REPORT OF THE
STATE CORPORATION COMMISSION ON

# Alternative Premium Distribution Methods for Medical Malpractice Insurance

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA


# HOUSE DOCUMENT NO. 33

COMMONWEALTH OF VIRGINIA
RICHMOND
1989

COMMONWEALTH OF VIRGINIA

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STATE CORPORATION COMMISSION

January 9, 1989

TO: The Honorable Gerald L. Baliles
Governor of Virginia
and
The General Assembly of Virginia

We are pleased to transmit this Report of the State Corporation Commission on Alternative Premium Distribution Methods for Medical Malpractice Insurance.

The study was initiated and the report prepared pursuant to House Joint Resolution 186 of the 1988 Session of the General Assembly of Virginia.

Respectfully submitted,

Preston C. Shannon
Chairman

Thomas P. Harwood, Jr.
Commissioner

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# EXECUTIVE SUMMARY

The State Corporation Commission's Bureau of Insurance was requested by the 1988 Session of the General Assembly to study medical malpractice insurance and the feasibility and desirability of establishing a method of distribution of premiums among the various medical malpractice rate categories. The primary purpose of the study was to find a fair method of allocating medical malpractice insurance costs among physicians. One solution offered in the study resolution was the distribution of insurance costs attributable to high risk specialists among some of the lower risk specialties.

The Bureau's findings can be summarized as follows:

1. Wisconsin is the only state that has adopted a method of cost allocation among medical malpractice rate categories. Until 1986, the Wisconsin Patients' Compensation Fund had a nine class provider classification system. This was amended to reduce the number of classes to no more than four separate rate categories. The compression of the nine class system into a four class system resulted in a redistribution of insurance costs among the high and low risk specialists.

2. In its 1987 report, an academic task force established by the State of Florida rejected the idea of establishing a "risk class compression plan" as a means of reducing premiums charged to the high risk specialists. Allowing lower risk specialists to share the insurance costs of the high risk specialists was rejected on the grounds that it was inequitable, costly, and would require increased state intervention.

3. Most physicians and surgeons are opposed to spreading or sharing the costs of malpractice premiums; the insurance industry is also opposed to this idea. Remedies to alleviate the medical malpractice insurance crisis have been suggested by members of both the insurance industry and the medical profession.

4. Spreading insurance costs may be of benefit to a small number of specialists in the high risk categories but may create an affordability problem for a larger number of practitioners in the low risk categories. Ultimately, increased insurance costs could be passed along to the consumers at the primary care level.

5. Although physicians' and surgeons' medical malpractice premiums have increased significantly over the past several years, the rates charged for medical malpractice insurance in Virginia, as compared to other states, is relatively low.

6. Analysis of the medical malpractice closed claim reports submitted to the Bureau of Insurance over the past three years indicates that there was an increase in both the frequency and severity of claims closed between 1985 and 1987.

Based on the Bureau's findings, the State Corporation Commission concluded that no change in the current filed premium distribution system is warranted. The State Corporation Commission makes the following recommendations:

1. Revise Section 38.2-2228 of the Code of Virginia by requiring the following additional information on medical malpractice claims to be reported to the Bureau of Insurance:

   (a) the date the loss occurred;
   (b) the date the claim was reported to the company;
   (c) the date and the amount of the initial reserve;
   (d) the reserve valued at the end of the current calendar year;
   (e) a differentiation between the amount of settlement or judgment and the amount actually paid by the insurer (for cases where the settlement or judgment exceeds the insurer's limits of liability);
   (f) a breakdown between the amounts paid and the amounts reserved for attorney's fees and other expenses to the extent these amounts are known;
   (g) data on all opened and closed claims (current law only requires closed claim data to be reported); and
   (h) the date the claim was closed.

2. Establish a system of revising the individual claim reports required by Section 38.2-2228 so that up-to-date information can be maintained without creating duplicate reports.

3. Encourage the Department of Health Regulatory Boards to require all physicians and surgeons to report their medical specialty at the time their license is renewed.

# GENERAL ASSEMBLY OF VIRGINIA -- 1988 SESSION

## HOUSE JOINT RESOLUTION NO. 186

*Requesting the Bureau of Insurance to study medical malpractice insurance rates.*

Agreed to by the House of Delegates, February 16, 1988
Agreed to by the Senate, March 9, 1988

WHEREAS, medical malpractice premiums, on a national basis, represent eight-tenths of one percent of the total health care costs for the nation; and

WHEREAS, according to some analysts, the crisis in medical malpractice insurance is not an overall cost problem but an insurance allocation problem related to the small number of doctors in the high risk categories; and

WHEREAS, through passage of a bill in 1984 requiring closed claim reporting, the General Assembly recognized the importance of determining the appropriateness of premiums charged by the medical malpractice insurance carriers; and

WHEREAS, in 1986, the joint subcommittee studying the liability insurance crisis and the need for tort reform cited a need for more detailed oversight of the rate making process; and

WHEREAS, there is a need to find a fair method of allocating costs and one solution may be to distribute the insurance costs attributable to high risk specialists among some of the lower risk specialties; and

WHEREAS, total medical malpractice premiums in 1984 were less than $40 million and there were more than 10,000 physicians in the Commonwealth, resulting in an average annual medical malpractice premium of less than $4,000; and

WHEREAS, consideration of spreading the cost of insurance evenly over the more than 10,000 practitioners in Virginia reveals that even if gross earned premiums were as high as $50 million, the average cost per physician would be under $5,000 annually, a figure dramatically lower than high risk specialists currently pay; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Bureau of Insurance is requested to study medical malpractice insurance. The Bureau shall seek the assistance of the Joint Underwriters Association with this study. The study shall include consideration of the feasibility and desirability of a method of distribution of premiums among the various medical malpractice rate categories and other related issues as the Bureau deems appropriate.

Upon completion of this study, the Bureau should submit its findings to the Governor and the 1989 Session of the General Assembly as provided in procedures of the Division of Legislative Automated Systems for processing legislative documents.

## Legislative Request

The State Corporation Commission's Bureau of Insurance was requested by the 1988 Session of the General Assembly to study medical malpractice insurance and the feasibility and desirability of establishing a method of distribution of premiums among the various medical malpractice rate categories. This study was requested because (1) according to some analysts, the crisis in medical malpractice insurance is not an overall cost problem but an insurance allocation problem related to the small number of doctors in the high risk categories; (2) there is a need to find a fair method of allocating costs, and one solution may be to distribute the insurance costs attributable to high risk specialists among some of the lower risk specialties; and (3) spreading the cost of insurance evenly over the more than 10,000 practitioners in Virginia reveals that even if gross earned premiums were as high as $50 million, the average cost per physician would be under $5,000 annually.

## Methodology

The Bureau of Insurance began its research by conducting several surveys. The first survey was sent to the other state insurance departments to determine whether any states (1) required the low risk specialists to help subsidize the insurance costs of the high risk specialists or (2) had established any method of cost allocation for medical malpractice insurance.

A second survey was sent to various insurance industry representatives, medical professionals, and other interested parties to determine (1) who would be in favor of requiring the costs of medical malpractice insurance attributable to high risk specialists to be allocated evenly to all practitioners in the state, and (2) who would be in favor of requiring any type of cost allocation method.

A third survey was sent to all insurers in Virginia that had direct written premiums for medical malpractice insurance during calendar year 1987. This survey requested information on the number of hospitals insured in Virginia; the number of physicians and surgeons insured in Virginia; the number of specialists insured; and the amount of premiums written, incurred losses, and loss adjustment expenses for 1987. A survey was also sent to the Department of Health Regulatory Boards, the Medical Society of Virginia, and the Virginia Hospital Association to determine the number of licensed practitioners in the state and the number of members affiliated with each organization.

In addition to these surveys, the report also includes:

(1) a review of the medical malpractice closed claim reports submitted to the Bureau of Insurance for the past three years;

(2) a review of the medical malpractice rate filings of the top five companies writing physicians' and surgeons' professional liability coverage in the state; and

(3) a rate comparison of physicians' and surgeons' professional liability coverage in 41 other states.

Information from the commercial liability claim reports required pursuant to Section 38.2-2228.1 was not available at the time of this report. This information will be available for future reports.

**Requirements of Other States**

The other state insurance departments were contacted to determine whether any states require the medical malpractice insurance costs of the high risk specialists to be subsidized by the low risk specialists. Wisconsin is the only state that requires this type of premium distribution among physicians. In Florida an academic task force studying insurance and tort systems recommended against establishing a risk class compression plan as a means of bringing down the premiums for high risk classes. The Florida Task Force concluded that a risk class compression plan would be inequitable, would require increased state intervention in the private sector, and would destroy any competition that already exists in the medical malpractice insurance market.

Wisconsin has a mandatory Patients' Compensation Fund which serves as an excess insurer for limits over the primary carrier limits (set by statute at $400,000/$1,000,000). Originally the Patients' Compensation Fund had a nine class provider classification system. In 1986 this was amended to a four class system. According to the Chief of the Compensation Fund, the compression of the nine class system into a four class system reduced the fees charged to the high risk specialties and increased the fees assessed against the more populated lower risk provider specialty groups.

Additional information on Wisconsin's Patients' Compensation Fund is provided in Appendix A. Information on 12 other states' Patients' Compensation Funds is also provided in Appendix A. An excerpt from the report of the Florida Task Force has been submitted as an attachment to the official position paper submitted by the American Insurance Association. This is included in Appendix B (see next section).

**Opinion Poll**

A questionnaire was sent to various insurance industry representatives, medical societies, and other interested parties to determine who would be in favor of requiring the costs of medical malpractice insurance attributable to high risk specialists to be allocated evenly to all practitioners in the state. A total of 45 questionnaires were mailed (31 to medical societies, 10 to insurance organizations, and four to other interested parties). Of these, 32 were returned (22 from medical society representatives, eight from insurance representatives, and two from other interested parties). Three of the 22 doctors indicated that they would be in favor of such a method of premium distribution and 19 said they would be opposed to this idea.

All of the insurance representatives and other interested parties who responded indicated that they were opposed to this proposal.

Respondents were also asked their views on requiring any method of cost allocation for high risk specialists. Six doctors, two insurance representatives, and two others were in favor of some type of method of cost allocation. Alternate methods mentioned included a specialized tax levied against all citizens of the state or a patients' compensation fund. Several respondents noted that any alternate method of cost allocation should still be based on actuarial experience. Thirteen doctors and six insurance industry representatives were opposed to any system of cost allocation for the high risk specialists. Three offered no response to this question. Several respondents opposed to this idea reasoned that cost-based rating is the only equitable rating method and that any system of cost allocation creates unfair subsidization and promotes selective underwriting by insurance companies. Others suggested that a cost allocation plan would not only destroy competition in the medical malpractice insurance market but would also destroy quality control in the practice of medicine.

Even though the majority of those who responded to the questionnaire indicated that they were opposed to the idea of spreading insurance costs, a number of other suggestions were offered as solutions to the medical malpractice insurance problem. Some of these suggestions included:

1. effective risk management/quality assurance programs;
2. alternate dispute mechanisms;
3. effective licensing and disciplinary procedures;
4. periodic physician performance review programs;
5. meaningful tort reform;
6. no-fault medical malpractice insurance;
7. establishing a "premium impact equity plan" similar to the one proposed by the Florida Academic Task Force (this plan was not adopted by the Florida state legislature; details of this proposal are presented by the American Insurance Association in Appendix B);
8. establishing a new state agency to settle medical malpractice claims or giving the State Board of Medicine the authority to resolve disputes (see details provided by the Virginia Society of Internal Medicine in Appendix B);
9. developing a screening process to remove frivolous claims from the judicial process; and
10. amending the Code of Virginia to make the decisions of the medical malpractice review panels binding.

Several position papers were submitted with the questionnaire and are found in Appendix B. The 45 companies, agencies, and individuals that received the questionnaire are shown in Appendix C.

**Annual Medical Malpractice Survey**

Each year the Bureau of Insurance conducts a medical malpractice survey in preparation for the hearing held annually to determine whether the Commission's Order subjecting medical malpractice rates to prior filing should be continued. This year the survey was sent to all insurers in Virginia that had direct written premiums for medical malpractice insurance during calendar year 1987. Information was requested on the number of hospitals insured in Virginia; the number of physicians and surgeons insured in Virginia; the number of specialists insured; and the amount of premiums written, incurred losses, and loss adjustment expenses for calendar year 1987. This information is summarized below:

Number of hospitals insured in Virginia (by company)

| | Nursing Homes | Acute Care | Psychiatric | Long-term Care | Non-Hospital Entities |
|---|---|---|---|---|---|
| Bituminous | 2 | | | | |
| Church Mutual | 3 | | | | |
| Continental | 23 | | | | |
| Hartford & Twin City | 16 | | | | |
| PHICO | 1 | 2 | 5 | | |
| St. Paul | 8 | 8 | | | |
| Travelers | | | | | 1 |
| Virginia Insurance Reciprocal (VIR) | | 76 | | 47 | 39 |
| TOTAL: | 53 | 86 | 5 | 47 | 40 |

Number of physicians and surgeons insured under hospital policies in Virginia (by company)

| | |
|---|---|
| PHICO | 43 |
| VIR | 556 |
| TOTAL | 599 |

Other physicians and surgeons insured in Virginia (by company)

| | |
|---|---|
| Amer Cas./National Fire (CNA) | 33 |
| Cincinnati | *.... |
| Medical Protective | 418 |
| PHICO | 1,763 |
| St. Paul | 4,159 |
| VIR | 2,350 |
| JUA | 404 |
| TOTAL | 9,127 |

*Indicated that the company insured a few but was unable to identify specific policies.

Total number of physicians and surgeons insured in Virginia

| | |
|---|---|
| Under hospital policies | 599 |
| Under individual policies | 9,127 |
| TOTAL | 9,726 |

In 1987 the Virginia Insurance Reciprocal, St. Paul, and PHICO insured 91% of the total number of physicians and surgeons insured in Virginia. A breakdown of the physicians and surgeons insured by each of these companies is shown in Appendix D (Exhibits 1-3).

According to the figures reported in the annual medical malpractice survey, the total amount of premiums written in Virginia for physicians' and surgeons' professional liability coverage during 1987 was $58,088,666. The Virginia Insurance Reciprocal, St. Paul, and PHICO wrote 92% of the premium volume for physicians' and surgeons' malpractice coverage during that year. Specific information on premiums written, premiums earned, paid losses, and paid loss adjustment expenses for calendar year 1987, as reported by each company insuring physicians and surgeons in Virginia, is shown below. Also shown below are figures reported by each company for their unpaid losses and loss adjustment expenses valued as of December 31, 1987:

American Casualty/National Fire (CNA)

| | |
|---|---|
| Written Premiums: | $ 6,090 |
| Earned Premiums: | $ 1,459 |
| Paid Losses: | $ 0 |
| Paid ALAE: | $ 0 |
| Reported Case Reserves: | $ 0 |
| Reported ALAE Reserves: | $ 0 |
| IBNR Loss Reserves: | $ 711 |
| IBNR ALAE Reserves: | $ 0 |

Medical Protective Company

| | |
|---|---|
| Written Premiums: | $ 1,851,053 |
| Earned Premiums: | $ 1,127,077 |
| Paid Losses: | $ 0 |
| Paid ALAE: | $ 31,781 |
| Reported Case Reserves: | $ 7,500 |
| Reported ALAE Reserves: | $ 7,334 |
| IBNR Loss Reserves: | $ 800,000 |
| IBNR ALAE Reserves: | $ 228,663 |

PHICO

| | |
|---|---|
| Written Premiums: | $ 6,303,670 |
| Earned Premiums: | $10,787,616 |
| Paid Losses: | $ 3,786,581 |
| Paid ALAE: | $ 868,818 |
| Reported Case Reserves: | $14,635,925 |
| Reported ALAE Reserves: | $ 1,760,496 |
| IBNR Loss Reserves: | $ 8,122,000 |
| IBNR ALAE Reserves: | $ 1,666,000 |

St. Paul

| | |
|---|---|
| Written Premiums: | $27,888,238 |
| Earned Premiums: | $32,481,212 |
| Paid Losses: | $14,365,804 |
| Paid ALAE: | $ 3,835,225 |
| Reported Case Reserves | $61,555,863 |
| Reported ALAE Reserves | $15,722,220 |
| IBNR Loss Reserves: | $ 7,367,178 |
| IBNR ALAE Reserves: | * |

*Company does not differentiate between IBNR ALAE Reserves and Reported ALAE Reserves.

Virginia Insurance Reciprocal

| | |
|---|---|
| Written Premiums: | $19,500,814 |
| Earned Premiums: | $16,971,626 |
| Paid Losses: | $ 3,349,210 |
| Paid ALAE: | $ 1,052,941 |
| Reported Case Reserves | $11,675,733 |
| Reported ALAE Reserves | $ 1,433,419 |
| IBNR Loss Reserves: | $ 5,832,750 |
| IBNR ALAE Reserves: | $ 4,555,000 |

JUA

| | |
|---|---|
| Written Premiums: | $ 2,538,801 |
| Earned Premiums: | $ 1,266,879 |
| Paid Losses: | $ 0 |
| Paid ALAE: | $ 63,840 |
| Reported Case Reserves: | $ 3,500 |
| Reported ALAE Reserves: | $ 3,500 |
| IBNR Loss Reserves: | $ 632,667 |
| IBNR ALAE Reserves: | $ 346,392 |

In addition to collecting insurance company data, information was also requested from the Department of Health Regulatory Boards to determine the number of physicians and surgeons licensed in Virginia. The Department of Health Regulatory Boards reported 11,814 in-state physicians and surgeons licensed in Virginia and 8,196 out-of-state physicians and surgeons licensed in Virginia. The total number of physicians and surgeons licensed in Virginia as reported by the Department of Health Regulatory Boards was 20,010 as of June 30, 1988. The total number of physicians and surgeons licensed in Virginia as of June 30, 1987, was 19,380. A total of 18,635 physicians and surgeons were licensed in Virginia as of June 30, 1986, and 17,522 the year before. These figures include physicians and surgeons who were licensed but not necessarily practicing medicine during each of those years.

A breakdown of physicians and surgeons by area of specialty was also provided by the Department of Health Regulatory Boards, but they recommended against using these figures because (1) licensees may change their specialties without informing the Board; (2) they may acquire additional specialties; and (3) some physicians practice a specialty when they are eligible for certification in that specialty without ever actually obtaining certification. According to the Department of Health Regulatory Boards, every practicing physician must renew his or her license with the Board of Medicine every two years. At the time of renewal the Board of Medicine does not ask for the physician's area of specialty. Licensees are not required to report their specialties to the Board of Medicine but may voluntarily provide this information.

As a matter of policy, the Department of Health Regulatory Boards does not become involved in determining a physician's qualifications to practice a certain specialty unless a complaint is filed. A physician can be penalized if the department finds that he has been practicing in an area of specialty for which he is not qualified.

The Medical Society of Virginia, the Virginia Hospital Association, the Department of Health, and the Department of Mental Health, Mental Retardation, and Substance Abuse Services also provided data for the annual medical malpractice survey. This data is summarized as follows:

Medical Society of Virginia

5834 (total membership) physicians and surgeons
5595 of total membership licensed and practicing in Virginia

Breakdown of total membership:
5595 Virginia members
239 out-of-state members
92 residents

Virginia Hospital Association

Members affiliated with Virginia Hospital Association:
400 personal members
120 institutional members

Breakdown by type of hospital:
95 acute care
2 specialty hospitals
1 long-term care institution
4 systems
18 psychiatric
2 veterans hospitals

Department of Health

108 acute care hospitals licensed in Virginia
193 nursing homes licensed in Virginia

Department of Mental Health

47 private psychiatric hospitals and psychiatric units in general hospitals licensed in Virginia

## Medical Malpractice Closed Claim Reports

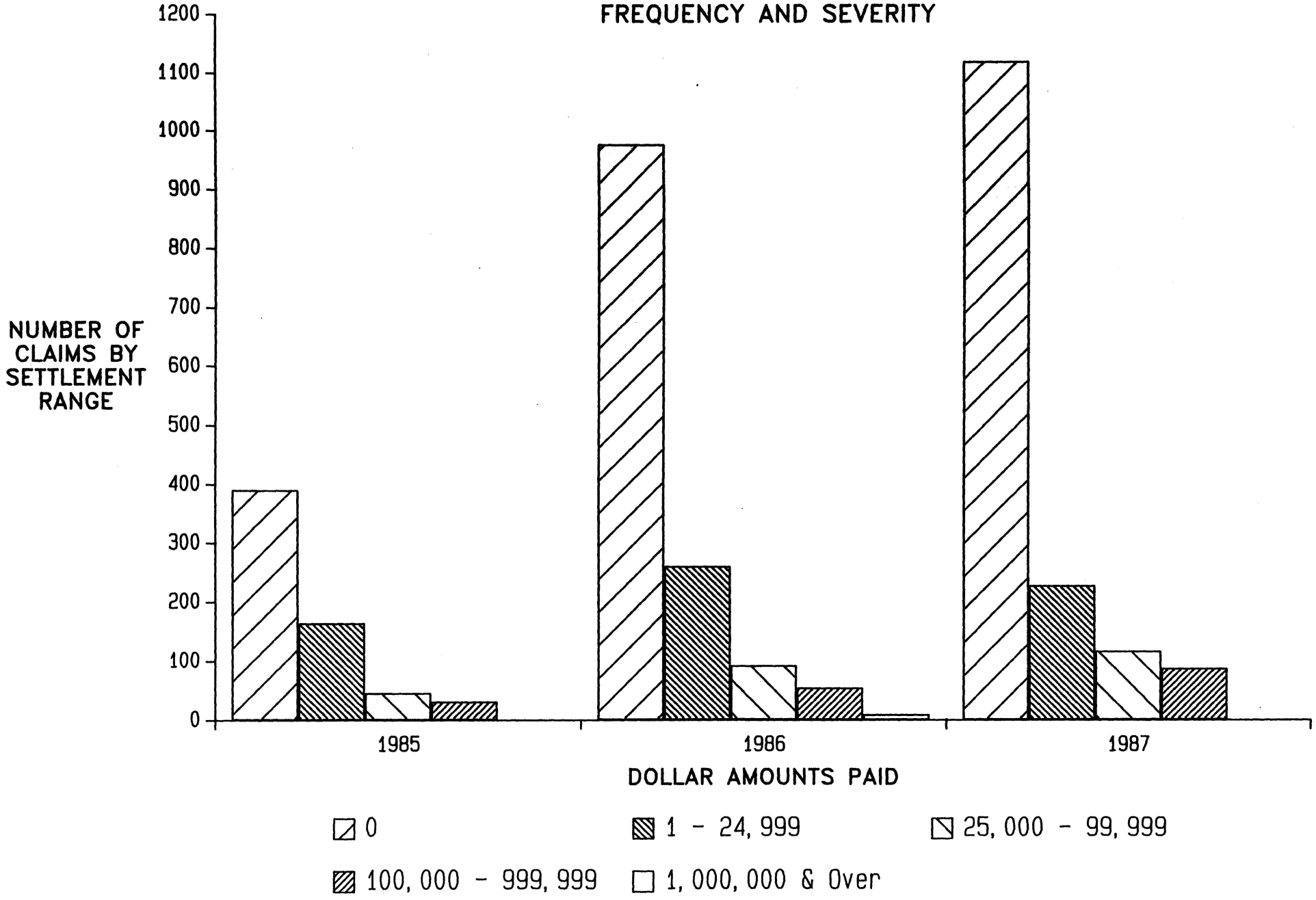
All medical malpractice claims settled or adjudicated to final judgment and all medical malpractice claims closed without payment during each calendar year must be reported annually to the Bureau of Insurance. This is required pursuant to Section 38.2-2228 of the Code of Virginia.

