	1,763.	14,200.	21,584.
NC	95.	122.	476.	628.
ND	150.	261.	1,197.	2,119.
Ohio	619.	1,077.	4,955.	8,770.
OK	374	557.	2,995.	4,552.
Ore.	305.	531.	2,438.	4,315.
Pa**	516.	769.	3,182.	4,837.
RI	191.	244.	957.	1,263.
SC	145.	252.	1,161.	2,055
SD	529.	920.	4,229.	7,485.
Tenn.	925.	1,378.	7,409.	11,262.
Tex.	-	-	-	-
Utah	686.	1,194.	5,479.	9,698.
Vt.	277.	413.	2,213.	3,364.
Va.	509.	886.	4,069.	7,202.
Wash.	341.	593.	2,727.	4,827.
W. Va.	365.	544.	2,921.	4,440.
Wisc.	719.	1,251.	5,751.	10,179.
Wyo.	518.	901.	4,147.	7,340.
Haw.	486.	724.	3,889.	5,911.
Alas.	295.	513.	2,357.	4,172.
PR	161.	280.	990.	1,752.
Virginia's National Ranking	21st	19th	20th	19th

*Source: Insurance Services Office

**This jurisdiction has numerous rating territories. Consequently, only the rates for the highest territory are listed.

APPENDIX C

THE "CLAIMS MADE" POLICY

In early 1975, St. Paul Fire and Marine Insurance Company developed a "new" [1/] type of malpractice insurance coverage. This new policy is called a "claims made" policy. It has been approved for physicians and surgeons in 34 states. It has also been approved for hospitals in 27 states. The Virginia Bureau of Insurance approved the "claims made" policy for physicians and surgeons in February, 1975 and for hospitals in July 1, 1975.

There has been considerable confusion and controversy surrounding the "claims made" policy. Much of this confusion and controversy results from a misunderstanding of what a "claims made" policy does and does not do. It is important to remember that it does not solve the malpractice problem. Nor, does it mean lower rates. Instead, it merely eliminates some of the guesswork inherent in the standard methods of determining adequate malpractice premium rate levels.

The following discussion will first describe the major differences between the new "claims made" policy and the traditional "occurrence" liability policy that was in effect for hospitals and doctors prior to 1975. It will then discuss the advantages and disadvantages of each.

1/ While the "claims made" policy is a relatively new development in the medical malpractice field, it has been widely used in other areas of professional liability, e. g., legal malpractice and directors' and officers' liability.

THE DIFFERENCE BETWEEN AN "OCCURRENCE" AND "CLAIMS MADE" POLICY

Under a traditional "occurrence" policy, the insurance company agrees to provide coverage for losses caused by any negligent act occurring during the year that the policy is in effect. The company is responsible for these losses irrespective of when the claims for these losses are reported to the company. For example, an "occurrence" policy in effect from January 1, 1975 to December 31, 1975 covers all losses from any negligent act or omission that takes place during 1975. Most of the claims based on 1975 incidents will not be reported during 1975. Instead, they will be reported to the insurance company anywhere from one to five years later. In addition, it can take considerably longer to finally resolve the claim by either paying it or close without payment. Accordingly, much of the cost of a 1975 "occurrence" policy will depend not only on the number of negligent acts causing injury, but also the degree to which the public makes a claim and inflation -- factors that can change radically in a 3-5 year period. Viewed in this perspective, an insurance company selling a 1975 "occurrence" policy is quoting a price in 1975 without knowing the full extent of the losses it will have to pay. Nor, will it have any reasonable estimate of this cost for at least 2-5 years.

The new "claims made" policy differs from the "occurrence' policy in that it covers only claims reported during the

period of coverage. Lets assume that a physician obtained his first "claims made" policy in December, 1974, and that this policy will be effective from January 1, 1975 to December 31, 1975. Under this policy, the insurance would cover only the losses that were (1) caused by negligent acts occurring in 1975; and (2) reported to the insurance company in 1975. Claims based on negligent acts that occurred prior to 1975 would be covered by the old "occurrence" policy that was in effect prior to 1975. Claims reported after 1975 for losses caused by 1975 negligent acts will be covered by subsequent "claims made" policies.