Medical malpractice closed claim reports submitted to the Bureau of Insurance over the past three years were reviewed. This data was analyzed, and several summary reports are provided in Appendix E (Exhibits 1-3). These reports include a breakdown by provider type and by company. According to the data collected:

(1) there was an increase in both the frequency and severity of medical malpractice closed claims between 1985 and 1987;
(2) the total number of claims closed between 1985 and 1987 increased by 144%;
(3) the total number of claims paid increased by 77%;
(4) the total amount of settlements or judgments increased by 185%;

# CLAIMS CLOSED BETWEEN 1985 AND 1987

## FREQUENCY AND SEVERITY



(5) the total amount of attorney's fees and expenses increased by 145%;
(6) the majority of claims were closed without payment (usually between 61% and 72% each year); and
(7) over the three-year-period only one claim payment totaled at least $1,000,000.

The graph on the preceding page shows the trend in claim frequency and severity for claims closed between 1985 and 1987.

Although the data collected in the medical malpractice closed claim reports provides useful information relative to the frequency and severity of claims closed, it does not provide information that enables the Bureau to analyze claim development trends or claim reserving practices. The following list shows the types of additional information that should be collected for this purpose:

1. the date the loss occurred;
2. the date the claim was reported to the company;
3. the date and the amount of the initial reserve;
4. the reserve valued at the end of the current calendar year;
5. a differentiation between the amount of settlement or judgment and the amount actually paid by the insurer (for cases where the settlement or judgment exceeds the insurer's limits of liability);
6. a breakdown between the amounts paid and the amounts reserved for attorney's fees and other expenses to the extent these amounts are known;
7. data on all opened and closed claims (current law only requires closed claim data to be reported); and
8. the date the claim was closed.

A system needs to be devised to enable the Bureau to distinguish between the original claim and a revised one, thus eliminating duplicate reports. On occasion, the same claim will be reported twice because the company made additional payments after the claim was closed. For example, a claim is reported to the Bureau as closed in 1987. The following year additional expenses are incurred because the bill was submitted to the company after the closing date. The company should report only the additional expenses on a separate claim form instead of resubmitting the entire claim which now includes the additional bill.

**Rate Review**

This study reviewed the medical malpractice rate filings for the top five companies writing physicians' and surgeons' professional liability coverage in the state. The

Virginia Medical Malpractice Joint Underwriting Association (J.U.A.) was included as one of the top five companies.

A comparison of the annual premiums charged by each of the companies for 68 provider specialties is shown in Appendix F (family practice is shown as a specialty; not all specialties are shown). The premiums were determined by using Territory 1 (Northern Virginia) mature claims-made rates effective on July 1, 1988, using limits of $1,000,000/$1,000,000. The J.U.A.'s rates were based on limits of $1,000,000/$3,000,000 as they do not file rates using $1,000,000/$1,000,000 limits. A footnote on the chart in Appendix F shows that a 33 1/3% surcharge must also be added to each year's premium charged by the J.U.A. for the stabilization reserve fund. This surcharge is required pursuant to Section 38.2-2807 of the Code of Virginia.

As shown in Appendix F, physicians who perform no surgery pay the lowest annual premiums for medical malpractice insurance. The next lowest level of premiums are paid by physicians who perform minor surgery, followed by physicians who perform major surgery. Cardiac surgeons, orthopedic surgeons, and thoracic surgeons are among the highest rated classes of providers, followed by obstetric surgeons and neurosurgeons. To demonstrate the difference in premiums, an allergist in Northern Virginia insured with PHICO would pay $3,474 per year while a neurosurgeon also practicing in Northern Virginia and insured with PHICO would pay $48,742 per year (using July 1, 1988 rates with limits shown above).

Rates vary by geographic territory as well. Most medical malpractice insurers divide Virginia into four geographic territories. The following chart illustrates the rate differentials between territories for a family practitioner insured with St. Paul (using the same rates and limits of liability as shown above):

| Territory 1 (No. Va.) | Territory 2 (Tidewater) | Territory 3 (Remainder) | Territory 4 (Richmond Area) |
|---|---|---|---|
| $6058 | $5625 | $4536 | $3865 |

The following chart shows the extent to which each of the top five companies have increased their physicians' and surgeons' professional liability rates since 1985. This information was supplied by the insurers. In one case, Bureau analysis yielded a slightly lower percentage.

Virginia Insurance Reciprocal

| Year | % Increase | Date Effective |
|---|---|---|
| 1985 | 20% | 11/1/85 |
| 1986 | 45% | 8/1/86 |
| 1987 | no increase taken | |
| 1988 | 15% | 4/1/88 |

PHICO

| Year | % Increase | Date Effective |
|---|---|---|
| 1985 | 20% (Base Rates) | 6/1/85* |
| 1986 | 50% (Base Rates) | 7/1/86* |
| 1987 | no increase taken | |
| 1988 | rate filing pending | |

St. Paul

| Year | % Increase | Date Effective |
|---|---|---|
| 1985 | 15% (Base Rates) | 9/10/85 |
| 1986 | 14% (Base Rates) | 7/24/86 |
| 1987 | 15% (Base Rates) | 10/1/87 |
| 1988 | 13.6% (Base Rates) | 7/1/88* |

Medical Protective Company

Began writing in Virginia in November, 1986. No increases taken.

J.U.A.

Began writing in November, 1986.

| Year | % Increase | Date Effective |
|---|---|---|
| 1987 | no increase taken | |
| 1988 | 17% | 6/1/88 |

*Increased Limits Factors Also Increased

As shown above, medical malpractice insurance rates for physicians and surgeons have increased significantly over the past several years. The most significant rate increases took place in 1986.

In an effort to compare the medical malpractice rates in Virginia with those of other states, St. Paul provided a rate comparison chart for 42 states, shown in Appendix G, which compares the company's proposed average rates for physicians' and surgeons' professional liability coverage after July 1, 1988. Based on the information provided, the medical malpractice insurance market in Virginia compares favorably with that of the other 41 states in which St. Paul offers physicians' and surgeons' professional liability insurance coverage. Only five other states have average rates that are lower than the average rate in Virginia. These states are Arkansas, North Carolina, South Carolina, South Dakota, and Tennessee.

**Advantages and Disadvantages of Premium Redistribution**

Before determining whether cost shifting among medical specialties is feasible and desirable, a discussion of the nature and purpose of insurance is in order.

No one universally accepted definition of insurance exists. Various definitions are found in insurance literature. Some definitions state that insurance is a device under which at least two entities transfer the financial consequences of potential losses to an insurer. These definitions accept as insurance a combination of as few as two entities, or exposure units. Other definitions

suggest that a large number of exposure units must exist and that pooling is an essential condition of insurance; combining or pooling of a sufficient number of exposure units makes individual losses collectively predictable. Most authors of insurance textbooks agree that regardless of the number of exposure units insured, there should be homogeneity among those exposure units. All should face about the same probability of loss occurrence. This is true whether the insurer intends to insure only one type of exposure or several different types.[1]

Once an insurer decides to insure a particular type of exposure, it must be able to establish sufficient premiums to pay losses and expenses as well as provide a reasonable profit. This is the primary objective of the rate-making process.[2] Another objective of the rate-making process is to develop a rating structure that is neither excessive, inadequate, nor unfairly discriminatory. This is required by law pursuant to Sections 38.2-1904 and 38.2-2005 of the Code of Virginia. All rating classification systems involve some type of discrimination. However, the law only prohibits unfair discrimination. Virginia law supports the concept that each person should pay a premium commensurate with his or her loss experience and states that no rate shall be considered unfairly discriminatory if a different rate is charged for the same coverage and (i) the rate differential is based on sound actuarial principles or (ii) is related to actual or reasonably anticipated experience. As long as the rate differentials between classes accurately reflect the differences in loss exposure, the discrimination is fair and legal.

Medical malpractice insurance rates discriminate between the various classes of physicians and surgeons according to the nature of their practice and their actual or anticipated loss experience. Most companies that write physicians' and surgeons' professional liability coverage use a provider classification system that divides specialty groups into anywhere from 8 to 10 classes. The differences between rates among the various classes of providers are called class relativities. Class relativities are factors which are applied to the base rate for a particular line of insurance to determine the actual rates for each of the classes within a line of insurance. Frequent changes in base rates are fairly common, but class relativities usually remain unchanged over a period of years.

[1]C. Arthur Williams, Jr., et al., Principles of Risk Management and Insurance, Vol. I (Malvern, PA: American Institute for Property and Liability Underwriters, Inc., 1981), pp. 107, 223-228, 234-237.

[2]Bernard L. Webb, et al., Insurance Company Operations, Vol. II (Malvern, PA:American Institute for Property and Liability Underwriters, Inc., 1984), p.1.

Cost shifting among the various medical specialties could be achieved by compressing the 8, 9, or 10 class provider classification system into as few as 4 classes or less. This would be comparable to the system used by the Wisconsin Patients' Compensation Fund mentioned earlier in this report. The effect of such a compression would be the sharing of insurance costs among high and low risk specialists. The premiums charged to the lower risk specialists would increase while the premiums charged to the high risk specialists would decrease. The extent of the increase or decrease would depend on the extent of the compression. The greater the compression, the greater the reallocation of insurance costs. This would have the effect of producing what is called "social equity."

The principle of social equity, as opposed to actuarial equity, maintains that a rate is equitable only if it is affordable to people who need insurance. The principle of actuarial equity, favored by the insurance industry, maintains that a rate is equitable if it reflects the expected loss and expense characteristics of the insured. Under the current provider classification system premiums actuarially reflect the expected loss frequency and severity of each class of provider. If a system of cost shifting were developed, premium distribution would be less actuarially equitable but more socially equitable since the costs of insurance would be distributed over a larger but less homogeneous group of exposure units. Under such a system class relativities would still be used but to a much smaller extent depending on the number of classes contained in the classification system. Pooling all risks into one large group would effectively eliminate all class relativities as there would only be one base rate applicable to all physicians and surgeons regardless of the area of specialization.

The disadvantage of this type of system is that while it may promote social equity, especially for high risk specialists, it increases the insurance costs of all other providers who do not perform high risk procedures and who, therefore, receive lower fees for their services. Those who favor the idea of social equity would argue that the lower risk specialists should help share the insurance costs of the high risk specialists because the low risk specialists refer high risk medical procedures to the other specialists and, therefore, should share in the responsibility of each patient's treatment. However, increasing the insurance costs of low risk specialists may lead to increased fees charged for low risk medical procedures. The costs of insurance may not only be shifted from the high risk specialists to the lower risk specialists but more realistically from the high risk patients to the lower risk patients. Ultimately, increased cost shifting may lead to increased fees for primary care services as these costs get passed along to the consumer.

One might question whether cost shifting by means of a risk class compression plan would really achieve the goal of social equity. Some already argue that the high risk specialists can well afford the premiums they are currently being charged for their professional liability coverage. In fact, cost shifting may create a greater financial hardship for the lower risk specialists than that which is currently being faced by the high risk specialists. In the final analysis, cost shifting may actually make medical malpractice insurance less affordable for a larger group of individuals. If malpractice insurance becomes so unaffordable for the low risk providers that they can no longer afford to stay in practice, the citizens of Virginia may become faced with a more serious problem... a scarcity of doctors at the primary care level.

The other major disadvantage of shifting the costs of medical malpractice insurance from the high risk specialists to the lower risk specialists is the problem of adverse selection. Adverse selection occurs when applicants for insurance are primarily those most likely to suffer a loss rather than a true random sample of the population. If all physicians and surgeons paid the same premium, the lower risk specialists would seek coverage at lower rates through non-admitted carriers or through self-insured specialty organizations. This would lead to adverse selection since insurers would only be left with the high risk specialists. In order to avoid adverse selection the voluntary market would attempt to insure only the lower risk specialists at a competitive rate, leaving the high risk specialists to seek coverage through the Joint Underwriting Association. Rather than reducing the insurance costs of the high risk specialists, the result would be even higher rates for those same individuals.

One final concern is the effect that cost shifting or cost sharing may have on cost control. If the costs of malpractice insurance are transferred from the high risk specialists to the lower risk specialists, there may be less incentive to control costs. Cost control measures may become diminished as the responsibility for one's performance becomes diminished. Requiring lower risk specialists to help share the costs of the high risk specialists without giving them the authority to control those costs may lead to even greater premiums for physicians' and surgeons' malpractice insurance in the future.

Despite the disadvantages previously mentioned, shifting the insurance costs among the various medical specialties would guard against the possibility of losing qualified physicians and surgeons who might choose to leave their area of specialization because of the high costs of insurance. It would also help encourage doctors entering the medical profession to pursue the high risk specialty areas and not be discouraged from entering their chosen

specialty because of the high costs of insurance associated with that specialty. Even though there appears to be an increase in the number of physicians and surgeons practicing in Virginia every year, there is no way to determine whether the number practicing in a given area of specialization is increasing or decreasing. If this information could be made available by the Department of Health Regulatory Boards, it would be a very useful tool in determining whether the citizens of Virginia were experiencing a shortage of physicians in certain specialty areas.

Even though there are certain advantages in establishing a method of premium distribution among the various medical specialties, the disadvantages would seem to outweigh any benefits that may be gained by reducing or compressing the classification system currently being used by medical malpractice insurance writers in Virginia. A class compression plan could create a greater financial hardship for a larger number of individuals, promote unfairly discriminatory rates among the various classes of providers, promote adverse selection, and reduce cost control measures. The final outcome may be the reduction rather than an expansion of affordable medical malpractice insurance in Virginia.

## RECOMMENDATIONS

Based on the findings contained in this report, the State Corporation Commission does not recommend establishing a method of cost allocation (i.e., a risk class compression plan) whereby the insurance costs attributable to the high risk specialists are distributed among the lower risk spcialists. The State Corporation Commission makes the following recommendations.

1. Revise Section 38.2-2228 of the Code of Virginia by requiring the following additional information on medical malpractice claims to be reported to the Bureau of Insurance:

   a. the date the loss occurred;
   b. the date the claim was reported to the company;
   c. the date and the amount of the initial reserve;
   d. the reserve valued at the end of the current calendar year;
   e. a differentiation between the amount of settlement or judgment and the amount actually paid by the insurer (for cases where the settlement or judgment exceeds the insurer's limits of liability);
   f. a breakdown between the amounts paid and the amounts reserved for attorney's fees and other expenses to the extent these amounts are known;
   g. data on all opened and closed claims (current law only requires closed claim data to be reported); and
   h. the date the claim was closed.

2. Establish a system of revising the individual claim reports required by Section 38.2-2228 so that up-to-date information can be maintained without creating duplicate reports.

3. Encourage the Department of Health Regulatory Boards to require all physicians and surgeons to report their medical specialty at the time their license is renewed.

Appendix H contains proposed Code language which could be incorporated into Section 38.2-2228 to effect the changes recommended in this report.

## CONCLUSION

The State Corporation Commission's Bureau of Insurance was asked to study medical malpractice insurance and the feasibility and desirability of establishing a method of premium distribution among the various medical malpractice rate categories. Although a system of premium distribution could be established by means of a risk class compression plan (compressing the current 8-10 class provider classification system into fewer classes), neither the medical profession nor the insurance industry appear to support adopting such a proposal. The State Corporation Commission has recommended several changes to Section 38.2-2228, including a requirement that all medical malpractice claims (not just closed claims) be reported to the Bureau of Insurance on an annual basis. The continued collection of medical malpractice claim reports will enable the Bureau of Insurance to track the frequency and severity of medical malpractice claims in Virginia. The proposed changes will provide the Bureau of Insurance with the additional data to monitor claim development trends and claim reserving practices.

# APPENDICES

## APPENDIX A

### Patients' Compensation Funds

State: Colorado
Code Cite: 10-4-801
Description: The Medical Liability Extraordinary Loss Fund is to be created by the Commissioner when the cost of medical malpractice insurance on the open market is so unreasonably high as to be practically unavailable, or coverage is unavailable. The fund would pay awards over $100,000. It is funded by a surcharge on health care providers.

State: Florida
Code Cite: New 1988 Statute (effective January 1989)
Description: The new statute creates a no-fault pool to provide unlimited life-time medical expenses and limited wage loss replacement for infants who suffer serious birth-related neurological injuries as a result of a physician's negligence.

State: Illinois
Code Cite: I.C. Section 700
Description: The Patients' Compensation Fund pays medical malpractice awards over $100,000 (or as set by the board, but never over $500,000). The fund operates when the Director of the Illinois Department of Insurance finds medical malpractice insurance is not available in the voluntary market to cover amounts over $100,000. The fund will not be activated unless the Director and seven members of the board (out of eleven) certify that activation of the fund is necessary.

State: Indiana
Code Cite: 16-9.5-1-1
Description: A Patients' Compensation Fund is created by an annual surcharge on all health care providers in Indiana. The Commissioner of Insurance administers the fund and pays claims over $100,000.

State: Kansas
Code Cite: 40-3401
Description: The Health Care Stabilization Fund is established for the purpose of paying damages for medical malpractice claims. Condition for participation by health care providers is maintenance of basic coverage for $200,000 of liability and payment of a premium surcharge.

State: Nebraska
Code Cite: 44-2829
Description: The Excess Liability Fund pays medical malpractice claims in excess of $100,000 against health care providers. The fund is held by the state treasurer in trust, funds coming from a surcharge levied on all health care providers in Nebraska.

State: North Carolina
Code Cite: 58-254.19
Description: The North Carolina Health Care Excess Liability Fund pays the amount of the award, settlement or judgment which is in excess of the health care provider's insurance (which must be at least $100,000) up to a limit of $2,000,000.

State: Oregon
Code Cite: 752.090
Description: The Medical Excess Liability Fund will pay amounts above the coverage required by law for each type of provider. If the amount in the fund is insufficient to pay all claims, each claimant will get a pro-rata share of the fund. The funds are contributed by physicians who wish to limit their liability.

State: Pennsylvania
Code Cite: 40-85-701
Description: The Medical Professional Liability Catastrophic Loss Fund is a contingency fund to pay awards, judgments and settlements in excess of health care providers' basic coverage. The upper limit is $1,000,000 for each occurrence. The fund is administered by a director appointed by the governor. Funding comes from a surcharge against health care providers.

State: South Carolina
Code Cite: 38-79-420
Description: The South Carolina Patients' Compensation Fund pays settlements or judgments of over $100,000 for claims against health care providers. The providers participate by paying assessments.

State: Virginia
Code Cite: 38.2-5000
Description: The Virginia Birth-Related Neurological Injury Compensation Act provides compensation for injuries occurring in the course of labor and delivery. Suit may be filed against the doctor or hospital instead of seeking compensation from this fund. Financing is provided by assessments of physicians and hospitals.

State: Wisconsin
Code Cite: 655.27
Description: The Patients' Compensation Fund is established for the purpose of paying claims over $200,000. Payments made pursuant to awards or settlements that are designated for future medical expenses are paid into this fund and dispersed as needed until the patient dies.

State: Wyoming
Code Cite: 26-33-105
Description: The Medical Liability Compensation Account covers excess liability of health care providers for amounts over $50,000. Providers pay an assessment into the fund; the Commissioner may use some of the assessments to purchase reinsurance.

APPENDIX B

## AMERICAN INSURANCE ASSOCIATION

Response to Bureau of Insurance Survey
on Allocation of Medical Malpractice Insurance Costs

The American Insurance Association ("AIA") is a national trade association consisting of 183 property and casualty insurers. Collectively, our members write over $50.9 billion in premiums annually and have assets of $104 billion. In 1987, about 55% of the Virginia market for medical malpractice insurance (based on direct written premiums) was written by our members.

We appreciate this opportunity to participate in the survey being conducted by the Virginia Bureau of Insurance pursuant to House Joint Resolution No. 186. Based on our reading of the resolution and your July 19, 1988 letter, we understand that the principal purpose of the Bureau's study is to determine the feasibility and desirability of developing a method for distributing premiums among the various medical malpractice rate categories for physicians. These plans are frequently called premium allocation or rating class compression schemes, and for the purposes of our survey response, we use the shorthand reference "premium allocation" plans.

### Question 1 -- AIA Opposes Premium Allocation Schemes

The AIA opposes premium allocation schemes. We are gravely concerned that the implementation of such plans to

reduce artificially the true premium costs for some health care providers at the expense of others, regardless of their financi need, will seriously impair, and possibly destroy, the competitive medical professional liability insurance market that currently exists in Virginia.[1] In our view, state mandated rate cross-subsidization cannot effectively reduce premium costs for high risk practitioners unless the state preempts or severely curtails free competition by private insurers. To work, premium allocation plans would require the creation and promotion of a state-run medical malpractice insurance monopoly or the oppressive regulation of competition to avoid adverse risk selection problems and to prevent the exodus of low risk practitioners to non-admitted or alien insurers, who are free to charge actuarially-based, and therefore lower, rates.

The basic mechanism of premium allocation plans is tha lower risk practitioners be charged higher than actuarially-based premiums to subsidize lower than actuarially based premiums for higher risk practitioners regardless of their financial need.

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[1]Although the State Corporation Commission recently found that competition is not an effective regulator of rates charged for medical malpractice liability insurance in Virginia, 4 Virginia Register 2659 (Aug. 15, 1988), it is AIA's view that a competitive market exists for this line of insurance. The Bureau of Insurance's 1988 study of the competitiveness of selected lines of insurance revealed that in 1987 25 insurers reported writing medical professional liability in Virginia and that 11 of those companies were actively seeking new business. Such data stand in stark contrast to the availability problems many jurisdictions experienced in the mid-1970's and again in the mid-1980's. The adoption of a premium allocation plan could quickly destroy this competitive environment.

Most jurisdictions, including Virginia, have adopted the traditional standard for evaluating rates -- rates should not be excessive, inadequate or unfairly discriminatory. Va. Code § 38.2-1904 (Supp. 1988). Premium allocation schemes violate all three of these basic tenets because they ignore the correlation between the premiums charged each rating classification and their respective losses and expenses in order to generate a cross subsidy. Thus, the rates charged would be inadequate for the higher risk specialists, and excessive and unfairly discriminatory for the lower risk practitioners.

At least one other state task force has recently considered a premium allocation scheme and flatly rejected it as too costly and inequitable. We commend to the Bureau the November, 1987 findings and recommendations on this issue (excerpt attached) of the Florida Academic Task Force for Review of the Insurance and Tort Systems (the "Task Force"). The Task Force, established by the Florida Tort and Insurance Reform Act of 1986, consisted of the presidents of three major Florida universities and two businessmen with distinguished public service backgrounds. Graced with ample resources and access to experts in a wide range of disciplines, the Task Force studied a variety of medical malpractice reform proposals over an 18-month period and presented the governor with ten recommendations.

One of these ten recommendations was the rejection of any risk class compression plan requiring a state-operated or other mandatory insurance pool. The Task Force found that "such

approaches are unnecessarily costly and that they would provide an inequitable remedy for any genuine affordability problems caused by medical liability insurance." Florida Academic Task Force for Review of the Insurance and Tort Systems, Medical Malpractice Recommendations 48 (Nov. 6, 1987).

Premium allocation plans also raise important public policy questions about whether subsidies for all high risk specialists, regardless of genuine financial need, are justified. This point was explored by the Task Force, which pointed out that high risk physicians frequently earn high incomes and many of them may not need premium assistance financed at the expense of their lower risk colleagues and their patients. The Task Force stated: "Routine subsidization of physicians with high premiums, regardless of need or equity, would result in premiums for low risk physicians, and costs to their patients, that are higher than those actuarially sound and higher than those that are warranted by the genuine financial difficulties of a few high risk physicians." Id. at 49. Cross-subsidization of high risk practitioners regardless of financial need will drive many lower risk providers to seek coverage with non-admitted or alien insurers offering actuarially-based rates and undermine the licensed medical liability insurance market.

Aside from the inequities fostered by state mandated premium allocation schemes, such an approach could have a devastating and lasting impact on Virginia's market for medical professional liability insurance. Market economics will motivate

licensed insurers to write as many of the lower risk specialists as possible at the artificially higher rate and to avoid the higher risk specialists at the artificially lower rate unless the state intervenes and alters the operation of the private insurance market through harsh anticompetitive regulations. Consequently, the risk pool will be skewed and adverse selection problems will emerge that could drive insurers with a preponderance of high risk practitioners out of business because they would be compelled, by law, to collect an inadequate premium to cover their losses and expenses. Meanwhile, lower risk specialists will be turning to non-admitted or alien insurers, not subject to Virginia's rating laws, who are able to offer lower, actuarially-based rates. This exodus of lower risk providers would quickly strip the risk pool of the best risks and leave the least attractive high risk providers for the admitted Virginia insurers. As the Florida Task Force rightly concluded: "[A] state operated pool could effectively destroy any existing vitality and competitiveness in the private market for medical malpractice insurance in the state of Florida." Id. at 49. It is unlikely that many admitted carriers could survive in this environment for very long given these severe competitive disadvantages.

Unless the state concocted an elaborate risk allocation scheme so that every admitted insurer would have its fair share of the higher and lower risk practitioners (an administrative nightmare), Virginia would have to dismantle its private market

and install a monopolistic, state-operated medical malpractice facility in its place. Every health care provider practicing in Virginia, as a condition of licensure, would then be required to purchase insurance from this facility at the artificially adjusted rates. Not only does this alternative displace the private market and shift massive administrative burdens and expenses onto the State, but it raises the specter that the facility could generate future operating deficits and face solvency problems similar to those now confronting a number of medical malpractice JUA's across the country.

## Question 2 -- Alternative Methods of Cost Allocation

In considering alternatives to premium allocation schemes, we commend to the Bureau the analytical framework adopted by the Florida Task Force in analyzing redistribution of insurance costs proposals: (1) loss cost allocation should continue to be determined by the private sector in a competitive market subject to regulatory review; (2) risk class determination should be on an actuarially sound basis; (3) both public and private administrative costs should be minimized; and (4) health care provider loss costs should be borne by health care providers. Id. at 56.

The Florida Task Force rejected the use of general tax revenues to subsidize physicians with high malpractice premiums. Although the Task Force did not elaborate on this point, it seemed to be opposed to the use of tax dollars to subsidize

"high premium" physicians, who frequently have high incomes, regardless of their financial need.

To avoid this inequity, the Task Force devised a "Premium Impact Equity Plan" that preserves the private market for medical malpractice insurance and does not result in subsidies for the high risk physicians who really do not need it. Id. at 50-56 (excerpt attached). Briefly, this plan would provide eligible full-time physicians with a subsidy if that health care provider's medical malpractice premiums exceeded a specified percentage of gross revenues and the physician's net income from the practice of medicine were less than a specified threshold amount. No adjustments to the actuarially justified rates for each rating classification would be necessary. Funding for this program would be derived from a direct pass-through premium surcharge on all physician medical malpractice insurance policies. Thus, these subsidies would be financed entirely by health care providers.[2]

## Question 3 -- Additional Comments

The AIA is in the process of reviewing and preparing a rebuttal to the many inaccuracies underlying Delegate Bernard Cohen's tract entitled "The Truth about Insurance Company Losses." If this piece will be included in the Bureau's report as an "official position paper," we respectfully request that the

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[2]As an historical note, the Florida Legislature declined to enact a Premium Impact Equity Plan during the 1988 session.

record in this matter be held open so that we may submit an appropriate response by the beginning of September.

As the Bureau analyzes information gathered pursuant to House Joint Resolution No. 186, we urge you to consider the contributions the other major groups can make to stabilize the medical malpractice situation in Virginia. Health care providers should be encouraged to improve and promote peer review, risk management, professional discipline, provider/patient communication, and continuing medical education. Attorneys should be encouraged to refrain from filing frivolous medical malpractice actions and to participate in continuing legal education programs aimed at sharpening their ability to assess the merits of highly complex and emotionally-charged medical malpractice cases. And health care consumers need to be educated about the limits of modern medical care and the civil justice system to compensate for less than perfect results.

The AIA appreciates this opportunity to participate in the Bureau's survey and to offer these comments on premium allocation plans. We stand ready to assist you in any way possible, whether it be providing data on the insurance industry or our analysis of the proposals that may evolve from your work. The Bureau's work is extremely important and deserves the complete cooperation of all interested parties to ensure the continued availability and affordability of medical professional liability insurance, in general, and coverage for high risk

health care providers in Virginia, in particular. Please do not hesitate to call on Taylor Cosby, AIA's Mid-Atlantic Regional Vice President (202) 828-7196, or Jim Roberts, Esquire, our Virginia legislative counsel (804) 697-1200, at any time.

RSG/wp/275
(8/19/88)

# ACADEMIC TASK FORCE FOR REVIEW OF THE INSURANCE AND TORT SYSTEMS

## MEDICAL MALPRACTICE RECOMMENDATIONS

November 6, 1987

## SUMMARY OF RECOMMENDATIONS

*  *  *

9. The Task Force recommends rejection of any risk class compression plan requiring a state operated (or other mandatory) insurance pool.

## III. REDISTRIBUTION OF INSURANCE COSTS

The research conducted by the Task Force and reported in the Preliminary Fact Finding Report on Medical Malpractice established that, in some cases, escalating medical malpractice liability insurance premiums "... represent an increasing financial burden to physicians, with significant variation seen between medical specialties." Moreover, there may be a diminished opportunity for physicians to pass on higher business costs with the result that malpractice liability insurance has become "functionally unavailable" for some physicians in the state. As a result, some physicians have responded in ways that have resulted in either the complete or partial withdrawal of needed medical services. The Task Force recommends the Premium Impact Equity Plan, outlined in this section, to provide immediate relief for those physicians who can demonstrate that malpractice premiums are causing special financial difficulties.

### A. Risk Class Compression Plans: A Negative Recommendation

Most proposals to provide physicians with rate relief, including the three proposals discussed in the Discussion Draft on Medical Malpractice Reform Alternatives, involve risk class compression as a means to bring down the premiums for the highest risk classes. The Task Force believes that such approaches are unnecessarily costly and that they would provide an inequitable remedy for any genuine affordability problems caused by medical liability insurance.

Mandatory risk class compression plans would require charging low risk physicians more than actuarially sound premiums in order to subsidize lower than actuarially sound premiums for high risk practitioners. Often these high risk practitioners also earn high incomes, and the Task Force believes that subsidies for high income physicians are not justified. Routine subsidization of physicians with high premiums, regardless of need or equity, would result in premiums for low risk physicians, and costs to their patients, that are higher than those actuarially sound and higher than those that are warranted by the genuine financial difficulties of a few high risk physicians.

Mandatory risk class compression proposals would also require increased state intrusion into the operation of the private insurance market. One prominent proposal would establish a state operated insurance pool to provide the mandatory first layer of malpractice liability insurance. The Task Force believes that such a state operated pool could effectively destroy any existing vitality and competitiveness in the private market for medical malpractice insurance in the state of Florida. Neither the market that would exist for private insurance to provide excess coverage above the limits offered by the state pool nor the prospect that the state operated pool would be a temporary measure is enough, in the opinion of the Task Force, to prevent a state mandated pool from severely impairing the private market in Florida.

For these reasons, the Task Force recommends against any state mandated risk class compression plan.

## B. Subsidization With General Tax Revenues: A Negative Recommendation

Other proposals that have been advanced, and which were considered in the Discussion Draft, would use general tax revenues to subsidize physicians with high malpractice premiums. The Task Force opposes using general state revenues to subsidize malpractice premiums, particularly those of physicians who may be "high premium," but also high income, physicians.

## C. The Premium Impact Equity Plan

Instead of a risk class compression plan or subsidization using general state revenues, the Task Force recommends adoption of the "Premium Impact Equity Plan". This plan avoids the pitfalls of subsidizing many high risk physicians who really do not need subsidies and also does not damage the private market for medical liability insurance in Florida. At the same time, it is a cost effective method to provide immediate relief to those high premium physicians experiencing genuine financial difficulties during the next several years, as the other reforms outlined in these recommendations have time to begin to control loss payments and to provide greater efficiencies in the tort system.

This plan would provide selective relief to physicians who affirmatively establish that their medical malpractice liability insurance premiums represent a financial burden. The plan would be financed and effectively controlled by physicians and would sunset at the end of five years.

1. Eligibility

The Premium Impact Equity Plan is designed to provide financial relief to any full-time physician who affirmatively demonstrates the following:

(1) The physician's medical malpractice premiums exceed a specified percentage of gross revenues, e.g., fifteen percent of gross revenues;

(2) The physician's net income from the practice of medicine is less than a specified amount, e.g., $75,000.

(3) The physician is not being charged a higher malpractice premium because of a surcharge resulting from past medical malpractice paid claims, past disciplinary proceedings or other factors suggesting that he or she as an individual is a "bad risk."

The fifteen percent of gross revenues threshold and the $75,000 of net income threshold are included for illustrative purposes only. Further analyses of these levels and the amount of revenue available to fund this program are necessary before final threshold numbers can be established.

The threshold criteria permit equity payments to be made to physicians in all specialties in all parts of the state. Thus, a general practitioner in a northern, rural part of the state and a neurosurgeon in South Florida both may be eligible. This feature is not present in a risk class compression plan. The latter simply reduces premiums for high risk classes and makes up the

lost revenue by increasing the premiums for lower risk classes. Risk compression plans are both over inclusive and under inclusive: they provide rate relief to physicians who do not need it and may exclude financially burdened physicians.

Eligibility under this plan also is restricted to those physicians whose current malpractice premium does not include a surcharge for claims experience, past disciplinary proceedings or other factors suggesting that he or she individually (as opposed to practicing in a high risk specialty) is a "bad risk." To subsidize surcharges resulting from medical negligence would contradict other aspects of this overall plan.

Only full-time practitioners would be eligible under this plan. For example, physicians who are beginning to retire by gradually reducing the size and extent of their practice to a part-time basis would not be eligible. The burden of proof to establish full-time practice would fall upon the physician.

2. Benefits

Eligible physicians would be entitled to request a premium impact equity payment in an amount sufficient to bring the percentage of gross practice revenue represented by the malpractice premium down to the threshold figure. In the example above, a physician whose malpractice premium was 19 percent of gross revenue and whose net income was less than $75,000 would be entitled to an amount equal to 4 percent of gross revenues. If such an amount would increase net income above the trigger point (in this case $75,000), then the physician would only be entitled

to the benefits necessary to bring his or her net income up to $75,000.

3. Financing

This program would not involve existing state revenues and would be funded by a tax on medical malpractice liability insurance premiums. All types of insuring organizations which provide medical malpractice liability insurance for physicians would be subject to the levy. This would include, but is not necessarily limited to, commercial insurers, the Florida Medical Malpractice Joint Underwriting Association, self-insurers, and risk retention groups.

Medical malpractice premiums in Florida for the year 1987 are roughly $300 million dollars. Although the portion paid by physicians is unknown because the figure includes amounts for nurses, chiropractors and other groups not included in this plan, the bulk of these premium dollars is probably paid by physicians. If physicians' premiums totaled $250,000,000, then each percentage point of a tax would generate $2,500,000 for the program. The amount of funds needed to finance the plan would depend upon the benefits provided. Physicians would play a prominent role in the administration of the program, as described below, and would have considerable discretion in determining the eligibility limits for both the net income threshold and the premium percentage threshold.

The surcharge on premiums would be collected by each insuring organization and remitted directly to the agency in charge of physician supervision and regulation. The funds would

be maintained in a separate account and would not be available for any purposes other than the disbursement of equity payments and the administration of the program.

In the event of a deficit, general revenues would be used temporarily to cover the shortfall. In determining the premium tax for the following year, however, the plan would collect sufficient funds to provide current year equity payments and to reimburse general revenues for the amount of the previous year's deficit plus interest.

4. Management

This program would be managed by the state agency responsible for the supervision and regulation of physicians. As discussed previously, this agency would be managed by a board consisting of physicians elected by Florida physicians and approved by the Governor, and public members appointed by the Governor.

The Board or its designee would determine the eligibility of a physician applying for equity payments. Because eligibility is measured against specific quantifiable standards, the possibility for dispute as to eligibility is reduced. The burden would be on the physician to establish eligibility under all criteria by clear and convincing evidence. Submission of federal tax returns for the previous year would be required. This review of the physician's affairs is warranted by the physician's voluntary decision to apply for a premium equity payment. Physicians are not required to disclose income data unless they choose to apply

for the equity payment. Any income or losses not attributable to the practice of medicine would be excluded in the determination of eligibility.

The Board should periodically review the eligibility limits.

5. Termination of the Program

The Task Force recommends that the Legislature review this program five years after adoption to determine the need for continuing the program. As the other reforms contained in this package control future loss payments, future malpractice premium increases should be reduced and premiums as a percentage of physician gross revenues should stabilize and possibly decline. In addition, as noted in the Preliminary Fact-Finding Report on Medical Malpractice, the dramatic acceleration in increases for medical malpractice premiums was a contributing factor to Florida's malpractice problems. Because the premium increases occurred so quickly, some physicians may not have been able to pass these increased costs immediately through to patients. It is likely that in the years ahead physician net income will continue to increase, thereby reducing the need for this program.

6. Summary

The Task Force believes that some temporary redistribution of the costs of medical malpractice liability insurance is desirable in order to ensure the continued delivery of needed medical services in the state of Florida and to encourage physicians to continue to practice in critical high risk specialties. This redistribution should be based upon the

following principles: a) administrative costs (both private and public) should be minimized, b) loss cost allocation should continue to be determined by the private sector in a competitive market subject to regulatory review, c) risk class determination should be on an actuarially sound basis and d) physician malpractice loss costs should be borne by physicians.

Based upon the above-stated goals, the Task Force recommends the adoption of the "Premium Impact Equity Plan". Unlike general risk class compression plans, the equity plan targets premium relief to financially burdened physicians in any part of the state and in any medical specialty. The cost of this program is appropriately borne by physicians rather than shifted to some other group.

While shifting a portion of physician malpractice costs to hospitals would probably result in desirable loss control incentives, the Task Force is concerned about the ability of hospitals to absorb such increased costs. Finally, general cost shifting of physicians malpractice costs to the citizens of Florida, either through the Medical Malpractice Joint Underwriting Association or through general taxation, would be an unnecessary subsidy of all high risk physicians, including ones that do not need it, by all the residents of Florida regardless of financial circumstances.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA 46885

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July 28, 1988

JoAnne Goodman Scott
Principal Research Analyst
Bureau of Insurance
State Corporation Commission
P. O. Box 1157
Richmond, Virginia 23209

Dear Ms. Scott:

Our response to the questions asked in your letter of July 19 will be found on an enclosed paper. You may consider this to be our official position, and you may include it in your report if you wish.

Yours very truly,

Michael S. Mullen
President

MSM:ag
Enclosure

1. The Medical Protective Company would not be in favor of requiring the cost of medical malpractice insurance attributable to high risk specialists to be allocated evenly to all practitioners in the state.

While this approach seems laudable to the high risk specialist, it appears quite different to a doctor in a low insurance risk specialty. The result of making a requirement of this nature is to force the doctors in the low risk specialties to secure their insurance through their national specialty organizations and, thereby, to maintain a far lower rate. The broad spectrum insurers, such as The Medical Protective Company, must then respond by insuring only low risk practitioners so as to have a premium competitive with that the specialty programs would develop. Consequently, the high risk specialist would quickly find no source of insurance available other than the Joint Underwriting Association at rates which would be extremely high, considering the top-heavy population of the JUA at that time. Rather than reducing the cost to the high risk specialist, the result would be far higher rates for those same individuals.

If the alternative requirement is made that all insurers must charge a rate dictated by the Bureau of Insurance, the state would be following the devastating example of Massachusetts where every insurer immediately left the state, and the JUA became the sole source of insurance for doctors. The JUA in Massachusetts has accumulated a deficit of about three-quarters of a billion dollars by this time.

2. Requiring some type of "cost allocation" for high insurance risk physicians presumes that society requires the services of these individuals, and so it does. The appropriate method of subsidization is not as obvious, however. Some efforts have been made in various locations to subsidize these doctors through payments of their insurance premiums by the hospitals or clinics where the doctors work. One county in Maryland has recently announced its plan to indemnify doctors who provide delivery services to indigent women. A broader application of this principle might be investigated. A more feasible approach might be to subsidize these doctors by contributions from the general fund of the state by establishing a patient's compensation fund which would pay all awards or settlements over a specific amount, perhaps $100,000. Although this would apply to all physicians, regardless of specialty, the vast majority of such cases would involve the high risk specialists and, thereby, would grant them considerable relief inasmuch as they would be required to fund no more than the primary $100,000 limit policy. At the same time, establishing such a fund would establish the position of the Commonwealth as a direct supporter of services needed by its citizens.

3. The Medical Protective Company would support the establishment of a patient's compensation fund in Virginia to alleviate the financial burden on physicians and to aid in moderating the medical malpractice problem.

NATIONAL INSURANCE
CONSUMER ORGANIZATION

August 17, 1988



Ms. JoAnne Goodman Scott
Principal Research Analyst
Bureau of Insurance
State Corporation Commission
P.O. Box 1157
Richmond, VA 23209

Dear Ms. Scott:

This is in response to the letter of July 19, 1988 from Mr. Kaufmann asking my opinion on two questions about medical malpractice insurance.

The answer to the first question is No. I am not in favor of requiring costs to be allocated evenly to all practitioners.

The answer to the second question is Yes. I would be in favor of a method of cost allocation for high risk specialists.

For further clarification of these answers, I am enclosing a copy of my comments to the Governor's Task Force on Medical Malpractice Insurance of the state of Colorado that was given in Denver on December 11, 1987.

Thank you for the opportunity to express my opinion.

Sincerely,

J. Robert Hunter,
President

121 N. Payne Street
Alexandria, Virginia 22314
(703) 549-8050

**Comments of J. Robert Hunter, President,
National Insurance Consumer Organization
before the Governor's Task Force
on Medical Malpractice Insurance**

**State of Colorado**

**Denver, December 11, 1987**

1. The Medical Malpractice "Crisis" in Colorado is NOT Due to an Expensive Aggregate System Cost.

If you look at the total costs of the Medical Malpractice system in Colorado it is an inexpensive system. For example, the latest available data from the National Association of Insurance Commissioners (NAIC) shows total premiums in Colorado of $20.8 million during 1985. That's $6.50 per person (The Statistical Abstract of the United States shows 3.2 million people in Colorado in 1984).

For perspective, the average American spends $133 per year on tobacco products.

Another way to look at system cost is vis-a-vis total medical costs in the state. According to the Colorado Department of Health, Colorado spent $1,536 per capita on health care in 1986. Thus, even if you capped medical malpractice awards at zero, you would only lower the state's health care costs by 0.4% ($6.50 divided by $1,536). I dare say that if you had no system to compensate the victims of malpractice and someone offered to do it for you for a percentage this small, you'd probably grab it.

2. Allocation is the Problem.

The problem is cost allocation, not total system costs.

There are about 6,000 doctors in Colorado (Statistical Abstract, 1986). This drives the cost high, to about $3,500 per doctor on average, some of which is positive because of deterrence effects, but some of which may be inappropriate.

If you think of the medical profession as a pyramid, with the relatively many G.P.'s at the bottom and the relatively few specialists at the top, I think the problem becomes easier to visualize.

If I wake up in the morning with a bad back and go to my G.P., the likelihood of a major malpractice suit arising is negligible. But if my back is a serious medical problem, I will be referred up the specialty ladder until I get to the neurosurgeon. COPIC insures only 233 of these of their 3,744 insureds as of 9/30/87.

At the top of the pyramid, where the number of insureds is least, the risk is greatest. Bad outcomes become more likely. The chance of lawsuit rises, and the cases are much more complex.

I believe it violates insurance spread-of-risk principles to force so much through such a narrow base. (Even though neurosurgeons net income, after med mal premiums, is excellent -- see attached).

For one thing, why should the defense costs for the complex suits neurosurgeons <u>win</u> be forced to be spread through only the neurosurgeons? Why shouldn't the referring physician and the hospital granting privileges bear some of the cost of successful suits (as incentives for safer referrals/privilege granting)?