At the end of 1975, the physician would obtain a 1976 "claims made" policy. This policy will not only cover reported claims resulting from 1975 incidents, but it will also cover claims reported in 1976 as a result of 1976 negligent acts. Similarly, the physician's 1977 "claims made" policy will cover all claims reported during 1977 as a result of negligent acts occurring in 1977, 1976 and 1975 -- the first year that the first "claims made" policy went into effect.

Because the initial "claims made" policy covers only reported claims resulting from negligent acts occurring during the first year it is in effect, the first year "claims made" premium will be substantially lower than that which would have been charged for an "occurrence" policy covering that same year. Subsequent "claims made" policies will cover both reported claims resulting from negligent acts occurring

during the current year and those resulting from negligent acts occurring in prior years during which the physician was covered by that company's "claims made" policy. Accordingly, the "claims made" premium will increase each year it is renewed due to the continually increasing backlog of cases that it covers. Although the "claims made" premium for the basic "claims made" policy will always be 10-20% lower than an adequate "occurrence" policy rate, the premiums for both the basic coverage and the supplementary coverage to cover claims reported after death or retirement should approximate that charged for an "occurrence" policy.

Another important difference between the "claims made" and "occurrence" policy relates what happens when a physician terminates coverage for any reason, e. g., retirement, leaving the jurisdiction, disability, death or merely a desire to change insurance companies. Since an "occurrence" policy covers all incidents occuring during the period that the policy is in force irrespective of when a claim is reported, a retiring doctor does not have to worry about claims reported after he retires. This is not the case when the doctor has a "claims made" policy. In this instance, the doctor has

to obtain supplementary insurance to cover all claims reported after his retirement resulting from negligent acts occurring during the period that the "claims made" coverage was in force. This supplementary insurance is an integral part of any "claims made" policy and its availability guaranteed by many of the insurance companies that issue a "claims made" policy. This supplementary coverage goes by the technical name of "The Reporting Endorsement."

ADVANTAGES AND DISADVANTAGES OF THE "CLAIMS MADE" POLICY

The primary advantage of the "claims made" policy is that it minimizes the guesswork inherent in the present process of pricing a malpractice policy. It also permits greater use of Virginia rather than countrywide experience.

In order to explain why this is so, it is necessary to briefly summarize the data and projection problems associated with the pricing of the traditional "occurrence" malpractice insurance policy, it is quoting a price today for a product whose full cost will not be known for at least five years. In making such estimates, insurance companies must use both Virginia and countrywide data. Insurance companies begin with Virginia's actual claims experience. Once this is established, the company must estimate whether this experience will increase or decrease over the next five years. This

estimate of future trends must be based on countrywide rather than Virginia data because Virginia's relatively small data base does not permit statistically reliable projections.[2/]

Traditional actuarial methods -- which have worked well in the past -- do not work well in pricing malpractice insurance rates because of (1) dramatic increases in the frequency and severity of malpractice claims since 1965; (2) rapid and unexplained fluctuations in this experience; (3) sustained double-digit inflation in recent years; and (4) the significantly longer period required to process malpractice as opposed to other types of personal injury claims. The seriousness of the problem is illustrated by St. Paul's Virginia experience since 1969.

Clearly, the traditional method of pricing insurance coverage no longer works for malpractice insurance. The "claims made" policy is an attempt to rectify this situation. By its very nature, the price of a "claims made" policy will be revised each year as the claims experience develops. In addition, projections of future trends are made only one year in advance which minimizes the need to rely on countrywide trend data and the establishment of large reserves for incurred but not reported claims. For example, a "claims made"

2/ For example, in 1974, St. Paul had 3,768 plus claims reported against physicians and surgeons countrywide. In 1974, only 269 claims were reported in Virginia.

policy issued on January 1, 1975 is subject to renewal on December 31, 1975. At that time, the company must quote a price for the 1976 policy. In estimating this price, the insurance company will already have over one year's claims experience resulting from 1975 incidents which will shed some light on how claims experience for 1975 is developing. In addition, the company will only have to estimate the number of 1975 claims that will be reported during 1976 -- a considerably easier task than determining the 1975 experience four to five years in advance. At the end of 1976, even more information will be available when 1976 policies are up for renewal. Clearly, the "claims made" policy permits a company to annually adjust its rate level to reflect actual Virginia experience as it develops.[3/]

3/ Some responsible critics have either disagreed or counsel caution. For example, a recent review of the "claims made" policy in New York concluded that the "claims made" approach would result in only slightly more accurate rate making. It was argued that the ability to predict frequency under "claims made" or the "occurrence" approach in New York was essentially the same because of New York's relatively stable claims frequency. It was also argued that in New York there is an extremely long delay between the time a claim is reported and its ultimate resolution. This being so, actuaries well have to make similar estimates under both types of policies with respect to the future impact of inflation.

However, these same critics are quick to recognize that what may be true for New York may not be elsewhere. They point out that the "claims made" policy would provide greater accuracy when claims frequency is increasing rapidly and where the time required to resolve claims after they have been reported is significantly shorter than the New York experience.

Both conditions are present in Virginia. Virginia claims are increasing at a more rapid rate than New York's. This is so because New York's litigious atmosphere developed several years ago and may have reached a saturation point. Virginia, on the other hand, is just embarking upon a period of increased claims consciousness. In addition, Virginia claims are resolved faster than they are in New York.

This distinct benefit is not without its disadvantages. As previously pointed out, a "claims made" policy covers only incidents reported during the year it is in effect. Unlike an "occurrence" policy, it does not cover all incidents occurring during the year of coverage. Accordingly, a doctor under a "claims made" policy must obtain supplementary insurance to cover claims resulting from negligent acts committed while he was in active practice and which will not be reported until after he retires. Doctors have expressed concern because they do not now know how much this supplementary insurance will cost five, ten or fifteen years from now. The physicians argue that they want some indication <u>now</u> regarding its cost because if the cost is prohibitive, they want to make plans to reire or to leave the jurisdiction. If, on the other hand, they wait, tney will have no choice -- they will be forced to obtain the supplementary insurance irrespective of its cost.

Many doctors fail to understand that insurance companies are unable to give accurate price estimates for this supplementary insurance five or ten years in advance for the very same reasons that insurance companies are unable to accurately price the traditional "occurrence" policy.

Despite these difficulties, there are a number of ways to solve the problem. For example, when a doctor's "claims made" policy is coming up for renewal at the end of this year,

an insurance company can be required to quote the doctor a rate for both next year's "claims made" policy and the supplementary insurance (complete reporting endorsement coverage) that could be obtained at the end of next year. The doctor would then be in a position to know whether or not he wishes to make other arrangements before he is "locked in" to paying an unacceptable rate. There are also other alternatives, such as the payment of an additional surcharge each year which would be held in escrow and applied against the premiums for the supplementary insurance whenever the doctor wished to leave the jurisdiction or retire.

It should be pointed out that this problem does not exist for hospitals since hospitals are institutions whose operations continue in perpetuity.

In view of the foregoing, the "claims made" policy has much in its favor. It will bring credibility back into the rating process and will permit us to emphasize Virginia more than countrywide experience -- advantages vociferiously advocated by all interested parties, including the medical profession. These advantages far outweigh the potential problems that may arise with respect to the supplementary insurance coverage -- particularly when means are available to ameliorate most, if not all, of the doctor's concerns.