The overall system cost is reasonable in your state. Your

focus should be on the allocation process, in my estimation.

3. COPIC Rate Filing

I have reviewed the October 1, 1987 rate filing for COPIC Insurance Company as well as the September 14, 1987 Actuarial Rate Review of Victor Schinnerer and Co., Inc. and the Company's Annual Statement and Insurance Expense Exhibit.

a) Allocation

COPIC proposes to reclassify family practice doctors doing OB from rating class 3 to 3A, which gives them a 50% increase in price over any general rate level adopted. There is no statistical justification presented in the rate filing to back up this decision.

COPIC recognizes the serious impact of this decision. In an October 3, 1987 document, COPIC says that "We believe, and have been advised by many rural family medicine physicians, that they will be forced to stop delivering babies."

The detailed statistical support of their decision, including the impact of the major tort law change recently enacted in Colorado, should be obtained before the insurance commissioner acts of the rate filing, in my opinion.

b) Rate Level

I agree with Mr. Schinnerer's comments that this filing is "the most conservative posture on all matters of premium level" (p. 18). Indeed, there are several areas that need full exploration in the rate hearing next week, viz:

Trend

As Mr. Schinnerer points out, a 15% trend is not documented

strongly but is to "be used to provide a higher level of assurance of rate adequacy." This means it is a high trend.

The trend is based on these data (See Exhibits 1 and 3 of the Rate Filing):

| Accident Year | Class 1 Exposure | Developed Losses (000) | Pure Premium |
|---|---|---|---|
| 1981 | 1,423 | $ 405 | $ 285 |
| 1982 | 6,848 | 6,883 | 998 |
| 1983 | 7,234 | 12,580 | 1,739 |
| 1984 | 7,528 | 12,900 | 1,714 |
| 1985 | 7,857 | 15,200 | 1,935 |

NOTE: The 1986 data, which should be available, were not filed. This is a very serious deficiency in this filing.

The filers, properly in my view, rejected the 1981 data as not mature. But they did use the 1982 data which is also appears not to be mature. The trend based on 1982-1985 indicated a 16% trend factor and the filer used 15%.

However, had they chosen to use the 1983-1985 expenses, the indicated trend would be 5.5%.

For sensitivity purposes, had a 5.5% trend been used in rate level (Exhibit 1), the overall rate change would have fallen from an indication of + 46.7% to + 0.7%. Thus, the whole rate revision is based on selecting trends that are not well documented. This is particularly concerning when the next item I discuss is considered.

Tort Law Changes Impact

COPIC factors in no explicit impact for the tort changes enacted in Colorado. This omission should be carefully studied. At least trends in loss costs should be impacted and lowered by

some factor to reflect these significant legal system changes.

Insurers tend not to reflect any law changes that diminish losses but do immediately factor in law changes which increase losses. St. Paul in Florida quantified the tort changes in that state as negligible, for example, where forced to price them (see attached). For COPIC (as for St. Paul in their April 24, 1987 rate filing) the law changes are simply ignored.

Profit

The filing in no way measures the overall, total return of COPIC. In fact, it ignores the significant investment income available from reserve investment. This is a major omission, in my estimation.

The National Association of Insurance Commissioners has adopted a resolution calling for Total Return ratemaking in regulated insurance cases.

Economists in current contested insurance rate cases are allowing approximately 13% for post-tax returns on surplus. COPIC's approximate premium to surplus ratio of 2 to 1 is acceptable as the leverage in most rates cases for liability insurance. In other words, it does not need excess earnings to build surplus -- it has sufficient surplus.

The post-tax investment income of COPIC, related to mean surplus is, according to their 1986 Annual Statement, 27.5% (investment income of $1.0 million plus realized gains of $0.8 million less federal tax of $0.6 million divided by surplus of $4.4 million -- the year end surplus is $5.4 million and the year start surplus was $3.3 million).

The Rate Filing implies continuation of this level of earnings. The underwriting profit needed to produce a reasonable overall return maybe of the order of -10% to -15%. Full fledged analyses of this filing, including cash flow analysis, is needed to determine the precise level of profit required for COPIC. Another approach which might be considered is to discount reserves to present value based upon COPIC's claims payout patterns.

This item alone would lower the otherwise indicated rate by at least 10%, I believe.

Loss Development

Loss development is a very important issue in most contested rate cases. Schinnerer makes an important point, that there is a "substantial upward shift in case reserve development" (p. 9) based on "a change in the case reserve policy of COPIC" (p. 10). This puts reserves on "a more realistic plateau." (p. 10) He is worried enough about loss development to say that they should be "regularly monitored." (p. 11)

If reserves are strengthened, as it appears they have been here, then there is a possibility that loss development based on strengthened reserves, applied to incurred losses also based upon strengthened reserves, will produce a pyramid effect and overstate losses.

Data is needed to properly explore this issue. These data are not currently available, to my knowledge.

## Expenses

### Overhead

According to COPIC's 1986 Insurance Expense Exhibit, expenses other than loss adjustment expenses totaled 19.7%, yet they have asked for expenses of 23.8% for Class 1. This should be explored in the rate case.

### Loss Adjustment Expense

According to the Schinnerer report, Page 15 and 16, paid loss adjustment expense is averaging about three-quarters of paid indemnities. This remarkably high and should be explored.

## Other Issues

Much of what is in the rate filing is unexplained or no justification is presented. For example, the class relativity experience is not shown, yet the rate filing proposes certain classification changes. The increased limits experience is not displayed, neither is the basis for revising the reporting form year factors, nor the basis of a 3% load for premium waiver. All of these should be obtained by the Commissioner in his review of the filing.

The Schinnerer report calls the reporting form year factors "excessive" (p. 5), yet the rate filing increases them (Exhibit 7). This must be studied.

Increased limits is reviewed in the Schinnerer document (p. 7), but he calls the old factor "historically supported." There is no real increased limits review undertaken in the filing, so it is currently impossible to say whether increased limits factors should be changed or in which direction. All things

equal, tort reform should lower increased limits, but that is not factored into this part of the filing either.

Conclusion

It appears clear that an increase in prices as large as COPIC has requested is not fully justified. It is likely that COPIC rates should not be raised significantly at this time and it is possible that a small reduction in price might be in order. The filing should undergo intense scrutiny and the missing information sought, including more recent 1986 data, to determine what the overall price change should be.

VIRGINIA SOCIETY OF INTERNAL MEDICINE

August 22, 1988

Mr. Stephen J. Kaufmann
Deputy Commissioner
Regulatory Policy Division
State Corporation Commission
Bureau of Insurance
Box 1157
Richmond, Virginia 23209



Dear Mr. Kaufman:

I have thought at length about your questionnaire of July 20, 1988 concerning your study of medical malpractice insurance pursuant to the House Joint Resolution 186. You asked if members of the Virginia Society of Internal Medicine would be in favor of requiring the cost of medical malpractice insurance attributable to high risk specialists to be allocated evenly to all practitioners. I polled the members of our organization and found them to be uniformly and totally opposed to this proposal. You must understand that the physicians who have the highest malpractice liability premiums are also the physicians who earn most. A typical neurosurgeon might earn 2-3 times what an average internist would earn. Even obstetricians earn almost twice what an internist earns. The proposal you mentioned would only distort this inequity by making the lower paid internist pay part of the higher paid surgical subspecialist overhead. Also, the surgical subspecialist could lower their risk by spending more time with their patients, explaining their treatment in detail and helping their patients deal with their fears and apprehensions. One reason the surgeon's malpractice premiums are so high is that some surgeons spend little time talking to the patient and much time doing their procedures which are highly paid. Our society is trying to help this situation by encouraging insurance companies and Medicare to pay more for time spent with the patient and less for the procedures done to the patient.

I fear that if malpractice cost of the higher earning physicians were shifted to the primary care physicians we would have difficulty recruiting family physicians for our rural areas as we would lose them to adjacent states that did not penalize them in this way. My society believes that the AMA's proposal

P.O. BOX 7157 FALLS CHURCH, VIRGINIA 22046 703-538-4204

last January represent a more responsible approach to this problem. I am particularly proud of the AMA's Medical Liability Project as it is definitely one of the finer activities that organization has sponsored. I have enclosed a copy of the report. I have also enclosed a copy of a very informative article by one of the law professors here at the University of Virginia, Kenneth Abraham.

Thank you for allowing me to participate in your study.

Sincerely,

William F. Tompkins, III, M.D., President
Virginia Society of Internal Medicine

WFT/bsh
Enclosure

AMA/Specialty Society
Medical Liability Project

a coordinated effort by America's
physicians to address professional liability

Steering Committee

American Academy of Family Physicians
American Academy of Orthopaedic Surgeons
American College of Cardiology
American College of Obstetricians & Gynecologists
American College of Physicians
American College of Radiology
American College of Surgeons
American Medical Association
American Society of Anesthesiologists
American Society of Internal Medicine
American Society of Plastic & Reconstructive Surgeons
Council of Medical Specialty Societies
Society of Thoracic Surgeons

American Academy of Dermatology
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology—Head & Neck Surgery
American Academy of Pediatrics
American Association for Thoracic Surgery
American Association of Neurological Surgeons
American Association of Plastic Surgeons
American College of Emergency Physicians
American College of Gastroenterology
American Psychiatric Association
American Society of Clinical Pathologists
American Society of Cytology
American Urological Association
College of American Pathologists
Congress of Neurological Surgeons
Joint Commission for the Accreditation of Hospitals
Society of Abdominal Radiology
Society of Nuclear Medicine
Society of Vascular Surgery

**For Release January 13, 1988 at 11:00am**

**MEDICAL GROUPS OFFER PROPOSAL TO RESOLVE MALPRACTICE CRISIS**

**For further information, see attached list of Medical Association Representatives**

**Washington, D.C. — A radical proposal to resolve medical malpractice claims fairer and more efficiently was unveiled today by the American Medical Association and 32 national medical specialty organizations (The AMA/Specialty Society Medical Liability Project).**

**The proposal calls for a fault-based administrative system, under the jurisdiction of strengthened state medical boards or a new state agency, which would totally replace the existing court/jury system. It is proposed at this time only as one promising alternative to the tort system — an alternative that needs to be tested in one or more states before it can be proposed broadly as a solution to the continuing problem of medical professional liability.**

**"Organized medicine is not abandoning the court system or traditional tort reform, but we have an obligation to patients and physicians to experiment with different approaches to medical professional liability", says James S. Todd, M.D., Senior Deputy Executive Vice-President, speaking on behalf of the AMA/Specialty Society Medical Liability Project, an umbrella group which has been studying possible long-range solutions to the continuing medical malpractice problems.**

**"We have worked for over a year with a unique coalition of lawyers, physicians and public policy experts — inside and outside of organized medicine — to design what is above all a fair system — fair to the patient, the physician and the public. We believe that more patients injured by medical negligence will be compensated under this plan, but that fewer dollars will be spent on meritless claims and unnecessary transaction costs," Dr. Todd explains.**

North Dearborn • Chicago, Illinois 60610

The proposed system has three basic parts: (1) a claims resolution function; (2) a credentialling and disciplinary process; and (3) a codification of the legal elements of medical liability. All three aspects are to be administered by a revamped state medical board or a new state agency, whose members are appointed by the governor. Physician members would play an important role on the Board, but would not be in a majority.

1. The Claims Resolution Function

Rather than through a court action before a jury, complaints of medical malpractice will be presented to an expert administrative agency where an initial screening will be performed by experienced claims reviewers who have authority to examine medical records and to interview the parties. It is believed that most claims will be dismissed or settled at this stage. Also at this stage, and throughout the administrative process, lawyers from the agency's office of general counsel will be provided to any claimant who wishes such representation and at no cost. If the claim is not settled, it will be assigned to a hearing examiner with broad authority to conduct a full and prompt hearing on the merits of the claim. The hearing examiner's decision will be subject to review by the Board, which will have discretion to award fees and costs incurred in the appeal against the losing party.

Keith White, M.D., the American College of Obstetricians and Gynecologists' representative on the Steering Committee of the AMA/Specialty Society Medical Liability Project, states, "As the reviewers and examiners gain experience and expertise they should be better able than a jury to evaluate medical negligence claims and, for the first time, the decision-making process should be consistent in both liability determinations and the size of damage awards. The system also should be quicker than the current system and thereby save both plaintiffs and defendants the substantial expense incurred in litigating cases for years in a state court. Of equal significance, patients will be able to enter the system and obtain compensation without finding and paying for a lawyer themselves."

2. The Credentialling and Disciplinary Functions

All settlements and awards will be reported to the investigative branch of the agency for screening with other malpractice or disciplinary reports to determine if a pattern of substandard conduct exists. In addition, all health care entities will be required to conduct periodic physician performance credentialling and to report to the Board any conclusion that a physician's overall performance has been substandard. Insurers will be required to report cancellations and failures to renew for reasons related to competence. All of this information must be maintained in a clearinghouse accessible to those who conduct professional review activities, and certain credentialling

agencies, like hospitals, will be required to check with the clearinghouse on a regular basis. "Linking the claims process with the medical board's separate disciplinary system will enable the board to oversee more effectively physicians' performance," says Paul Nora, M.D., representing the American College of Surgeons.

3. The Legal Elements of Medical Liability

The rules governing standard of care based on custom and locality would be abolished in favor of a standard that focuses on whether the challenged actions fall within a range of reasonableness, to be determined by reference to the standards of a prudent and competent practitioner in the same or similar circumstances. A variety of factors would determine the range of reasonableness, including the expertise of and means available to the health care provider, the state of medical knowledge, the availability of facilities and access to transportation and communications facilities.

The liability standard would also be modified to allow recovery if the physician's negligence was a "contributing factor" in causing the injury, even if the physician was less than 50 percent at fault. The informed consent doctrine would be codified under the current "minority" rule which requires that the adequacy of the disclosure should be measured from the perspective of the reasonable patient. Non-economic damages (and punitive damages) would be capped at an amount that is tied to a percentage of the average annual wage in the state. Economic damages would be awarded under a series of guidelines designed to ensure that those damages represent a realistic "replacement cost." The rule of joint and several liability would be abolished so that defendants would be liable for damages only in proportion to their actual liability. In addition, any award of future damages, where the present value of such damages exceeds $250,000, would be made in accordance with a periodic payment schedule. Finally, damages generally would be reduced by collateral source payments.

"This is the first comprehensive proposal for a radically new system for compensating victims of medical negligence and reducing the incidence of substandard care" says Dr. Todd. "The Medical Liability Project invites discussion and debate of the proposal by all interested groups and hopes that some state will put the proposal to the test soon."

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(January 1988)

## SUMMARY OF PROPOSAL

The AMA/Specialty Society Medical Liability Project is proposing a comprehensive alternative administrative system for deciding medical liability disputes on the basis of fault and for improving the states' ability to monitor medical practices. Specifically, the Project proposes giving existing Medical Boards authority to resolve medical liability disputes under new rules while retaining and expanding their traditional authority to review medical practices. Alternatively, a state may wish to create a separate agency to resolve medical liability claims and to coordinate its activities with the existing Medical Board. The Project does not urge the adoption of its administrative system in all states at the same time. To the contrary, it proposes that the administrative system be considered and hopefully enacted in one, or perhaps a few, states to permit an evaluation of whether a radical alternative to the current system might be fairer to all parties, more efficient and capable of decreasing instances of medical negligence.

One important benefit to patients of the proposed system will be the provision by the Medical Board of free legal representation in every case in which the Board had made an initial determination that an injury may have been caused by medical negligence. A second important benefit is that physician performance will improve because of increased efforts by the Medical Board to enhance the quality of each physician's practice. A third benefit is that legal standards will be modified to make it easier for patients to recover some compensation whenever there is evidence of medical negligence.

One important benefit for physicians and their insurers will be enhanced predictability and consistency in awards. Physicians also will benefit from legal standards making it clear that there is no single correct treatment decision and that physicians are not guarantors of good outcomes. Finally, patients, health care providers, insurers and the public generally will benefit from a more efficient, and therefore less expensive, medical liability system for resolving disputes. The proposal is a balanced effort to respond to the crisis in health care caused by medical malpractice litigation. Unlike some proposals for reform, this proposal does not seek to advance the interests of any one group at the expense of others.

In presenting this fault-based administrative system, the medical profession is not abandoning other avenues of reform. Instead, it offers this proposal as an experimental approach that warrants serious scrutiny and debate about its feasibility by all concerned with medical care.

(January 1988)

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## Important Features of the Proposed Fault-Based Administrative System

The proposal has three key elements: First, it uses an administrative agency, as opposed to the courts, to decide medical liability cases. Second, it strengthens the administrative agency's authority to monitor medical practices. Third, it codifies the law of medical liability. Each of these elements contains features worthy of particular attention.

1. Medical Liability Adjudications By Agency

   - Patient with non-frivolous claim represented at no cost by counsel for the Medical Board
   - Expert and experienced triers of fact
   - Early dismissal of claims with no merit
   - Strong incentives for early settlements
   - Availability of neutral expert witness
   - All cases resolved within short time frame
   - Expert Board to provide clearer guidance on legal standards
   - Expert Board to ensure consistency in liability determinations and awards
   - Rule-making authority to provide guidance to health care providers

2. Performance Monitoring By Agency

   - Creation of a clearinghouse of information for all physicians
   - All medical liability determinations and settlements reported to clearinghouse
   - Periodic physician performance reviews conducted by hospitals for all physicians under modified JCAHO standards
   - Mandatory reports to clearinghouse of non-renewals and cancellations of insurance for non-class-based reasons
   - Obligations imposed upon all health care providers to report impaired providers to credentialing entities
   - Required periodic review of all clearinghouse information by insurers, credentialing entities and the Medical Board
   - Required physician participation in risk management/quality assurance programs

- o Required continuing medical education each year
- o Board authority to conduct on-site review when necessary to protect patient health or safety
- o Expanded Board authority to educate, rehabilitate and discipline physicians

3. Legal Elements of Medical Liability

- o All important legal standards codified
- o Use of the "prudent and competent practitioner" standard of care and consideration of the range of reasonable treatment options
- o Elimination of the 50 percent causation rule and adoption of a pure comparative fault system
- o Adoption of a patient-oriented informed consent rule
- o Tightening of expert witness qualifications to limit use of "hired gun"
- o Graduated cap on non-economic damages
- o Use of "replacement cost" as a guide to economic damages
- o Abolition of joint and several liability
- o Periodic payment for future damages in excess of $250,000
- o Offset of collateral source benefits

(January 1988)

#

# PRESS CONTACTS FOR MEDICAL LIABILITY DEMONSTRATION PROJECT

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(January 1983)

# Medical Liability Reform

## A Conceptual Framework

Kenneth S. Abraham, JD

IN THE past decade, proposals for the reform of medical liability law have proliferated. These proposals have in some cases merged with the movement for the general reform of tort law generated by the liability insurance crisis that struck broad areas of business and professional enterprise during 1985 and 1986. The result has been the development of a wide variety of approaches to liability reform. This is, therefore, a pivotal time in the history of medical liability reform; the debate over medical liability has now evolved beyond a focus on litigation technicalities and into a fundamental reexamination of basic options.

Different medical liability reforms, of course, would have different implications for a broad range of public policy considerations: health care providers' incentives, the quality of care provided, whether to rely more or less on governmental regulation of health care, systems of medical discipline, and the compensation of patients. For example, as liability is limited, more regulation of health care may be demanded, and as alternative sources of compensation become more available to patients, the use of lawsuits as a source of compensation may decline.

These issues of policy can best be debated when all parties have a sophisticated understanding of the nature of possible reforms. Because the conceptual foundations and interrelations of these reforms often have not been clear, however, productive debate sometimes has been impeded. In this article I attempt to clear some of the underbrush that obscures these foundations and to present a more understandable picture of the reform alternatives that are now on the scene.

Medical liability reform is essentially an exercise in choosing variables from a series of categories representing the different components of the system. The variables chosen then can be assembled into a single package that modifies existing law. There are five categories from which these variables must be selected: (1) the compensable event, (2) the measure of compensation, (3) the payment mechanism, (4) the forum used to resolve disputes, and (5) the method of implementing the new rights and responsibilities. Traditional medical malpractice law is just one of many possible combinations of variables from each category. Virtually every proposed and adopted reform of medical liability is simply a different combination of these variables. Because each of the five categories contains several variables, the range of reform alternatives is considerable.

From the University of Virginia School of Law, Charlottesville.
Reprint requests to University of Virginia School of Law, Charlottesville, VA 22901 (Mr Abraham).

### THE COMPENSABLE EVENT

The compensable event is the combination of medical treatment and resulting injury or disease that triggers a patient's right to compensation. The event may be based on malpractice, on the occurrence of a treatment-related injury even in the absence of malpractice, or on the occurrence of a defined loss regardless of whether it is related to malpractice or treatment. For convenience, I refer to these three different triggers as *fault*, *cause*, and *loss*.

#### Fault

A medical injury caused by malpractice is the compensable event embodied in traditional medical liability law. A bad medical outcome is not necessarily caused by malpractice. Rather, in theory, malpractice is defined as the failure to conform to an accepted medical standard of performance, although in practice there is often doubt that the jury is capable of understanding and applying such standards. Even without moving to a no-fault compensable event, the character of the fault standard might be altered by excluding the testimony of partisan experts, for example, or by requiring proof of gross negligence as a prerequisite to recovery of damages.

#### Cause

Instead of basing the right to compensation on the occurrence of a malpractice-related injury or disease, that right could be triggered whenever the patient suffers an iatrogenic injury or disease or some defined subset of these adverse outcomes. This is the so-called designated compensable event (DCE) system.[1] The birth-related neurologic injury compensation legislation enacted recently in both Florida and Virginia and the Federal Childhood Vaccine Injury Compensation Act are examples. "Medical no-fault" compensation proposals generally adopt these cause-based approaches.[2] By encompassing a range of compensable injuries far broader than those caused only by malpractice, this approach removes any fault inquiry from the compensation decision.

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logous

There are two other important implications, however, entailed in the cause-based approach to compensation. First, because iatrogenic injury is a far more inclusive notion than malpractice-related injury, cause-based compensation may radically expand the number of persons entitled to compensation. For example, one study estimated that only 17% of the potentially compensable events that occur in hospitals result in tort compensation.[3] A system that compensated close to 100% of these injuries would either raise the overall cost of providing compensation or require a reduction in the amount of compensation payable to any given patient.