Appendix D

SUMMARY OF STATE ACTION TO STRENGTHEN DISCIPLINARY PROCEEDINGS AND PEER REVIEW

A. Reporting of Malpractice Claims

Arkansas	Every licensed physician must report malpractice claims and suits to State Medical Board within 10 days after receipt.
California	Requires insurers to report malpractice statistics to commissioner on an annual basis.
Colorado	Reports of recommendation for disciplinary action go to state board of medical examiners if disciplinary action taken.
Florida	Requires insurers to report annually claims against medicine or osteopathic practicioners.
Kansas	Requires insurer to report annually to commissioner of insurance.
Michigan	Requires peer review (osteopathic) groups to report disciplinary action to medical practice board. Same reporting procedure for doctors of medicine.
Michigan	Insurer must report specified data to insurance commissioner at prescribed times. Information is confidential at the discretion of the commissioner.
Nevada	Any review panel of a hospital, screening panel or medical society must file with the board or the county medical society.
	Requires insurer to furnish medical malpractice information from any state to the commissioner.
New York	Insurer must file every 6 months and follow up all claims with the superintendent of insurance and commissioner of health.
Ohio	Licensed individuals, associations or societies shall report to the state board information appearing to show a violation.
Oregon	Any licensed physician, association, or society shall and any other person may report to the board of medical examiners any information showing

	medical incompetancy, unprofessional or dishonorable conduct or mental or physical incapacity. Also requires insurer of self-insurance association to report claims within 30 days to the board.
Texas	Requires insurer to file annual reports with the state board of insurance.
Wisconsin	Requires insurer to report annually by class certain information to the insurance commissioner.

B. Grounds for Disciplinary Action

Florida	Review committees and hospital disciplinary powers.
Indiana	Creates a medical licensing board with power to discipline.
Louisiana	Creates state board of medical examiners (physicians) to license, control and discipline.
Massachusetts	Board of registration and discipline; itemized list of grounds for disciplinary action.
Michigan	Board of registration in podiatry has power to license and law lists grounds for disciplinary action.
Nevada	Defines gross malpractice, unprofessional conduct, professional incompetency and provides remedies and punishment for their breach as well as the procedures.
New York	Creates board for professional medical conduct and provides for, investigation, proceedings, hearings, defines professional misconduct and provides for disciplinary action.
Ohio	Lists 18 specific grounds for disciplinary action by the state medical board.
Oregon	Broadens the board of medical examiners grounds for suspension or revocation of license by adding 2 new areas relating to preforming brain surgery without permission of the psychosurgery review board and refusing an informal interview with the board. Allows limitations on the license to practice, temporary suspension of license prior to hearing, require mental, physical or medical competency examinations.

C. Consumer Participation

Indiana	Medical Licensing Board (legislators and physicians).
Massachusetts	Board of Registration and Discipline consisting of 5 physicians and 2 representatives of the public.
Michigan	Board of Registration in Podiatry (disciplinary powers) is composed of 5 persons, 4 of whom are podiatrists and 1 lay person.
New York	Creates a state board of professional medical conduct consisting of 18 physicians and 7 lay members. Committees to investigate and conduct disciplinary proceedings consist of 4 physicians and 1 lay member selected from the board.
Ohio	Creates a state medical board consisting of 9 members 8 of whom shall be physicians and 1 member representing the consumer.
Washington	Board of medical examiners, appointed by the governor, consisting of 6 licensed practitioners of medicine and 1 who is not.
Tennessee	Creates a pre-trial review board to hear all malpractice claims prior to trial. The seven member board consists of a judge, an attorney, two physicians and two members of the general public.
Wisconsin	Pre-trial panels which are required to hear all malpractice claims before suit is brought are composed of: informal, three member panel consisting of an attorney, a health care professional by specialty and a petit juror; formal, five member panel consisting of a physician, a specialist in the same area, an attorney and two members of the public.