Also, it is by no means clear that a cause-based standard can be easily applied in practice. Determining what "caused" a patient's injury or disease accounts for a considerable portion of the litigation costs of the current system; even if disputes over cause were resolved by panels of experts under a cause-based system, separating compensable, iatrogenic injuries from noncompensable, previously existing conditions and their natural progressions on a case-by-case basis could prove difficult and expensive.[4] A DCE system might avoid this problem, but unless the list of compensable events were sufficiently detailed to afford compensation for most iatrogenic injuries in the category in question, a right to sue for events not on the DCE list probably would have to be preserved. Whether this approach would obviate most lawsuits would depend on the percentage of events caused by malpractice it actually covered; the capacity of a DCE system to achieve this goal remains to be demonstrated.

### Loss

An even more broadly applicable set of compensable events can be defined by reference to specified losses without regard to cause.[5] This is the method adopted by health and disability insurance whether it is publicly or privately financed. Medical and hospitalization insurance cover specified expenses incurred for the provision of health care regardless of the cause of the condition requiring care. Similarly, disability insurance covers wages lost as a result of the inability to work regardless of the origin of that inability.

At present, a loss-based system of compensation composed of health and disability insurance operates parallel to malpractice liability. Patients who are entitled to malpractice recoveries may also receive benefits from their own insurance, though sometimes, by law or contractual agreement, payments from one source offset payments from the other. The loss-based system could be relied on more heavily or exclusively, however, if liability for malpractice were limited or abolished. This could be accomplished either by requiring the universal purchase or provision of private health and disability insurance or through expansion of the governmentally provided forms of social insurance for medical expenses (Medicare, Medicaid, veteran's benefits) and disability (Social Security Disability Insurance) that now create a "safety net" for those without the means to protect themselves against such losses.

## THE MEASURE OF COMPENSATION

The second important feature of any approach to medical liability is the measure of compensation available to those who suffer compensable events. In theory, the most generous compensation available is payable under the tort system's current rules. This generous measure, however, could be reduced in a variety of ways, whether the system continues to be based largely on fault or is expanded to encompass cause or loss as well.

### Full Tort Damages

A successful plaintiff in any tort liability suit, including those for medical malpractice, is entitled to recover compensation for all losses proximately caused by the defendant's actions. These losses normally include medical expenses and lost wages together with a sum that may vary a great deal from case to case to compensate for the conscious pain and suffering associated with these other losses. In effect, the tort system promises the plaintiff all losses if his or her suit succeeds, though the vast majority of suits are settled before trial for less than the amount the plaintiff claims.[6]

### Full Out-of-pocket Losses

An alternative measure of compensation would award no sum for pain and suffering but full compensation for actual expenses incurred in connection with the compensable event. If tort litigation remained the method of recovery and plaintiffs therefore continued to require legal services, however, denial of damages for pain and suffering would put plaintiffs at a disadvantage, for they would have no fund out of which to pay their attorneys' contingent fees without themselves suffering a net loss. The alternative methods of paying attorneys' fees discussed below might therefore be required. On the other hand, if the fault-based system were abolished, there would be much less need for legal services to recover cause- or loss-based compensation, and the abolition of damages for pain and suffering might prove less objectionable.

### Partial Out-of-pocket Losses

Most non-tort systems of compensation do not award even full out-of-pocket losses. Rather, they tend to contain copayment provisions—floors in the form of deductibles, ceilings on amounts payable, and coinsurance requirements. Copayment provisions are a means of limiting costs and creating incentives against overconsumption of benefits such as insured medical care.[7] Thus, much health insurance embodies deductibles and coinsurance, disability insurance requires a waiting period before a work loss is covered, and some proposals for no-fault compensation proposals contain "threshold" levels of losses that must be incurred before any right to compensation is afforded.

### "Scheduled" Damages for Specified Losses

The administrative expense of making individualized loss determinations is a cost of any of the measures of compensation discussed so far. In cause- and loss-based systems this expense is likely to be small, because payments normally are limited to objectively determinable expenses. When the losses in question are subjective, however—damages for pain and suffering payable in the tort system, for example—the cost of determining the extent of a plaintiff's loss can be high. Moreover, jury awards for similar losses are likely to vary considerably precisely because of the subjectivity of both the suffering and each jury's valuation of it.

An alternative to complete denial of compensation for such subjective losses—whether in tort suits or under other approaches—would be to award payments in a way that makes no effort to individualize. This is the compromise struck in workers' compensation, in which there is no explicit award for pain and suffering, but scheduled sums above out-of-pocket losses often are awarded. For instance, specified sums could be awarded automatically for specified injuries—loss of a limb, wound infection after surgery, and paraplegia, to name only three of many possible specifications. This approach would recognize that serious injuries impose more than merely monetary expenses on those who suffer them,

but the approach also would avoid the variability in awards and the high costs that are entailed in individualizing compensation for such losses.

In a sense, the legislative ceilings on pain and suffering damages adopted in a number of states in the past several years are a crude example of this approach. They place a limit on the amount of individualization permitted in awarding compensation to the most seriously injured claimants. Because these ceilings exact such a sacrifice from only one group of claimants, they have been subject to legal challenge in a number of states, with varying results.

### Periodic Payment of Losses

Cutting across the preceding variables is the distinction between lump-sum and periodic payment of losses. Medical liability awards generally are paid in a lump sum to compensate for actual past and estimated future losses. This avoids the cost of periodically reassessing the scope of a patient's losses and maximizes his incentive to recuperate. Such awards might of course be calculated only at the time of the trial and then be paid periodically as annuities, but they might also be recalculated periodically to avoid overpayment or underpayment. Many cause- and loss-based systems adopt this latter approach, incurring extra administrative costs to achieve greater accuracy and avoid making windfall payments. In making periodic payments, however, such systems risk the "moral hazard," or disincentive to avoid continuing loss, associated with any approach that pays a victim as long as he or she does not completely recuperate.

### Limits on Counsel Fees

The typical medical malpractice plaintiff pays his or her attorney a percentage of any amount recovered. Since recoveries for pain and suffering are generally understood to help finance such payment, placing limits on counsel fees that can be charged plaintiffs is an indirect method of reducing the measure of compensation. Such limits can be achieved by placing a ceiling on the percentage an attorney may charge at different levels of recovery. Limits can also be achieved by prohibiting the contingent percentage fee system altogether and requiring defendants to pay a successful plaintiff's counsel fees (one-way fee shifting) or by requiring the losing party to pay the successful party's counsel fees whether that party is the plaintiff or the defendant (two-way fee shifting). Placing limits on contingent fees or adopting two-way fee shifting, however, may reduce access to the courts for all but the most wealthy and, thereby, may preclude otherwise meritorious claims.

## THE PAYMENT MECHANISM

There are three basic approaches to the payment of compensation for injury and disease and a fourth variation that is largely a hybrid. The payment mechanism adopted depends on the party or parties selected to bear "liability" under the system in force—health care providers, patients, the government, or some combination of the three.

### Third-Party Insurance

Third-party insurance is an appropriate financing mechanism when a party other than the patient is responsible for paying compensation. Thus, third-party insurance is the payment mechanism used preponderantly to pay medical malpractice judgments. Third-party insurance could also be used to finance payment under cause-based systems such as medical no-fault. Health care providers would simply pay premiums based roughly on the probability that their patients would suffer compensable injury, and insurers would compensate patients suffering such injuries without any fault inquiry. Because these premiums could be experience-rated even in the absence of a fault inquiry, the system could preserve some of the incentive-creating advantages of the current system while eliminating some of its disadvantages.

### First-Party and Social Insurance

In contrast, first-party and social insurance are used to finance the payment of compensation under loss-based approaches. Both these forms of insurance, however, could also be used to finance payment under cause-based systems of compensation. Under first-party insurance, patients would purchase coverage before treatment, with premiums roughly calibrated to the probability that the patient (or patients in the same risk class) would suffer a compensable iatrogenic injury. Social insurance could finance such a system as well, through taxes assessed in any number of ways, followed by governmental payments to those qualifying for compensation under the system in question.[8] Under either of these approaches, however, the incentive-creating effects of a third-party insurance system would be sacrificed.

### The Patient Compensation Fund

In some states, ceilings on the amounts for which health care providers are liable in malpractice suits have been adopted, but without restricting the amounts that can be paid to the successful plaintiff. This apparent anomaly is resolved by the creation of a state-operated "Patient Compensation Fund" that is responsible for the portion of any award above the ceiling. Such funds need not be limited to awards above the ceiling, however; they can be employed to finance sums awarded under any of the systems explored so far. Moreover, the method of creating and replenishing the fund might also vary, including assessments against health care providers alone, assessments against patients alone, general revenue, or some combination of these sources. The method and proportions adopted can be used to reflect the degree of responsibility for the medical injury problem that the body politic ascribes to each source of funding.

## THE FORUM FOR RESOLUTION OF DISPUTES

The next feature of any approach to liability/compensation issues is the forum that resolves disputes over the rights of patients and providers. This is an important issue, for the identity and qualifications of the decision maker can dramatically influence both the outcome of the dispute and the parties' attitude toward the decision.

### Trial by Jury

The chief characteristic of the American jury system that impinges on the medical liability problem is the use of lay jurors. Several consequences follow from this practice. One is potential inconsistency. Virtually the same issues may be decided for the patient by one jury and for the health care provider by a different jury. Moreover, partly because jurors are lay people and partly for reasons of history, trials by jury are highly formal. Rules of evidence apply, information is produced mainly through questions by counsel, and jurors may not question the parties or witnesses. The result may be a sense that neither party was allowed to tell his or her side of the story. Finally, because of the medical complexity of the issues, because of the need to educate the jury from scratch about both the facts and these medical issues, and because of the formal procedure of the trial itself, the typical medical malpractice case is preceded by years of pretrial information gathering or "discovery" (including oral depositions and writ-

ten interrogatories) and may take several weeks or more in full-scale trial.

The great advantage of this approach is its political legitimacy. For the most part, trial by jury in civil cases is constitutionally required at both the state and federal levels. Jury trials are accepted by the public as an important protection for the powerless as well as a means by which decisions about legal rights may be made without relying on an entrenched bureaucracy or on rule by a class of experts. In addition, the right to bring a lawsuit before a lay jury may satisfy the primitive impulse for vindication in a way that should not be overlooked. Thus, although the United States is the only major nation that still uses juries in civil liability suits and although any number of reforms that would streamline the jury system while still retaining it have been considered, most would detract from the legitimacy of the process precisely because they might undermine the nearly free reign of the jury in deciding medical liability cases.

### Expert Review Panels

One variation on pure trial by jury that would retain the jury is to provide an impartial expert assessment of the technical issues to the parties before the trial and to the jury during the trial. Such an assessment might encourage settlement or guide the jury if a settlement does not occur. The panel may consist exclusively of medical experts (a medical review board) or include legal or lay members as well (a screening panel).[9] Unfortunately, experience in many states over the past decade with different versions of the expert review panel suggests that this device has minimal if any impact on rates of settlement or results at trial.

### Bench Trial

This is simply a trial without a jury—that is, a trial before a judge alone. The principal difference between this approach and the use of a jury is that bench trials provide less opportunity for emotionalism and can proceed with somewhat less formality. In addition, because judges would become accustomed to deciding medical liability cases, some semblance of uniformity of treatment might emerge. The major drawback is that, like any other reform that makes no change in other applicable legal standards—including binding arbitration—the US Constitution and the constitutions of most states preclude dispensing with the use of a jury unless both parties consent.

### Binding Arbitration

Under binding arbitration, an arbitrator or arbitrators chosen by the parties hear a presentation of the claim and the provider's response to it and decide the case. The recent proposal of the American Medical Association Specialty Society Medical Liability Project for fault-based arbitration is a version of this approach.[10] Normally, the arbitrator has some expertise in the subject area of the case, and his or her decision can be appealed to a court only if there is a failure to follow the terms of the arbitration agreement. Because of the arbitrator's expertise, the proceeding can be streamlined and can be shorter than a trial by jury or a bench trial, and it is much less likely to involve emotionalism than trial by jury. However, because arbitration decisions are essentially unreviewable in court, they do not necessarily follow existing law, and if one or both parties are dissatisfied with the decision, they have little recourse.

### Administrative Panels

Once the requirement of malpractice is eliminated as a feature of the compensable event, there is little need to use any of the above devices to determine whether that event has occurred. Typically, a cause-based system financed by health care providers would use an administrative system of compensation under which a board either in permanent existence or specially convened would determine whether the patient had suffered a compensable event and the amount of the losses suffered. This is an especially attractive approach when making the compensability determination requires expertise that can be accumulated through multiple proceedings,[10] and when, because damages for pain and suffering have been eliminated, calculation of losses suffered is largely an objective exercise.

### Insurance Company Determination

In contrast, a cause- or loss-based system based on first-party insurance would not even require administrative panels. Health, life, or disability insurers would simply determine whether the insured compensable event had occurred and award the compensation required by the insurance policy embodying its contract with the claimant. Because these decisions tend to be clerical, disputes would arise only infrequently. Unresolved disputes could be treated in the same way personal insurance claims are adjudicated under the current system: they could be made the subject of lawsuits for breach of contract, with extra damages awardable to successful plaintiffs to deter unjustified denials of coverage by insurance companies.[11]

## THE METHOD OF IMPLEMENTATION

The last determination that must be made in fashioning medical liability reform is how to implement the reformed system. There are two basic approaches: legislation and contract.

### Legislation

One legislative alternative would be simply to prescribe a new mandatory system that would replace the current malpractice liability approach. By statute, a new set of variables would be adopted, and patients and health care providers would be required to act accordingly. On the other hand, legislation implementing the new system need not be mandatory; instead, it might be "elective" in one or more ways, specifically authorizing patients and health care providers to fashion their own legal relationship. Such an approach would of course require detailed description of the contract options available and the options (if any) foreclosed.

A series of issues would have to be addressed by the reform legislation: (1) It would have to prescribe the legal rule that would apply if no election were made. This "background rule" might be the current system of liability for fault or a rule that there would be no liability in the absence of an election. (2) The time or times at which election might be made would have to be prescribed—before or after treatment, before or after injury resulting from treatment.[12] (3) Whether the system would be elective at the option of patients, health care providers, either party, or only if both parties agreed by contract would have to be determined.[13] (4) The legislation would have to indicate whether the parties could fashion their own combination of variables, whether a range of specifically detailed, exclusive options would be made available, or whether only one legislatively authorized alternative to the current system (or a no-liability system) would be permitted.

The questions of policy associated with these different ways of fashioning elective systems are of course substantial. They include concern that any election or waiver of existing rights be voluntary and informed and concern that "bias" in election should neither prejudice patients or health care pro-

Categories and Choices of Reform Alternatives

| Compensable Event | Measure of Compensation | Payment Mechanism | Forum for Resolution of Disputes | Method of Implementation |
|---|---|---|---|---|
| Fault | Full tort damages | First-party insurance | Jury trial | Legislation |
| Cause | Full out-of-pocket losses | Third-party insurance | Expert review panels | Mandatory reform |
| Loss | Partial out-of-pocket losses | Taxation | Bench trial | Elective options |
| | Scheduled damages | Hybrid funding | Binding arbitration | Private contract |
| | Lump-sum payment | | Administrative boards | |
| | Periodic payment | | Insurance company decision | |

viders by foreclosing strong claims and leaving weak ones in the current system, nor double the burden on health care providers by forcing them to pay both malpractice and no-fault compensation.[14] Resolving these questions would require both hard choices and very careful design to avoid undesirable side effects.

### Private Contract

The nonlegislative method of implementing reform is for patients and health care providers to fashion their own legal relationship by contract. Under this approach, they might adopt any combination of variables that would constitute their legal rights and responsibilities. The great advantage of this approach, of course, is that it would allow the parties freedom of choice. There are two disadvantages, however, that might be difficult to overcome: (1) It is doubtful that the courts would approve such a contractual approach in the absence of prior legislative authorization, at least in cases in which a patient's legal rights seemed to be limited rather than expanded.[15] (2) The pure contract approach requires the agreement of both parties; in contrast, a legislatively authorized optional system could permit the replacement of malpractice liability at the election of only one of the parties in cases in which this seems desirable. In short, at this point in the evolution of medical liability law, the prospects for moving to a pure contract system are not good.

## THE VARIABLES COMBINED: A FULL RANGE OF REFORMS

A full range of reform alternatives can be created by combining the variables chosen from all five of the categories discussed into systems that could replace current medical liability law. The choices available are reflected in the Table. Recognizable reform proposals—for example, medical no-fault without damages for pain and suffering, retention of the malpractice standard but substitution of expert arbitration for jury trials, or the abolition of malpractice liability and reliance on expanded health and disability insurance—are simply combinations of variables selected from the categories in each column. The differences between these and other reform proposals generally involve nothing more than the difference in the choice of a variable from one or more categories.

Of course, merely because a given variable or combination of variables is conceptually available does not mean it is appropriate for use under all circumstances. The purpose of this article has been to show how different variables might be combined to form new systems, not to argue that all variables necessarily fit comfortably with each other. For example, it would make little sense to declare that a loss-based system financed by taxation would be optional—everyone eligible would elect it, just as everyone entitled to Social Security on retirement now claims it. It is also open to question whether it would be fair to abolish the payment of damages for pain and suffering while retaining the tort system without creating alternative arrangements for paying patients' counsel fees. The current debate on these and the many other normative questions should be informed by an understanding of the conceptual foundations that underlie controversies over public policy toward medical liability.

In sum, the possibilities for medical liability reform are no longer limited to tinkering with tort law by altering a few technical legal doctrines governing litigation. There is more to potential reform than merely making lawsuits more accurate, predictable, or cost efficient. Retaining the basic model of adversarial litigation is by no means the only available approach. A whole range of alternatives has developed, providing the reformer with a series of choices that must be made on the way to reform. No combination of reforms is without its problems, but no effort to adopt the most appropriate system of liability and compensation should ignore the variety of options that are available to deal with the concerns raised by the critics of reform.

### References


1. Havighurst CC: 'Medical adversity insurance': Has its time come? *Duke L J*, 1975, pp 1233-1303.
2. Tancredi LR: Designing a no-fault alternative. *Law Contemp Probs* 1986;49:277-286.
3. Mills DH: Medical insurance feasibility study. *West J Med* 1978;128:363-365.
4. Henderson JA: The boundary problems of enterprise liability. *Md L Rev* 1982;41:659-694.
5. Abraham KS: Individual action and collective responsibility: The dilemma of mass tort reform. *Va L Rev* 1987;73:845-907.
6. Danzon PM: *Medical Malpractice: Theory, Evidence, and Public Policy*. Cambridge, Mass, Harvard University Press, 1985, p 23.
7. Abraham KS: The relevance of insurance to public policy, in *Distributing Risk: Insurance, Legal Theory, and Public Policy*. New Haven, Conn, Yale University Press, 1986, pp 1-7.
8. Sugarman SD: Doing away with tort law. *Calif L Rev* 1985;73:555-664.
9. Henderson JA: Agreements changing the forum for resolving medical malpractice claims. *Law Contemp Probs* 1986;49:243-252.
10. American Medical Association Specialty Society Medical Liability Project: *A Proposed Alternative to the Civil Justice System for Resolving Medical Liability Disputes: A Fault-Based Administrative System*. Chicago, American Medical Association, 1988, pp 17-35.
11. Abraham KS: Translating insurance rights into remedies: The claims process, in *Distributing Risk: Insurance, Legal Theory, and Public Policy*. New Haven, Conn, Yale University Press, 1986, pp 173-206.
12. O'Connell J: A 'neo-no-fault' contract in lieu of tort: Preaccident guarantees of postaccident settlement offers. *Calif L Rev* 1985;73:898-916.
13. Robinson GO: Rethinking the allocation of medical malpractice risks between patients and providers. *Law Contemp Probs* 1986;49:173-199.
14. O'Connell J: Neo-no-fault remedies for medical injuries: Coordinated statutory and contractual alternatives. *Law Contemp Probs* 1986;49:125-141.
15. Epstein RA: Medical malpractice: The case for contract. *ABF Res J* 1976;87:150.

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August 25, 1988

Joanne Goodman Scott
Principal Research Analyst
Bureau of Insurance
State Corporation Commission
Post Office Box 1157
Richmond, Virginia 23209

Dear Ms. Scott:

I recently replied to Mr. Kaufmann's questionaire regarding your study of medical malpractice insurance. As you requested I wrote the American Society of Internal Medicine for a statement of their official position on this problem. After I wrote my reply to you, I received a reply which I am forwarding to you to supplement my response.

Thank you for your interest in this matter.

Sincerely,

William F. Tompkins, III, M.D.F.A.C.P.
President, Virginia Society of Internal Medicine

WFT/bam

American society of internal medicine



August 9, 1988

William F. Tompkins, III, MD, President
Virginia Society of Internal Medicine
P.O. Box 7157
Falls Church, VA 22046

Re: Virginia Bureau of Insurance Study on Medical Malpractice

Dear Dr. Tompkins:

Thank you for your letter of July 26, 1988. I am enclosing the following items to help you respond to the Bureau of Insurance, State Corporation Commission:

1. Policy statements on medical liability and equitable risk classification which are found in ASIM's 1986-87 policy manual.

2. February 1986 position paper on the medical liability crisis.

3. Updated policy on the medical liability crisis adopted by the 1987 House of Delegates.

At its October 1987 meeting and at your urging, ASIM's Board of Trustees adopted the position that the society should oppose attempts by states to enact legislation that shifts the professional liability burden to lower risk specialists such as internists where it is not actuarially justified. This was in response to the Virginia Birth-Related Neurological Injury Compensation Act which had already become law.

If there is any additional information you need or if I can be of any further assistance, please let me know.

Sincerely,

James M. Ott
Vice President, Division of Management
and Member Services

M-JO-4491/mmf

cc: Irvin E. Bomberger

8.11.3 Specimen Handling Fee

ASIM continues to support and promote a reasonable handling and drawing fee that would be recognized by all third party payors, including private insurers. (HoD 86)

8.11.4 Physician Ownership of Clinical Laboratories

ASIM believes that clinical appropriateness, reasonableness of cost, availability and accessibility, and demonstrated quality of service should be the main determinants of utilization of clinical laboratories and that financial interest in, or ownership of, a clinical laboratory by a referring physician should not in itself prohibit referral of patients to that laboratory. (HoD 82)

8.11.5 Physicians' Office Laboratories

ASIM supports and promotes the physician's office laboratory that delivers laboratory testing to patients in a timely, efficient, accurate and cost-effective manner. (HoD 85)

## 8.12 MEDICAL LIABILITY, MALPRACTICE

Background:

The problem of medical liability has assumed crisis proportions in recent years. This crisis has come about through an interaction of complex forces, many of which are not controlled by the medical profession.

Evaluation:

The magnitude of this crisis now adversely affects both the availability and cost of medical care. It has forced some physicians to withhold essential services in cases they judge to carry a high risk of malpractice suit. It has forced physicians to obtain unnecessary procedures in an attempt to document each of their clinical decisions as a protection against suit.

Policy:

The American Society of Internal Medicine recognizes two principles that must be considered in any determination of medical liability:

- An act of negligence may be committed by a physician. This may represent either an error of omission or one of commission. When a patient suffers injury, disability or death as a result of such an act of negligence, a malpractice action is justified.

- the patient's response to therapy is an unpredictable biological variable. An unanticipated therapeutic outcome that follows appropriate medical care is not malpractice action. Further, patients who sustain disability following appropriate medical care should not be compensated for such disability through any insurance mechanism either directly or indirectly supported by professional liability insurance. (BoT 8/75)

### 8.12.1 Medical Liability Insurance for Hospital Medical Staff Appointment

The American Society of Internal Medicine urges that medical liability insurance coverage not be a mandatory requirement for hospital medical staff appointment. (HoD 78)

### 8.12.2 Equitable Risk Classification in Medical Liability Premiums

The American Society of Internal Medicine supports the concept that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category. (HoD 79)

## 8.13 PHYSICAL EXAMINATIONS

### 8.13.1 The Periodic Health Evaluation (PHE) by the Internist

A periodic health evaluation (PHE) of a patient by an internist is a valid tool of preventive medicine.

Since the optimum frequency of such evaluations has not yet been established, the periodicity of such examinations should be determined by the internist, based upon his or her training, knowledge, and experience.

ASIM believes an internist's PHE should include safe and inexpensive methods to detect asymptomatic disorders which are often favorably influenced by early diagnosis and intervention. Additional studies depend upon the clinical judgment of the internist. (HoD 77; rev. HoD 81)

ASIM encourages additional well-designed studies to determine the optimum frequency and cost effectiveness of the procedures that should be included in the internist's PHE. (HoD 81)

### 8.13.2 Employer-Sponsored Physical Examinations

Comprehensive physical examinations which are done in the interest of maintaining employees' health should be performed wherever possible by a qualified personal physician who is in a position to continue to care for the patient and to take immediate action with regard to any abnormalties or medical conditions which are uncovered by such examinations. (HoD 81)

### 8.13.3 Medical Screening Programs

The American Society of Internal Medicine endorses medical screening programs that are cost effective and endorses full evaluation of the patient by a qualified physician (preferably the patient's own physician) prior to high-risk procedures involving specific diagnostic modalities performed as screening tests. (HoD 79)

### 8.13.4 Unsolicited Reports (Multiphasic Screening)

ASIM recommends to its members that:

- any unsolicited report received from a multiphasic screening center on a patient the physician has not seen or examined shall be returned to the

# AMERICAN SOCIETY OF INTERNAL MEDICINE

# POSITION PAPER

# ON THE

# PROFESSIONAL LIABILITY CRISIS

February 1986

## Overview of the Problem

Medical professional liability is now as it was in the mid-1970s one of the single most important issues facing the medical community. While the crisis of 10 years ago was primarily one of "availability," physicians are now dealing with what is frequently described as a crisis of "affordability" and how it has affected access to as well as the cost and adequacy of quality medical care.

Internists and internal medicine subspecialists are being adversely affected by the crisis although not to the degree of other high risk specialties. Naturally many of the problems of the professional liability crisis are common to all physicians such as escalating professional liability premiums which add significantly to overhead expenses (in a time when many factors such as Medicare are forcing physicians to hold the line on fees) and the increasing practice of defensive medicine which adds an estimated $15 billion to the nation's overall cost of medical care.

While there are some groups such as the American Trial Lawyers Association who still question whether a crisis truly exists, the problem has been well-documented by others. According to the A. M. Best Company, independent analysts of the insurance industry, medical malpractice losses (including loss expenses incurred) have been higher than premiums earned since 1980. This loss ratio (claim losses plus loss expenses divided by premiums) was 150% in 1982 and 142% in 1983.[1] To some extent this loss as been ameliorated by investment income (interest generated by premiums until they are utilized) but even then claim losses and loss expenses have exceeded total income.

Any evaluation of how the insurance industry is performing in the medical professional liability line of business must not be limited to an examination of premiums to "paid losses" but must also include the millions of dollars spent by insurance companies in overhead, in adjusting losses, in defending physicians against claims without merit and paying company expenses and taxes.

The liability "crisis" is not limited just to medical practitioners. Rather the problem has affected a broad range of society. Skyrocketing awards have been occurring in product liability cases with their attendant costs being passed on to consumers. Some drug manufacturers have ceased producing childhood vaccines because it is virtually impossible to obtain the liability insurance necessary to stay in the market. The cost of professional liability insurance for architects and engineers is also increasing dramatically and, in some instances, the coverage is unavailable. Municipalities are having difficulty obtaining liability insurance and

some are operating without it because they refuse to pay the premium that insurers are demanding or their insurers have dropped them. Further, there is evidence that many outside corporate directors are leaving their positions because their companies cannot maintain directors and officers liability insurance. If corporations maintain all-inside boards, questions obviously arise as to who is serving the shareholders.

Insurance companies are dramatically increasing rates because of their deteriorating financial position in underwriting medical professional liability insurance. Premiums vary dramatically from state to state. While average premiums for internists increased from approximately $2400 to $4400 from 1978 to 1983,[2] there are some areas of the country where annual premiums exceed $10,000.

While some argue that a few consistently negligent physicians have had a substantial impact on losses paid, the evidence shows that repeat offenders are not the problem. The fact is that most medical malpractice claims do not involve negligence. An estimated three out of four cases are ultimately settled in the provider's favor, but it is the high cost of defending claims that is also contributing to the dramatic rise in premiums.

The average physician risk of incurring a medical malpractice claim has increased nearly threefold since 1980. The incidence of claims filed against internists increased from 2.4 claims per 100 physicians prior to 1980 to 5.7 claims during the following five years.[3] An analysis of 1983 claims experienced by the 23 physician-owned medical professional liability insurance companies by the American Medical Assurance Company (AMACO), an American Medical Association subsidiary that provides reinsurance to the companies, shows that the incidence of claims has risen to 20.3 claims per 100 insured physicians. In other words, one in five physicians will be sued this year.

Claims loss severity is also increasing at an alarming rate throughout the country. Jury Verdict Research of Solon, Ohio, reports that the average medical malpractice verdict (including million dollar verdicts) in 1975 was $220,018 but by 1984 the average had risen to $666,123. In 1975 there were 3 verdicts over $1 million while in 1984 there were 71 verdicts over $1 million.

The legal system does not deal with physicians fairly. Based on a study released in 1985 by the Rand Corporation's Institute for Civil Justice, the Institute found that jurors were much more sympathetic to plaintiffs injured in medical malpractice cases than plaintiffs with the same injury that occurred on property, at work or in connection with product liability cases. Malpractice awards were as much as five times higher than injury-on-property cases.

Some experts believe that the practice of defensive medicine (the ordering of additional tests in anticipation of a medical malpractice lawsuit) may have more of an impact on health care costs than professional liability premiums. Equally, there are experts who believe that defensive medicine is simply the increased care which the malpractice system is intended to encourage and that it is not possible to distinguish defensive medicine from the overutilization that results from the economic incentives inherent in fee-for-service medicine.[4] Some defensive medicine is described as simply good medical practice. Various surveys have shown, however, that defensive medicine unquestionably is on the rise.

Indeed, surveys have shown that internists are keeping more detailed records, ordering more tests, obtaining more consultations, and are referring patients to other specialists more frequently.[5] In turn, the price of health insurance is increasing employee medical expenses thereby placing economic pressures on employers to implement cost-sharing features in their employee health benefit plans. Ultimately, the consumer of health care pays the price.

## By-Products of the Problem

Although many experts believe that a good doctor-patient relationship will lead to fewer suits, the fear of a malpractice claim is causing some internists to maintain a more businesslike, "arms length" relationship with patients. No matter how good the rapport is between a patient and doctor, paranoia about malpractice and the fear of a lawsuit, especially for those who have been sued at least once, is affecting doctors' behavior around their patients.

Another area where the public as much as the provider suffers is with regard to the inefficiencies of the legal system itself. Patients who are injured because of their treatment deserve to be compensated promptly and fairly. The current legal system does not permit such a luxury because medical malpractice cases often take years to resolve. Fully one-third of all claims take more than two years to resolve, and even then, only 28 to 40 cents on the dollar (with some estimates as low as 20 to 25 cents) is returned to plaintiffs as compensation. The rest goes to attorneys and insurance companies to cover costs such as administration, claims evaluation and litigation costs.[6]

While the purpose of a lawsuit is to seek compensation for victims of malpractice and deter substandard care through the threat of legal action, there is one result that is often overlooked—the effect a lawsuit has on a physician from a personal standpoint. It has been shown that most physicians who are sued find that it is enormously disruptive to their personal and professional life. Many physicians who have been sued suffer from symptoms indicative of depression and stress which, in the long run, is likely to have an impact on the ability of the physician to deliver quality health care.[7] Medical liability lawsuits have also served as an incentive for some physicians to leave their practice or to retire at earlier ages resulting, in some cases, in the reduction in availability of care.

## Tort Reform

Tort reform is not the ultimate answer to the medical malpractice problem. To the contrary, there are some tort reforms that have done little to reduce medical liability costs and others that simply have not had the effect that was originally intended. There are a few reforms, however, that when carefully drafted, can go a long ways towards reducing medical liability costs. This, in turn, would benefit patients by lowering costs and by ensuring the availability of liability insurance and, hence, availability of health care services.

Moreover, there are some states where the professional liability problem is not as serious as in others. For this reason, individual states are in the best position to determine the need for legislative relief. The following reforms are among those which have been demonstrated to provide measurable claims savings and hence a reduction in the costs of the medical malpractice system:

- Limitation on awards for non-economic damages (pain and suffering, mental anguish and loss of consortium).

- Elimination of the collateral source rule to prevent double compensation to plaintiffs. (The collateral source rule prohibits introduction of evidence of information about compensation that a plaintiff may receive from sources other than the defendant; e.g., reimbursement from a health insurance policy or workers' compensation plan for medical expenses.)

- Periodic payment of damages to eliminate windfalls to the heirs of plaintiffs who die earlier than anticipated and to more appropriately compensate patients with lifetime disabilities.

- Attorney fee regulation to ensure that reasonable compensation will go to injured plaintiffs without denying attorneys fair compensation. Earlier settlements will be encouraged (and tactics intended to delay settlements discouraged) by removing incentives to seek larger awards and therefore larger fees.

- Elimination of punitive damages from professional liability lawsuits. Punitive damages are intended to punish the wrongdoer and this responsibility should be left to the state licensing boards, medical societies, hospital peer review systems and the criminal justice system.

Standards of Care

Medical malpractice is negligent care by a health care provider that causes injury to a patient. To be awarded damages for medical malpractice, the plaintiff must prove that the legal standard of care has been breached, that there was injury and that the injury was caused by such breach. Establishing the standard of care in court is left to expert witnesses and the applicable standard is usually drawn from observation of customary practice. Eighteen states have laws establishing a medical standard of care.

One of the most difficult problems in medical malpractice cases is determining the standard of care (Should a local, state or national standard apply?). And in an era of increasingly sophisticated medical technology, when physicians cannot always agree on medical procedures, it is questionable whether a judge or lay jury can decide this issue.

Cost containment programs (Medicare's Prospective Payment System, for example) by their very nature, create pressures to restrict care which may affect its quality. Appropriate data collection and analysis should enable physicians to reach agreement on many treatment schedules (known as protocols) that would probably be helpful to some physicians who face these pressures. Any cost containment program, however, devoted to the delivery of high quality cost effective medical care should be constantly vigilant that quality of care is not compromised. A balance must be maintained in the cost-quality equation.

## Peer Review/Risk Management/Disciplinary Action

State medical societies and national medical specialty societies as well as hospitals should be encouraged to implement peer review and risk management programs to ensure quality care. While there is no clear proof that risk management programs reduce the likelihood of a lawsuit, at least one medical specialty society has developed a risk management program which is believed to have been the main reason for a reduction in premiums for their particular group.

State licensing boards should be encouraged to investigate cases of medical negligence and take disciplinary action where appropriate. Insurance companies should be required to make certain data available to state agencies to aid them in their investigations. State medical examining boards often have difficulty identifying the physicians generating multiple claims involving actual negligence because claims in this category are often settled "quietly." Historically, these boards have been ineffective in revoking licenses of physicians who have demonstrated recurring aberrant practice because of, among other factors, the fear of being sued by physicians whom they seek to discipline and also because of limited resources. Efforts should be made to provide these state licensing boards with adequate resources to handle the caseload of investigations. Moreover, hospitals and state medical societies should not only report examples of flagrant and recurring negligence to state examining boards, but also patterns of care which indicate inappropriate practice or that the physician in question may be marginal.

## Consumer Education/Communication

The professional liability problem is not a reflection of the quality of medical care. Rather, the evidence suggests that quality has never been higher. Publicity about medical advances, however, has raised the public's expectations about medical outcomes. Consumers have come to expect perfect results every time treatment is rendered. Consumers need to understand that physicians are human and occasionally, because of events beyond their control, either an adverse result occurs, or the patient does not experience an outcome that is 100% perfect.

Consumers also need to be fully apprised of the fact that when they hear of the million dollar verdicts, it is the consumer who ultimately pays for them. As professional liability losses escalate, so do premium dollars and ultimately, fees to patients.

In an age of rapidly increasing medical technology, specialization and impersonal medical care, doctors also need to evaluate and strengthen their relationships with their patients. More effective communication between doctor and patient would enhance these relationships.

## RECOMMENDATIONS

1. ASIM supports tort reform that encourages fair compensation to all deserving injured claimants or plaintiffs and prompt resolution of professional liability claims, and all personal injury claims.

2. ASIM believes that federal intervention may be necessary because of the magnitude of the problem, but also believes that states are in the best position to judge the seriousness of the problem and to implement appropriate legislative relief.

3. ASIM supports tort reform that accomplishes the following: limits awards for non-economic damages, eliminates punitive damages, eliminates the collateral source rule, and allows for periodic payment of damages. ASIM also supports tort reform which provides for attorney fee regulation in personal injury and medical malpractice cases.

4. ASIM supports the American Medical Association position regarding the concept of data collection and analysis to "correct inappropriate variations in treatment patterns and procedures."

5. ASIM encourages physicians' active involvement in peer review activities both at the medical society level and in hospital settings.

6. ASIM supports the development of risk management programs in hospitals as well as by specialty societies and state and local medical societies.

7. ASIM supports the strengthening of state licensing boards so they can more effectively investigate cases of medical negligence and take appropriate disciplinary action.

8. The public should be educated regarding expectations about medical outcomes and the effect the medical malpractice crisis is having on the cost, availability and quality of medical care.

9. Physicians should be encouraged to strengthen doctor-patient relationships to reaffirm the doctors' position as the patients' advocate.

/srl
A10-9349

## Definitions

Loss Expense - The cost to the insurance carrier of defending, investigating and adjusting a claim.

Reinsurance - Insurance that is purchased by insurance companies to reduce the chance of any one loss or types of losses significantly affecting a company's financial position.

Tort - The breach of a legal duty imposed by law other than by contract. A wrongful act committed by one person against another person or his or her property. Most tort claims against professionals arise from allegations of negligence or failure to exercise the required standard of care.

Tort Reform - An effort to change state laws affecting liability lawsuits.

Collateral Source Rule - The arrangement whereby a jury or a judge is not privy to other sources of payment that may be available to the plaintiff such as health insurance payments. Thus, there may be a "double award" - an award from the jury covering hospital expense and a second payment from the plaintiff's insurance company covering the same item.

## ENDNOTES

[1]Professional Liability in the '80s, Report 1, American Medical Association Special Task Force on Professional Liability and Insurance, October 1984, p. 8.

[2]What Legislators Need to Know About Medical Malpractice, Robert Pierce, senior research analyst, National Conference of State Legislators, based in part on presentations made at a national conference sponsored by The Urban Institute, February 1985, in Washington, D.C., entitled "Medical Malpractice: Can the Private Sector Find Relief?"

[3]AMA Socioeconomic Monitoring System (SMS) survey, 4th Quarter, 1984.

[4]"Evaluation of the Current Malpractice System," Patricia Danzon, presentation at the Urban Institute's national medical malpractice conference, "Medical Malpractice: Can the Private Sector Find Relief?" February 21-22, 1985.

[5]"What Doctors Are Doing About The Malpractice Threat," Physician's Management, September 1985, p. 69.

[6]Danzon, February 21-22, 1985, "Medical Malpractice: Can The Private Sector Find Relief?"

[7]"Sued and Nonsued Physicians' Self-Reported Reactions to Malpractice Litigation," Sara C. Charles, MD, Jeffrey R. Wilbert, M.A., and Kevin J. Franke, M.A., American Journal of Psychiatry, 142:4, April 1985.

## OTHER SOURCES

Professional Liability in the 80s, Reports 2 and 3, American Medical Association Special Task Force on Professional Liability and Insurance, November 1984 and March 1985.

"Medical Malpractice: The Employers Perspective," a report by the Washington Business Group on Health, August 1985.

A10-9349

# MEDICAL LIABILITY CRISIS

## BACKGROUND

Internists and internal medicine subspecialists are being adversely affected by the professional liability insurance problem which has again reached crisis proportions in the mid-1980s. The current crisis primarily deals with affordability of professional liability insurance and how it has affected access to, and the cost and adequacy of quality medical care.

## EVALUATION

The professional liability insurance problem has affected internists in many ways, such as the following:

- Other specialists and consultants (e.g., obstetricians and orthopedists) have been forced out of practice in some states because of a lack of professional liability insurance availability, increasing the burden upon internists or other physicians who continue in practice and whose patients may need access to those specialists.

- Escalating premiums add to overhead costs at a time when internists are being asked to hold the line on fees through various cost containment programs.

- The current tort system forces internists to practice defensive medicine and order additional and sometimes unneccesary tests in anticipation of a medical malpractice lawsuit thereby driving up the cost of health care.

- The fear of a malpractice claim is adversely affecting the doctor-patient relationship.

- Medical liability lawsuits (especially when they are frivolous lawsuits) are affecting internists from a personal standpoint, disrupting their personal and professional lives, thereby adversely affecting their ability to deliver quality care.

Certain tort reforms, when carefully drafted, could help reduce medical liability claim costs and this, in turn, would benefit patients by lowering costs of delivering health care services. However, the tort system is often an inefficient, wasteful and inequitable mecahnism for resolution of medical legal disputes.

## POLICY

ASIM supports tort reform that limits awards for non-economic damages, eliminates punitive damages, eliminates the collateral source rule (eliminates double compensation to plaintiffs for certain items) and allows for periodic payment of future damages and structured settlements. ASIM also supports tort reform which provides for attorney fee regulation in personal injury and medical malpractice cases.

ASIM encourages the use of studies and demonstration projects to determine if medical malpractice claims could be handled outside the traditional tort system and result in prompt resolution of claims and fair compensation to deserving claimants.

ASIM supports the development of risk management programs in hospitals as well as by specialty societies and state and local medical societies. ASIM supports the strengthening of state licensing boards so they can more effectively investigate cases of medical negligence and take appropriate disciplinary actions. ASIM also supports efforts to educate the public regarding expectations about medical outcomes and the effect the medical malpractice crisis is having on the cost, availability and quality of medical care.

/dmm
M-JO-0331

VIRGINIA CHAPTER
AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS

**HEADQUARTERS**

P.O. Box 130
Providence Forge, Virginia 23140
804-966-5966

Gwen E. Messler Harry
Executive Director



A POSITION PAPER on Medical Malpractice Insurance Rates

ISSUE:

Is it feasible and desirable to establish a method of distributing premiums among the various medical malpractice rate categories, as being studied pursuant to House Joint Resolution No. 186?

POSITION:

The Virginia Chapter of the American College of Emergency Physicians believes the unique characteristics of the various and diverse medical specialties and subspecialties each present different environments for malpractice risk exposure. If premiums were allocated among all practitioners, many physicians would be penalized for procedural risks not associated with the practices, nor for which they are necessarily credentialed to take.

RECOMMENDATIONS:

To ameliorate the issue of medical malpractice rising costs, it is appropriate to focus attention not only on the cost of malpractice insurance but also to focus on the basis for that cost--claims, litigation and awards. We therefore respectfully offer the following recommendations for your consideration:

1) Medical malpractice insurance premiums should continue to be individualized by specialty based upon relative risk and actuarial data.

2) Insurors should be required to consult with the appropriate medical specialty society and The Medical Society of Virginia in establishing or revising underwriting criteria for each specialty or risk classification category.

3) Amend the Code of Virginia regarding medical malpractice review panels to make findings and decisions of the panels binding.

4) Develop a screening process to remove frivolous claims from the judicial process and to protect physicians from the effects of such claims.

9/1/88

APPENDIX C

**Medical Malpractice Opinion Poll Mailing List**

Insurers
Virginia Insurance Reciprocal
Virginia Medical Malpractice Joint Underwriting Assoc.
PHICO Insurance Company
St. Paul Fire and Marine Insurance Co.
The Medical Protective Company

Insurance Trade Organizations
American Insurance Association
Alliance of American Insurers
National Association Independent Insurers
Independent Insurance Agents of Virginia
Professional Insurance Agents

Medical Societies
Medical Society of Virginia
Virginia Hospital Association
Virginia Allergy Society
Virginia Society of Anesthesiologists
Virginia Dermatological Society
American College of Emergency Physicians, Virginia Chapter
Virginia Academy of Family Physicians
Virginia Gastroenterological Society
Virginia Society of Hematology and Oncology
Virginia Society of Internal Medicine, Central Virginia Internists
Virginia Neurological Society
The Neurosurgical Society of the Virginias
Virginia Obstetrical/Gynecological Society
Virginia Occupational Medical Association
Virginia Society of Ophthalmology
Virginia Orthopaedic Society
Virginia Society of Otolaryngology-Head & Neck Surgery, Inc.
Virginia Society for Pathology
American Academy of Pediatrics, Virginia Chapter
American College of Physicians, Virginia Chapter
Virginia Society of Physical Medicine and Rehabilitation
Virginia Society of Plastic & Reconstructive Surgeons
Psychiatric Society of Virginia
American Association of Public Health Physicians, Virginia Chapter
American College of Radiology, Virginia Chapter
American College of Surgeons, Virginia Chapter
International College of Surgeons, Virginia State Chapter
Virginia Surgical Society
Virginia Urologic Society
Virginia Thoracic Society
Virginia Vascular Society

Other
National Insurance Consumer Organization
Department of Health Regulatory Boards
Children's Health Care System, Inc.
Mr. Allen C. Goolsby, III

# APPENDIX D

VIRGINIA PROFESSIONAL UNDERWRITERS, INC.
I N T E R O F F I C E  M E M O R A N D U M

TO: John Latham

FROM: Carolyn Godbey

DATE: March 16, 1988

RE: DISTRIBUTION OF INSURED PHYSICIAN FROM JANUARY 9, 1987, THROUGH DECEMBER, 1987

In follow up to Judy's memo dated March 9, 1988, the distribution of insured physicians by Severity Code for January, 1987, through December, 1987, is as follows:

| SEVERITY CODES | # OF ACCTS. | % OF ACCTS. | # OF PHYS. | % OF PHYS. |
|---|---|---|---|---|
| 1 | 679 | 43% | 1,035 | 44% |
| 2 | 188 | 12% | 249 | 11% |
| 3 | 111 | 7% | 196 | 8% |
| 4 | 64 | 4% | 107 | 4% |
| 5 | 213 | 14% | 276 | 12% |
| 5a | 65 | 4% | 112 | 5% |
| 6 | 136 | 9% | 194 | 8% |
| 7 | 91 | 6% | 159 | 7% |
| 8 | 17 | 1% | 22 | 1% |
| TOTALS | 1,564 | 100% | 2,350 | 100% |

The percentage of physicians did not change from 1986 to 1987 by more than one percentage point (up or down) in any code except Severity 7. Severity 7, which is OB/GYN, increased from 5% in 1986 to 7% in 1987.