D. Continuing Medical Education

Michigan	Effective December 1, 1976 the board of registration in podiatry shall not renew the license of a podiatrist unless he presents evidence satisfactory to the board that in the year preceding the application he has attended continuing education courses in programs approved by the board totaling at least 50 hours, on subjects related to the practice of podiatry.
Ohio	The state medical board will issue licenses to practice medicine every three years and require evidence of 150 hours of continuing medical education, certified by the Ohio Osteopathic Association and approved by the board.
Washington	Board of medical examiners may establish rules and regulations governing mandatory continuing education requirements which shall be met by physicians applying for renewal of licenses.

Appendix E

SUMMARY OF STATE ACTION REGARDING IMMUNITY MALPRACTICE AND FOR OTHER DISCIPLINARY INFORMATION

Arkansas	Immunity for members of committees.
	Immunity for members of peer review committees for civil liability; records are not subject to discovery nor introduceble in evidence in a civil trial; members are immune from testifying.
Colorado	Grants immunity for insurer, agents or employees in reporting to the Department of Insurance.
Florida	Grants immunity for insurer, agents or employees in reporting to the Department of Insurance.
	Immunity granted for hospital disciplinary action relating to staff privileges and acts; also grants immunity to review organizations.
Georgia	Grants immunity to medical review committees; proceedings not subject to discovery nor can be introduced in evidence; members cannot testify at later trial.
Hawaii	Proceedings or records of medical, dental, optometric societies or hospital are not subject to discovery.
Iowa	Defines peer review committee and grants immunity from civil liability.
Kansas	Grants immunity to insurer, commissioner and their employees for annual reports.
Louisiana	Grants immunity to physicians, hospital and committees where they furnish charts, reports, etc

	Grants immunity to dentists who serve on or are consulted by a peer review committee.
	Grants immunity to the state board of medical examiners and their employees.
Maryland	Immunity for liability for damages for communication of information to specified review committees on fitness and character.
Michigan	Grants immunity, both civil or criminal, in reporting child abuse cases; priviledged communications are abrogated except between attorney and client.
	Immunity for providing information used for research, education, standards, protection of government funded programs and evidence for discipline purposes.
	Grants immunity for board of podiatrists or chiropodists.
	Grants immunity to insurers and employees for reports to insurance commissioner.
Missouri	Grants immunity to chiropractors who are members of professional standards review committees.
	Grants immunity from civil and criminal liability for any person or institution reporting child abuse.
Montana	Nonliability for peer review or professional standards review committees.
Nevada	Immunity from civil action is granted to anyone who files an allegation with the board of medical examiners or county society.
New Hampshire	Grants immunity from liability for professional standards review organizations for dentists, nurses, optometrists, pharmacists, physicians or chiropractors.
New York	Grants immunity to members of a committee on professional conduct, members are not required to testify and proceedings and records are not subject to discovery.
North Dakota	Records and proceedings of medical review committees not subject to discovery or admissible as evidence.

Ohio	Grants immunity to any peer review committee or professional standards review committee and proceedings and records are not subject to discovery. Also grants immunity to any person, or society who gives information to the state medical board.
Oklahoma	Grants immunity to members of peer review committees.
Oregon	Grants immunity to the board of medical examiners, those who testify, investigate, prosecute, etc. Information supplied to the board is confidential, not subject to disclosure and not admissible. Any person supplying information is not subject to an action for civil damages.
South Dakota	No monetary liability and no cause of action against a member of a committee of a state or local professional society consisting of dentists. Grants immunity to licensed physicians who are members of peer review committees or professional standards review organization.
Tennessee	Immunity for any chircopractor who serves on any peer review or similar committee. Defines "medical review committee" and grants immunity from liability for furnishing data, reports or records which shall be confidential and not subject to discovery.
Texas	Relates to creation, membership and functions of chiropractic peer review committees and grants immunity for actions taken.
Washington	The board of medical examiners is granted immunity from civil liability.
West Virginia	Defines "health care professionals" and "peer review". Grants immunity from civil liability for those who provide information provided it is not knowingly false and is related. Also grants immunity to members of peer review organizations.