If there are any questions concerning this distribution, please let me know.

sp/M2/6
c: Bob McMillion
Abby Poindexter
Tammy Atkinson
Jennifer Hodges
Peggy Evans
Judy Kelley
Donna DeHart
Nancy Anderson
Randy Meador
Caprisa Scruggs

F. CLASSIFICATION TABLE:

Physicians' & Surgeons' Professional Liability
Claims-Made

Classifications

| | Code No. | Severity No. |
|---|---|---|
| Aerospace Medicine | 80230 | 1 |
| Allergy | 80254 | 1 |
| Anesthesiology | 80151 | 5A |
| This classification applies to all general practitioners of specialists who perform general anesthesia or acupuncture anesthesia. | | |
| Broncho-Esophagology | 80101 | 2 |
| Cardiovascular Disease - minor surgery | 80281 | 2 |
| Cardiovascular Disease - no surgery | 80255 | 1 |
| Dermatology - minor surgery | 80282 | 2 |
| Dermatology - no surgery | 80256 | 1 |
| Diabetes - minor surgery | 80271 | 2 |
| Diabetes - no surgery | 80237 | 1 |
| Emergency Medicine - including major surgery | 80157 | 5 |
| This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital, or rescue facility who performs major surgery. | | |

| | Code No. | Severity No. |
|---|---|---|
| Emergency Medicine - no major surgery | 80102 | 4 |
| This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital, or rescue facility who does not perform major surgery. | | |
| Endocrinology - minor surgery | 80272 | 2 |
| Endocrinology - no surgery | 80238 | 1 |
| Family Physicians or General Practitioners - minor surgery | 80423 | 3 |
| Family Physicians or General Practitioners - performing obstetrics | 80421 | 3 |
| Family Physicians or General Practitioners - no surgery | 80420 | 1 |
| Forensic Medicine | 80240 | 1 |
| Gastroenterology - minor surgery | 80274 | 2 |
| Gastroenterology - no surgery | 80241 | 1 |
| General Preventive Medicine - no surgery | 80231 | 1 |
| Geriatrics - minor surgery | 80276 | 2 |
| Geriatrics - no surgery | 80243 | 1 |
| Gynecology - minor surgery | 80277 | 2 |
| Gynecology - no surgery | 80244 | 1 |
| Hematology - minor surgery | 80278 | 2 |
| Hematology - no surgery | 80245 | 1 |
| Hypnosis | 80232 | 1 |
| Infectious Diseases - minor surgery | 80279 | 2 |
| Infectious Diseases - no surgery | 80246 | 1 |
| Intensive Care Medicine | 80283 | 2 |
| This classification applies to any general practitioner or specialist employed in an intensive care hospital unit. | | |

| | Code No. | Severity No. |
|---|---|---|
| Internal Medicine - minor surgery | 80284 | 2 |
| Internal Medicine - no surgery | 80257 | 1 |
| Laryngology - minor surgery | 80285 | 2 |
| Laryngology - no surgery | 80258 | 1 |
| Legal Medicine | 80240 | 1 |
| Neoplastic Diseases - minor surgery | 80286 | 2 |
| Neoplastic Diseases - no surgery | 80259 | 1 |
| Nephrology - minor surgery | 80287 | 2 |
| Nephrology - no surgery | 80260 | 1 |
| Neurology - including child - minor surgery | 80288 | 2 |
| Neurology - including child - no surgery | 80261 | 1 |
| Nuclear Medicine | 80262 | 1 |
| Nutrition | 80248 | 1 |
| Occupational Medicine | 80233 | 1 |
| Ophthalmology - minor surgery | 80289 | 2 |
| Ophthalmology - no surgery | 80263 | 1 |
| Otology - minor surgery | 80290 | 2 |
| Otology - no surgery | 80264 | 1 |
| Otorhinolaryngology - minor surgery | 80291 | 2 |
| Otorhinolaryngology - no surgery | 80265 | 1 |
| Pathology - minor surgery | 80292 | 2 |
| Pathology - no surgery | 80266 | 1 |
| Pediatrics - minor surgery | 80293 | 2 |
| Pediatrics - no surgery | 80267 | 1 |
| Pharmacology - clinical | 80234 | 1 |

| | Code No. | Severity No. |
|---|---|---|
| **Physiatry** | 80235 | 1 |
| **Physical Medicine and Rehabilitation** | 80235 | 1 |
| **Physicians - minor surgery** | 80294 | 2 |

**This is an N.O.C. classification.**

| | | |
|---|---|---|
| **Physicians - no major surgery** | 80422 | 3 |

**This classification applies to all general practitioners or specialists, except those performing major surgery, anesthesiology or acupuncture anesthesiology, who perform any of the following medical techniques or procedures:**

Acupuncture - other than acupuncture anesthesia

Angiography

Arteriography

Catheterization - arterial, cardiac, or diagnostic - other than (1) the occasional emergency insertion of pulmonary wedge pressure recording catheters or temporary pacemakers, (2) urethral catheterization or (3) umbilical cord catheterization for monitoring blood gases in newborns receiving oxygen.

Cryosurgery - other than use on benign or premalignant dermatological lesions.

Discograms

Lasers - used in therapy

Lumphangiography

Myelography

Phlebography

Rneumonencephalography

Radiation Therapy

Shock Therapy

| | | |
|---|---|---|
| **Physicians - no major surgery** | 80443 | 2 |

| | Code No. | Severity No. |
|---|---|---|

This classification applies to all general practitioners or specialists, except those performing major surgery, anesthesiology, or acupuncture anesthesiology, who perform any of the following medical techniques or procedures.

Colonscopy

ERCP (endoscopic retrograde cholangiopancreatography)

Needle Biopsy - including lung and prostate but not including liver, kidney, or bone marrow biopsy.

Pneumatic or mechanical esophageal dilation (not with bougie or olive)

Radiopaque Dye - Injections into blood vessels, lymphatics, sinus tracts of fistulae (not applicable to Radiologists Code 80280)

| | | |
|---|---|---|
| Physicians - no surgery | 80268 | 1 |

This is an N.O.C. classification.

| | | |
|---|---|---|
| Physicians' or Surgeons' Assistants | 80116 | 1 |

This classification applies to physicians' or surgeons' assistants who have completed an approved course of study leading to university certification and who perform their duties under the direct supervision of a licensed physician or surgeon, assisting in the clinical and/or research endeavors of the physician or surgeon.

| | | |
|---|---|---|
| Psychiatry - including child | 80249 | 1 |
| Psychoanalysis | 80250 | 1 |
| Psychosomatic Medicine | 80251 | 1 |
| Public Health | 80236 | 1 |
| Pulmonary Diseases - no surgery | 80269 | 1 |
| Radiology - diagnostic - minor surgery | 80280 | 2 |

This classification includes radiopaque dye injections into blood vessels, lymphatics, sinus tracts, or fistulae.

| | | |
|---|---|---|
| Radiology - diagnostic - no surgery | 80253 | 1 |
| Rheumatology - no surgery | 80252 | 1 |

| | Code No. | Severity No. |
|---|---|---|
| Rhinology - minor surgery | 80270 | 2 |
| Rhinology - no surgery | 80247 | 1 |
| Surgery - abdominal | 80166 | 5 |
| Surgery - cardiac | 80141 | 6 |
| Surgery - Cardiovascular disease | 80150 | 6 |
| Surgery - colon and rectal | 80115 | 2 |
| Surgery - endocrinology | 80103 | 2 |
| Surgery - gastroenterology | 80104 | 2 |
| Surgery - general | 80143 | 5 |

This is an N.O.C. classification. This classification does not apply to any general practitioner or specialist who occasionally performs major surgery.

| | | |
|---|---|---|
| Surgery - general practice or family practice - not primarily engaged in major surgery | 80117 | 2 |
| Surgery - geriatrics | 80105 | 2 |
| Surgery - gynecology | 80167 | 5 |
| Surgery - hand | 80169 | 5 |
| Surgery - head and neck | 80170 | 5 |
| Surgery - laryngology | 80106 | 5 |
| Surgery - neoplastic | 80107 | 2 |
| Surgery - nephrology | 80108 | 2 |
| Surgery - neurology - including child | 80152 | 8 |
| Surgery - obstetrics | 80168 | 7 |
| Surgery - obstetrics - gynecology | 80153 | 7 |
| Surgery - ophthalmology | 80114 | 2 |
| Surgery - orthopedic | 80154 | 6 |
| Surgery - otology | 80158 | 5 |

| | Code No. | Severity No. |
|---|---|---|
| This classification does not apply to general practitioners or specialists performing plastic surgery. | | |
| Surgery - otorhinolaryngology | 80159 | 5 |
| Surgery - plastic | 80156 | 5 |
| This is an N.O.C. classification | | |
| Surgery - plastic - otorhinolaryngology | 80155 | 5 |
| Surgery - rhinology | 80160 | 5 |
| Surgery - thoracic | 80144 | 6 |
| Surgery - traumatic | 80171 | 6 |
| Surgery - urological | 80145 | 2 |
| Surgery - vascular | 80146 | 6 |
| Urgent care physicians | 80424 | 3 |

This classification applies to any general practitioner or specialist providing immediate care in an outpatient clinic advertised as urgent care, emergi care etc., but not involving emergency practice. Similar practice in a hospital setting or that accepts ambulance service, shall be considered emergency medicine.

The following classifications and rates or corresponding osteopathic doctor classifications and rates apply for physicians and surgeons in active United States Military Service:

| | | |
|---|---|---|
| Physicians - no surgery<br>Applies to codes 80230 through 80238, 80240, 80241, 80243 through 80269, 80420 | 80131 | 1 |
| Physicians - minor surgery<br>Applies to codes 80270 through 80272, 80274, 80276 through 80294, 80443 | 80132 | 2 |
| Physicians - minor surgery<br>Applies to codes 80101, 80102, 80103, 80104, 80105, 80106, 80107, 80108, 80114, 80115, 80117, 80422 | 80172 | 2 |

| | Code No. | Severity No. |
|---|---|---|
| **Physicians or Surgeons - major surgery**<br>**Applies to code 80145** | 80173 | 3 |
| **Physicians or Surgeons - major surgery**<br>**Applies to codes 80106, 80141, 80143, 80151, 80155, 80157, 80158, 80159, 80160, 80166** | 80174 | 5 |
| **Physicians or Surgeons - major surgery**<br>**Applies to codes 80153, 80156, 80167, 80168, 80169, 80170** | 80175 | 7 |
| **Physicians or Surgeons**<br>**Applies to codes 80144, 80146, 80150, 80152, 80154, 80171** | 80176 | 7 |

# PHYSICIANS BY SPECIALTY
(1988 SURVEY)

| CATEGORY | DESCRIPTION | EXPOSURES |
|---|---|---|
| 1000 | PHYSICIAN - NMS - NOC | 20.00 |
| 1001 | ALLERGY | 3.00 |
| 1002 | ANESTHESIOLOGY | 29.00 |
| 1003 | BRONCHOESOPHAGOLOGY | 3.00 |
| 1005 | CARDIOVASCULAR DIS. - NS | 17.00 |
| 1006 | DERMATOLOGY - MS | 4.00 |
| 1009 | DIABETES - NS | 3.00 |
| 1011 | EMERGENCY MED. - NMS | 37.00 |
| 1013 | ENDOCRINOLOGY - NS | 14.00 |
| 1014 | FAMILY PHYS. - MS | 4.00 |
| 1015 | FAMILY PHYS. - NS | 43.00 |
| 1017 | GASTROENTEROLOGY - MS | 1.00 |
| 1018 | GASTROENTEROLOGY - NS | 7.00 |
| 1023 | GERIATRICS - NS | 2.00 |
| 1025 | GYNECOLOGY - NS | 1.00 |
| 1026 | HEMATOLOGY - MS | 1.00 |
| 1027 | HEMATOLOGY - NS | 14.00 |
| 1029 | INFECTIOUS DIS. - MS | 3.00 |
| 1030 | INFECTIOUS DIS. - NS | 11.00 |
| 1033 | INTERNAL MED. - NS | 52.00 |
| 1039 | NEPHROLOGY - MS | 2.00 |
| 1040 | NEPHROLOGY - NS | 4.00 |
| 1042 | NEUROLOGY - IC - NS | 22.00 |
| 1046 | OPHTHALMOLOGY - NS | 4.00 |
| 1050 | OTORHINOLARYNGOLOGY - NS | 6.00 |
| 1052 | PATHOLOGY - NS | 27.00 |
| 1053 | PEDIATRICS - MS | 19.00 |
| 1054 | PEDIATRICS - NS | 55.00 |
| 1056 | PHYSIATRY | 4.00 |
| 1057 | PHYSICAL MED. & REHAB. | 2.00 |
| 1059 | PHYSICIAN - NS - NOC | 1096.00 |
| 1062 | PSYCHIATRY - IC | 46.00 |
| 1063 | PSYCHOANALYSIS | 15.00 |
| 1066 | PULMONARY DIS. - NS | 5.00 |
| 1067 | RADIOLOGY - DIAG. - MS | 1.00 |
| 1068 | RADIOLOGY - DIAG. - NS | 30.00 |
| 1069 | RHEUMATOLOGY - NS | 4.00 |
| 1077 | SURGERY - GASTROENTEROLOGY | 1.00 |
| 1078 | SURGERY - GEN. - NOC | 31.00 |
| 1082 | SURGERY - HEAD & NECK | 4.00 |
| 1086 | SURGERY - NEUROLOGY - IC | 3.00 |
| 1087 | SURGERY - OB/GYN | 42.00 |
| 1088 | SURGERY - OPHTHALMOLOGY | 5.00 |
| 1089 | SURGERY - ORTHOPEDIC | 20.00 |
| 1090 | SURGERY - OTOLOGY | 1.00 |
| 1092 | SURGERY - PLASTIC - NOC | 12.00 |
| 1095 | SURGERY - THORACIC | 2.00 |
| 1097 | SURGERY - UROLOGICAL | 11.00 |
| 1098 | SURGERY - VASCULAR | 7.00 |
| 1101 | PHYSICIAN - NMS - NOC | 4.00 |
| 1102 | PHYSICIAN - NMS - NOC | 4.00 |
| 1109 | SURGERY - GYNECOLOGY | 5.00 |

PHYSICIAN AND SURGEONS

Exhibit 3

MARCH 31, 1988

STATE=VIRGINIA

| CLASS | EXPOSURE |
|---|---|
| 80101 | 9 |
| 80102 | 134 |
| 80114 | 146 |
| 80115 | 8 |
| 80117 | 8 |
| 30131 | 1 |
| 80141 | 5 |
| 80143 | 117 |
| 80144 | 22 |
| 80145 | 109 |
| 80146 | 68 |
| 80150 | 4 |
| 80151 | 207 |
| 80152 | 34 |
| 80153 | 229 |
| 80154 | 199 |
| 80155 | 24 |
| 80156 | 50 |
| 80158 | 1 |
| 80159 | 20 |
| 80166 | 4 |
| 80167 | 45 |
| 80169 | 4 |
| 80170 | 5 |
| 80171 | 14 |
| 80177 | 0 |
| 80178 | 2 |
| 80179 | 5 |
| 80230 | 1 |
| 80232 | 2 |
| 80233 | 4 |
| 80234 | 3 |
| 80235 | 16 |
| 80236 | 7 |
| 80237 | 1 |
| 80238 | 9 |
| 80240 | 3 |
| 80241 | 4 |
| 80243 | 2 |
| 80244 | 5 |
| 80245 | 12 |
| 80246 | 26 |
| 80248 | 1 |
| 80249 | 96 |
| 80252 | 27 |
| 80253 | 8 |
| 80254 | 23 |
| 80255 | 54 |
| 80256 | 41 |
| 80257 | 433 |

PHYSICIAN AND SURGEONS

MARCH 31, 1988

STATE=VIRGINIA

| CLASS | EXPOSURE |
|---|---|
| 80259 | 37 |
| 80260 | 21 |
| 80261 | 57 |
| 80262 | 7 |
| 80263 | 7 |
| 80265 | 4 |
| 80266 | 116 |
| 80267 | 281 |
| 80269 | 15 |
| 80271 | 1 |
| 80274 | 14 |
| 80277 | 5 |
| 80280 | 36 |
| 80281 | 6 |
| 80282 | 15 |
| 80283 | 9 |
| 80284 | 4 |
| 80286 | 1 |
| 80287 | 4 |
| 80288 | 9 |
| 80289 | 3 |
| 80291 | 1 |
| 80292 | 17 |
| 80293 | 15 |
| 80420 | 548 |
| 80421 | 49 |
| 80422 | 376 |
| 80423 | 26 |
| 80424 | 84 |
| 80443 | 114 |
| 80999 | 0 |
| 84102 | 1 |
| 84151 | 1 |
| 84153 | 1 |
| 84154 | 1 |
| 84257 | 3 |
| 84284 | 1 |
| 84420 | 4 |
| 84422 | 4 |
| 84423 | 1 |
| 84424 | 1 |
| 84999 | 0 |
| 86259 | 1 |
| 86420 | 0 |
| 99992 | 0 |
| STATE | 4,153 |

# APPENDIX E

Bureau of Insurance
Medical Malpractice Closed Claims Summary Report

EXHIBIT 1

| Settlement/Judgement Category | Claims Closed | Percentage of Total Claims Closed | Total Amount of Settlement/Judgement (Excluding Attorney Fees and Expenses) |
|---|---|---|---|
| No Settlement or Judgement | 391 | 61.58% | 0 |
| $ 1 - $ 24,999 | 165 | 25.98% | 689,566 |
| $ 25,000 - $ 99,999 | 47 | 7.40% | 2,241,938 |
| $ 100,000 - $999,999 | 32 | 5.04% | 7,855,229 |
| $1,000,000 and over | 0 | 0% | 0 |
| Totals for the year 1985 | 635 | 100.00% | 10,786,733 |
| No Settlement or Judgement | 977 | 70.44% | 0 |
| $ 1 - $ 24,999 | 261 | 18.82% | 1,610,071 |
| $ 25,000 - $ 99,999 | 93 | 6.70% | 4,583,005 |
| $ 100,000 - $999,999 | 55 | 3.97% | 15,542,565 |
| $1,000,000 and over | 1 | .07% | 1,096,562 |
| Totals for the year 1986 | 1,387 | 100.00% | 22,832,203 |
| No Settlement or Judgement | 1,119 | 72.10% | 0 |
| $ 1 - $ 24,999 | 228 | 14.69% | 1,534,299 |
| $ 25,000 - $ 99,999 | 117* | 7.54% | 6,208,595 |
| $ 100,000 - $999,999 | 88 | 5.67% | 23,033,613 |
| $1,000,000 and over | 0 | 0% | 0 |
| Totals for the year 1987 | 1,552 | 100.00% | 30,776,507 |
| No Settlement or Judgement | 2,487 | 69.59% | 0 |
| $ 1 - $ 24,999 | 654 | 18.30% | 3,833,936 |
| $ 25,000 - $ 99,999 | 257 | 7.19% | 13,033,538 |
| $ 100,000 - $999,999 | 175 | 4.90% | 46,431,407 |
| $1,000,000 and over | 1 | .02% | 1,096,562 |
| Totals for 1985, 1986 & 1987 | 3,574 | 100.00% | 64,395,443 |

*One company offered a $1 million claim settlement among 18 claimants. The company did not know the amount received by each claimant since distribution was made through the courts. For the purpose of this report, the $1 million payment was divided by 18 to arrive at $55,555 per claimant.