Appendix F

SUMMARY OF STATE ACTION
REGARDING ARBITRATION

1. Voluntary - nonbinding:

Arkansas	Voluntary; medical-legal panel; informal; non-binding except by agreement; no expert testimony required; findings not admissible at trial.

2. Mandatory - nonbinding - findings based on liability:

Florida	Mandatory; non-binding; medical-legal panel; informal; findings based on liability but may include damages by agreement; conclusions on liability admissible at later trial;
Indiana	Mandatory; non-binding; medical-legal panel; opinion based on liability and extent of disability; opinion admissible;
Louisiana	Mandatory (except by agreement to waive or arbitrate); non-binding; medical panel; informal; findings based on liability admissible at trial; panel members may testify; fee paid by majority opinion;
Massachusetts	Mandatory; non-binding; medical-legal panel; experts not required; determines liability only; opinions are admissible at later trial; requires a cost bond to appeal;
Nevada	Mandatory; non-binding; medical-legal panel; findings based on reasonable probability of negligence and causation; findings must be subsequently pleaded.

3. Mandatory - non-bindings - findings based on liability and damages:

New York	Mandatory; non-binding; medical-legal panel; informal; findings based on liability and damages; unanimous panel findings admissible and panel members may testify on findings at subsequent trial;
Tennessee	Mandatory; non-binding; medical-legal-public panel; informal; findings based on liability and damages are admissible at trial on request; financed by annual fee paid by health care providers;

Wisconsin — Mandatory; non-binding (may be by agreement); informal panel consists of three members, a health care provider, an attorney and a petit juror; formal panel consists of a physician, a specialist, an attorney and two public members; proceedings are formal or informal depending on amount and choice; informal panel findings not admissible; formal panel findings admissible on liability and may be on damages at court's discretion; financed by annual fee from health care provider;

Illinois — Mandatory; non-binding (except by agreement); medical-legal panel; formal; findings based on fact and law as to liability and damages; findings not admissible unless agreed in writing; costs are apportioned except party who rejects findings and does not prevail at trial may be assessed all costs including attorney fees.

4. Arbitration by agreement - binding:

Idaho — Not limited to malpractice; written agreements to submit any existing controversy to arbitration are valid, enforceable and irrevocable and the court may compel or stay arbitration; provides for appointment of arbitrators, proceedings, hearings, representation, costs, awards and appeal to the courts;

Louisiana — Provides for arbitration of medical and dental contracts where both parties agree in writing to be bound. Selection of the arbitrators may be in the agreement. All proceedings are governed by the state arbitration laws. Provision is made for notice to the patient of his rights prior to signing as well as his right to counsel or void the agreements. Such agreements are valid for five years;

Michigan — Persons who receive treatment in a hospital may execute an agreement to arbitrate any claim in contract or tort. The hospital may not revoke the agreement whereas the patient may in writing 60 days after execution. Agreements are good for one year. Hearings for the most part are informal and experts are not required. Three member panel consists of a doctor, an attorney and a lay person. Findings note the basis of liability, degree of fault of each defendant and the award. There are provisions for paying "lump sum" portions of the award, remedial services, annuities, etc.,

	Sets up an arbitration advisory committee to study the program, provides for policy changes to include arbitration and for financing through malpractice;
Ohio	Amends the present arbitration law to allow binding arbitration by agreement for malpractice. Provides for a three member board (one each by the plaintiff, defendant and the court). The arbitration form once signed is binding on the patient, however, it may be cancelled 60 days after discharge or termination of treatment;
Wisconsin	Amends the arbitration law to provide for selection of arbitrators in malpractice claims. If no provision is made in the agreement, a three member panel will be selected by the court consisting of an attorney, a health professional who is a specialist in the field and a non-professional (Effective, February 15, 1976).