EXHIBIT 2

Date:08/27/88

Bureau of Insurance
Medical Malpractice Closed Claims Summary Report



| NAIC CODE | Company Name | Year | Total Claims Closed | Claims Closed w/out Payment | Claims Paid | Amount of Settlement/ Judgement | Total Attorney Fees & Expenses | Attorney Fees & Expenses on Claims Closed w/out Payment | Attorney Fees & Expenses on Claims Paid |
|---|---|---|---|---|---|---|---|---|---|
| 19038 | AETNA CASUALTY AND SURETY COMP | 85 | 13 | 5 | 8 | 282,460 | 95,211 | 47,255 | 47,956 |
| 20281 | FEDERAL INSURANCE COMPANY | 85 | 12 | 3 | 9 | 207,056 | 29,494 | 5,354 | 24,140 |
| 11401 | GUARANTY NATIONAL INSURANCE CO | 85 | 3 | 2 | 1 | 356,312 | 72,311 | 8,911 | 63,400 |
| 22357 | HARTFORD ACCIDENT AND INDEMNIT | 85 | 4 | 0 | 4 | 29,000 | 29,676 | 0 | 29,676 |
| 19682 | HARTFORD FIRE INSURANCE COMPAN | 85 | 2 | 1 | 1 | 239,664 | 20,862 | 4,821 | 16,041 |
| 62189 | HUMANA INSURANCE COMPANY | 85 | 7 | 4 | 3 | 6,750 | 15,243 | 1,087 | 14,156 |
| 15865 | NATIONAL CHIROPRACTIC MUTUAL I | 85 | 2 | 2 | 0 | 0 | 2,536 | 2,536 | 0 |
| 23787 | NATIONWIDE MUTUAL INSURANCE CO | 85 | 2 | 0 | 2 | 57,500 | 4,719 | 0 | 4,719 |
| 22748 | PACIFIC EMPLOYERS INSURANCE CO | 85 | 3 | 2 | 1 | 70,000 | 12,269 | 1,876 | 10,393 |
| 20346 | PACIFIC INDEMNITY COMPANY | 85 | 1 | 1 | 0 | 0 | 4,943 | 4,943 | 0 |
| SL163 | PARTHENON CASUALTY COMPANY | 85 | 13 | 10 | 3 | 42,259 | 29,496 | 22,916 | 6,580 |
| 35718 | PHICO INSURANCE COMPANY | 85 | 144 | 77 | 67 | 287,102 | 169,127 | 150,578 | 18,549 |
| 24767 | ST PAUL FIRE AND MARINE INSURA | 85 | 325 | 236 | 89 | 7,033,064 | 1,497,385 | 720,767 | 776,618 |
| 25658 | TRAVELERS INDEMNITY COMPANY TH | 85 | 3 | 1 | 2 | 10,000 | 95,346 | 93,394 | 1,952 |
| 25887 | UNITED STATES FIDELITY AND GUA | 85 | 3 | 3 | 0 | 0 | 9,272 | 9,272 | 0 |
| 21113 | UNITED STATES FIRE INSURANCE C | 85 | 1 | 0 | 1 | 10,500 | 0 | 0 | 0 |
| 20397 | VIGILANT INSURANCE COMPANY | 85 | 6 | 4 | 2 | 175,000 | 110,889 | 49,051 | 61,838 |
| 33812 | VIRGINIA INSURANCE RECIPROCAL, | 85 | 91 | 40 | 51 | 1,980,066 | 847,609 | 373,603 | 474,006 |
| 1985 Totals: | | | 635 | 391 | 244 | 10,786,733 | 3,046,388 | 1,496,364 | 1,550,024 |
| 19038 | AETNA CASUALTY AND SURETY COMP | 86 | 16 | 3 | 13 | 195,466 | 53,975 | 13,956 | 40,019 |
| 19232 | ALLSTATE INSURANCE COMPANY | 86 | 1 | 1 | 0 | 0 | 4,589 | 4,589 | 0 |
| 22810 | CHICAGO INSURANCE COMPANY | 86 | 24 | 19 | 5 | 86,000 | 25,197 | 1,265 | 23,932 |
| 10677 | CINCINNATI INSURANCE COMPANY T | 86 | 2 | 0 | 2 | 5,411 | 8,798 | 0 | 8,798 |
| 20443 | CONTINENTAL CASUALTY COMPANY | 86 | 47 | 35 | 12 | 61,275 | 62,352 | 20,060 | 42,292 |
| 20281 | FEDERAL INSURANCE COMPANY | 86 | 49 | 31 | 18 | 210,835 | 486,539 | 357,701 | 128,838 |
| 62189 | HUMANA INSURANCE COMPANY | 86 | 10 | 8 | 2 | 85,000 | 20,846 | 7,661 | 13,185 |
| 67415 | INA LIFE INSURANCE COMPANY | 86 | 7 | 5 | 2 | 21,500 | 0 | 0 | 0 |
| 28800 | INSURANCE CORPORATION OF AMERI | 86 | 2 | 1 | 1 | 9,000 | 1,428 | 0 | 1,428 |
| 15865 | NATIONAL CHIROPRACTIC MUTUAL I | 86 | 1 | 0 | 1 | 102 | 0 | 0 | 0 |

| NAIC CODE | Company Name | Year | Total Claims Closed | Claims Closed w/out Payment | Claims Paid | Amount of Settlement/ Judgement | Total Attorney Fees & Expenses | Attorney Fees & Expenses on Claims Closed w/out Payment | Attorney Fees & Expenses on Claims Paid |
|---|---|---|---|---|---|---|---|---|---|
| 19445 | NATIONAL UNION FIRE INSURANCE | 86 | 2 | 1 | 1 | 500 | 3,158 | 1,773 | 1,385 |
| 23787 | NATIONWIDE MUTUAL INSURANCE CO | 86 | 2 | 2 | 0 | 0 | 0 | 0 | 0 |
| 22748 | PACIFIC EMPLOYERS INSURANCE CO | 86 | 3 | 3 | 0 | 0 | 0 | 0 | 0 |
| SL163 | PARTHENON CASUALTY COMPANY | 86 | 13 | 8 | 5 | 33,322 | 32,416 | 16,699 | 15,717 |
| 35718 | PHICO INSURANCE COMPANY | 86 | 209 | 152 | 57 | 2,180,302 | 963,218 | 476,676 | 486,542 |
| 15156 | SHELBY INSURANCE COMPANY, THE | 86 | 1 | 0 | 1 | 35,000 | 19,667 | 0 | 19,667 |
| 24767 | ST PAUL FIRE AND MARINE INSURA | 86 | 611 | 464 | 147 | 13,032,517 | 3,510,837 | 1,798,507 | 1,712,330 |
| 25658 | TRAVELERS INDEMNITY COMPANY TH | 86 | 3 | 1 | 2 | 20,000 | 36,450 | 17,714 | 18,736 |
| 87726 | TRAVELERS INSURANCE COMPANY | 86 | 3 | 0 | 3 | 219,274 | 8,616 | 0 | 8,616 |
| 25887 | UNITED STATES FIDELITY AND GUA | 86 | 7 | 5 | 2 | 31,500 | 24,541 | 19,293 | 5,248 |
| 33812 | VIRGINIA INSURANCE RECIPROCAL, | 86 | 374 | 238 | 136 | 6,605,199 | 1,349,235 | 500,844 | 848,391 |
| 1986 Totals: | | | 1,387 | 977 | 410 | 22,832,203 | 6,611,862 | 3,236,738 | 3,375,124 |
| 19038 | AETNA CASUALTY AND SURETY COMP | 87 | 7 | 3 | 4 | 245,678 | 36,378 | 16,740 | 19,638 |
| 20281 | FEDERAL INSURANCE COMPANY | 87 | 30 | 15 | 15 | 156,532 | 87,113 | 33,148 | 53,965 |
| 22357 | HARTFORD ACCIDENT AND INDEMNIT | 87 | 2 | 1 | 1 | 1,000 | 3,533 | 3,533 | 0 |
| 62189 | HUMANA INSURANCE COMPANY | 87 | 13 | 13 | 0 | 0 | 22,327 | 22,327 | 0 |
| 28800 | INSURANCE CORPORATION OF AMERI | 87 | 3 | 2 | 1 | 194 | 872 | 872 | 0 |
| SL163 | PARTHENON CASUALTY COMPANY | 87 | 11 | 5 | 6 | 130,750 | 40,241 | 7,497 | 32,744 |
| 35718 | PHICO INSURANCE COMPANY | 87 | 225 | 152 | 73 | 3,856,631 | 1,011,898 | 604,085 | 407,813 |
| 24767 | ST PAUL FIRE AND MARINE INSURA | 87 | 901 | 704 | 197 | 18,456,773 | 4,823,382 | 2,159,187 | 2,664,195 |
| 87726 | TRAVELERS INSURANCE COMPANY | 87 | 2 | 2 | 0 | 0 | 0 | 0 | 0 |
| 25887 | UNITED STATES FIDELITY AND GUA | 87 | 3 | 3 | 0 | 0 | 2,463 | 2,463 | 0 |
| 20397 | VIGILANT INSURANCE COMPANY | 87 | 1 | 1 | 0 | 0 | 9,303 | 9,303 | 0 |
| 33812 | VIRGINIA INSURANCE RECIPROCAL, | 87 | 354 | 218 | 136 | 7,928,949 | 1,430,564 | 535,483 | 895,081 |
| 1987 Totals: | | | 1,552 | 1,119 | 433 | 30,776,507 | 7,468,074 | 3,394,638 | 4,073,436 |
| Totals for 1985, 1986 & 1987 | | | 3,574 | 2,487 | 1,087 | 64,395,443 | 17,126,324 | 8,127,740 | 8,998,584 |

Bureau of Insurance
Medical Malpractice Closed Claims Summary Report



| Provider Code | Provider Name | Year | Total Claims Closed | Claims Closed w/out Payment | Claims Paid | Total Amount of Settlement/Judgement | Average Amount of Settlement/Judgement |
|---|---|---|---|---|---|---|---|
| 001 | Allergist | 85 | 1 | 0 | 1 | 9,218 | 9,218 |
| 002 | Anesthesiologist | 85 | 14 | 7 | 7 | 392,141 | 56,020 |
| 003 | Cardiologist | 85 | 3 | 2 | 1 | 15,500 | 15,500 |
| 041 | Chiropractor | 85 | 2 | 2 | 0 | 0 | 0 |
| 030 | Dentist | 85 | 45 | 17 | 28 | 407,142 | 14,540 |
| 004 | Dermatologist | 85 | 2 | 2 | 0 | 0 | 0 |
| 005 | Emergency Room Physician | 85 | 21 | 18 | 3 | 144,750 | 48,250 |
| 006 | Endocrinologist | 85 | 1 | 1 | 0 | 0 | 0 |
| 007 | Family or General Practitioner | 85 | 31 | 21 | 10 | 1,237,956 | 123,795 |
| 008 | Gastroenterologist | 85 | 4 | 3 | 1 | 1,144 | 1,144 |
| 328 | General Surgeon | 85 | 38 | 21 | 17 | 1,051,536 | 61,855 |
| 009 | Gynecologist/Obstetrician | 85 | 49 | 32 | 17 | 1,884,861 | 110,874 |
| 010 | Hematologist | 85 | 1 | 1 | 0 | 0 | 0 |
| 029 | Hospital | 85 | 215 | 99 | 116 | 2,173,525 | 18,737 |
| 011 | Internist | 85 | 23 | 19 | 4 | 189,500 | 47,375 |
| 013 | Nephrologist | 85 | 1 | 1 | 0 | 0 | 0 |
| 014 | Neurologist | 85 | 3 | 3 | 0 | 0 | 0 |
| 428 | Neurologist Surgeon | 85 | 8 | 5 | 3 | 689,328 | 229,776 |
| 035 | Nurse | 85 | 6 | 2 | 4 | 170,000 | 42,500 |
| 628 | Obstetric/Gynecologist Surgeon | 85 | 14 | 11 | 3 | 59,200 | 19,733 |
| 038 | Oncologist | 85 | 2 | 2 | 0 | 0 | 0 |
| 015 | Ophthalmologist | 85 | 2 | 2 | 0 | 0 | 0 |
| 034 | Optometrist | 85 | 4 | 3 | 1 | 25,000 | 25,000 |
| 528 | Orthopedic Surgeon | 85 | 18 | 17 | 1 | 298,606 | 298,606 |
| 033 | Orthopedist | 85 | 10 | 8 | 2 | 85,000 | 42,500 |
| 016 | Otologist | 85 | 1 | 1 | 0 | 0 | 0 |
| 017 | Otorhinolaryngologist | 85 | 5 | 4 | 1 | 30,000 | 30,000 |
| 018 | Pathologist | 85 | 5 | 3 | 2 | 215,075 | 107,537 |
| 019 | Pediatrician | 85 | 7 | 5 | 2 | 138,664 | 69,332 |
| 031 | Pharmacist | 85 | 1 | 1 | 0 | 0 | 0 |
| 728 | Plastic Surgeon | 85 | 14 | 12 | 2 | 15,000 | 7,500 |
| 032 | Podiatrist | 85 | 2 | 2 | 0 | 0 | 0 |
| 022 | Psychiatrist | 85 | 10 | 8 | 2 | 275,000 | 137,500 |

| Provider Code | Provider Name | Year | Total Claims Closed | Claims Closed w/out Payment | Claims Paid | Total Amount of Settlement/Judgement | Average Amount of Settlement/Judgement |
|---|---|---|---|---|---|---|---|
| 023 | Pulminary Specialist | 85 | 1 | 1 | 0 | 0 | 0 |
| 024 | Radiologist | 85 | 16 | 13 | 3 | 320,400 | 106,800 |
| 037 | Resident, Intern, or medical s | 85 | 1 | 1 | 0 | 0 | 0 |
| 028 | Surgeon | 85 | 13 | 9 | 4 | 434,675 | 108,668 |
| 828 | Thoracic Surgeon | 85 | 2 | 1 | 1 | 22,000 | 22,000 |
| 000 | Unknown | 85 | 33 | 25 | 8 | 501,512 | 62,689 |
| 027 | Urologist | 85 | 6 | 6 | 0 | 0 | 0 |
| 1985 Totals: | | | 635 | 391 | 244 | 10,786,733 | 44,207 |
| 001 | Allergist | 86 | 1 | 1 | 0 | 0 | 0 |
| 002 | Anesthesiologist | 86 | 28 | 22 | 6 | 959,165 | 159,860 |
| 003 | Cardiologist | 86 | 5 | 4 | 1 | 62,745 | 62,745 |
| 041 | Chiropractor | 86 | 1 | 0 | 1 | 102 | 102 |
| 228 | Colon and Rectal Surgeon | 86 | 1 | 1 | 0 | 0 | 0 |
| 030 | Dentist | 86 | 145 | 86 | 59 | 741,648 | 12,570 |
| 004 | Dermatologist | 86 | 7 | 7 | 0 | 0 | 0 |
| 005 | Emergency Room Physician | 86 | 49 | 29 | 20 | 1,133,571 | 56,678 |
| 007 | Family or General Practitioner | 86 | 75 | 47 | 28 | 2,880,635 | 102,879 |
| 008 | Gastroenterologist | 86 | 6 | 5 | 1 | 90,000 | 90,000 |
| 328 | General Surgeon | 86 | 69 | 47 | 22 | 3,218,501 | 146,295 |
| 042 | Geriatrician | 86 | 1 | 1 | 0 | 0 | 0 |
| 009 | Gynecologist/Obstetrician | 86 | 100 | 67 | 33 | 2,956,668 | 89,596 |
| 010 | Hematologist | 86 | 4 | 3 | 1 | 398 | 398 |
| 029 | Hospital | 86 | 485 | 337 | 148 | 3,626,617 | 24,504 |
| 011 | Internist | 86 | 51 | 40 | 11 | 955,564 | 86,869 |
| 013 | Nephrologist | 86 | 2 | 2 | 0 | 0 | 0 |
| 014 | Neurologist | 86 | 9 | 9 | 0 | 0 | 0 |
| 428 | Neurologist Surgeon | 86 | 13 | 9 | 4 | 594,557 | 148,639 |
| 035 | Nurse | 86 | 35 | 29 | 6 | 104,000 | 17,333 |
| 040 | Nursing student | 86 | 1 | 1 | 0 | 0 | 0 |
| 628 | Obstetric/Gynecologist Surgeon | 86 | 14 | 4 | 10 | 1,263,067 | 126,306 |

| Provider Code | Provider Name | Year | Total Claims Closed | Claims Closed w/out Payment | Claims Paid | Total Amount of Settlement/Judgement | Average Amount of Settlement/Judgement |
|---|---|---|---|---|---|---|---|
| 038 | Oncologist | 86 | 5 | 5 | 0 | 0 | 0 |
| 015 | Ophthalmologist | 86 | 17 | 15 | 2 | 51,250 | 25,625 |
| 034 | Optometrist | 86 | 2 | 2 | 0 | 0 | 0 |
| 528 | Orthopedic Surgeon | 86 | 46 | 33 | 13 | 1,408,502 | 108,346 |
| 033 | Orthopedist | 86 | 28 | 26 | 2 | 102,813 | 51,406 |
| 017 | Otorhinolaryngologist | 86 | 7 | 4 | 3 | 317,190 | 105,730 |
| 018 | Pathologist | 86 | 8 | 5 | 3 | 226,824 | 75,608 |
| 019 | Pediatrician | 86 | 22 | 20 | 2 | 387,851 | 193,925 |
| 031 | Pharmacist | 86 | 2 | 1 | 1 | 4,000 | 4,000 |
| 728 | Plastic Surgeon | 86 | 18 | 15 | 3 | 23,000 | 7,666 |
| 032 | Podiatrist | 86 | 6 | 3 | 3 | 87,750 | 29,250 |
| 022 | Psychiatrist | 86 | 23 | 20 | 3 | 59,000 | 19,666 |
| 036 | Psychologist | 86 | 3 | 3 | 0 | 0 | 0 |
| 023 | Pulminary Specialist | 86 | 2 | 1 | 1 | 400 | 400 |
| 024 | Radiologist | 86 | 25 | 16 | 9 | 489,985 | 54,442 |
| 037 | Resident, Intern, or medical s | 86 | 2 | 1 | 1 | 22,500 | 22,500 |
| 028 | Surgeon | 86 | 15 | 12 | 3 | 234,607 | 78,202 |
| 828 | Thoracic Surgeon | 86 | 5 | 4 | 1 | 101,000 | 101,000 |
| 000 | Unknown | 86 | 18 | 14 | 4 | 516,274 | 129,068 |
| 027 | Urologist | 86 | 26 | 22 | 4 | 162,019 | 40,504 |
| 928 | Vascular Surgeon | 86 | 5 | 4 | 1 | 50,000 | 50,000 |
| 1986 Totals: | | | 1,387 | 977 | 410 | 22,832,203 | 55,688 |
| 002 | Anesthesiologist | 87 | 43 | 34 | 9 | 1,045,123 | 116,124 |
| 128 | Cardiac Surgeon | 87 | 4 | 3 | 1 | 200,000 | 200,000 |
| 003 | Cardiologist | 87 | 12 | 10 | 2 | 92,000 | 46,000 |
| 228 | Colon and Rectal Surgeon | 87 | 1 | 1 | 0 | 0 | 0 |
| 030 | Dentist | 87 | 77 | 52 | 25 | 722,195 | 28,887 |
| 004 | Dermatologist | 87 | 9 | 5 | 4 | 40,989 | 10,247 |
| 005 | Emergency Room Physician | 87 | 46 | 35 | 11 | 385,200 | 35,018 |
| 006 | Endocrinologist | 87 | 2 | 1 | 1 | 6,250 | 6,250 |

| Provider Code | Provider Name | Year | Total Claims Closed | Claims Closed w/out Payment | Claims Paid | Total Amount of Settlement/Judgement | Average Amount of Settlement/Judgement |
|---|---|---|---|---|---|---|---|
| 007 | Family or General Practitioner | 87 | 145 | 109 | 36 | 2,448,356 | 68,009 |
| 008 | Gastroenterologist | 87 | 14 | 12 | 2 | 254,925 | 127,462 |
| 328 | General Surgeon | 87 | 89 | 64 | 25 | 2,459,101 | 98,364 |
| 009 | Gynecologist/Obstetrician | 87 | 135 | 95 | 40 | 5,778,875 | 144,471 |
| 010 | Hematologist | 87 | 3 | 3 | 0 | 0 | 0 |
| 029 | Hospital | 87 | 414 | 274 | 140 | 6,954,681 | 49,676 |
| 011 | Internist | 87 | 98 | 82 | 16 | 1,341,986 | 83,874 |
| 013 | Nephrologist | 87 | 2 | 2 | 0 | 0 | 0 |
| 014 | Neurologist | 87 | 14 | 10 | 4 | 206,500 | 51,625 |
| 428 | Neurologist Surgeon | 87 | 19 | 16 | 3 | 265,500 | 88,500 |
| 035 | Nurse | 87 | 12 | 11 | 1 | 50,000 | 50,000 |
| 628 | Obstetric/Gynecologist Surgeon | 87 | 22 | 9 | 13 | 545,732 | 41,979 |
| 038 | Oncologist | 87 | 5 | 5 | 0 | 0 | 0 |
| 015 | Ophthalmologist | 87 | 24 | 17 | 7 | 435,994 | 62,284 |
| 034 | Optometrist | 87 | 2 | 1 | 1 | 1,700 | 1,700 |
| 528 | Orthopedic Surgeon | 87 | 64 | 52 | 12 | 1,348,500 | 112,375 |
| 033 | Orthopedist | 87 | 52 | 44 | 8 | 513,632 | 64,204 |
| 017 | Otorhinolaryngologist | 87 | 30 | 8 | 22 | 1,639,385 | 74,517 |
| 018 | Pathologist | 87 | 14 | 12 | 2 | 54,500 | 27,250 |
| 019 | Pediatrician | 87 | 33 | 27 | 6 | 848,833 | 141,472 |
| 031 | Pharmacist | 87 | 1 | 0 | 1 | 1,000 | 1,000 |
| 039 | Phlebotonist | 87 | 1 | 1 | 0 | 0 | 0 |
| 728 | Plastic Surgeon | 87 | 30 | 26 | 4 | 137,500 | 34,375 |
| 032 | Podiatrist | 87 | 4 | 4 | 0 | 0 | 0 |
| 022 | Psychiatrist | 87 | 14 | 9 | 5 | 510,833 | 102,166 |
| 036 | Psychologist | 87 | 1 | 0 | 1 | 291,325 | 291,325 |
| 023 | Pulminary Specialist | 87 | 3 | 3 | 0 | 0 | 0 |
| 024 | Radiologist | 87 | 35 | 22 | 13 | 1,080,742 | 83,134 |
| 037 | Resident, Intern, or medical s | 87 | 2 | 2 | 0 | 0 | 0 |
| 025 | Rheumatologist | 87 | 1 | 1 | 0 | 0 | 0 |
| 028 | Surgeon | 87 | 18 | 11 | 7 | 789,333 | 112,761 |
| 828 | Thoracic Surgeon | 87 | 7 | 5 | 2 | 35,022 | 17,511 |
| 000 | Unknown | 87 | 8 | 5 | 3 | 103,295 | 34,431 |

| Provider Code | Provider Name | Year | Total Claims Closed | Claims Closed w/out Payment | Claims Paid | Total Amount of Settlement/Judgement | Average Amount of Settlement/Judgement |
|---|---|---|---|---|---|---|---|
| 027 | Urologist | 87 | 37 | 32 | 5 | 122,500 | 24,500 |
| 928 | Vascular Surgeon | 87 | 5 | 4 | 1 | 65,000 | 65,000 |
| 1987 Totals: | | | 1,552 | 1,119 | 433 | 30,776,507 | 71,077 |
| Totals for 1985, 1986 & 1987 | | | 3,574 | 2,487 | 1,087 | 64,395,443 | 59,241 |

APPENDIX F

Premium comparison using territory 1 mature claims-made rates with limits of $1,000,000/$1,000,000 (JUA's rates are based on $1,000,000/$3,000,000 limits) effective on 7/1/88. Chart does not include all provider specialty groups.

| Area of Medicine | Premium | | | | |
|---|---|---|---|---|---|
| | Med. Prot. | St. Paul | TVIR | JUA* | PHICO |
| Allergy - no surgery<br>Dermatology - no surgery<br>Forensic Medicine - no surgery<br>Pathology - no surgery<br>Psychiatry - no surgery | $3,218 | $4,948 | $4,155 | $5,653 | $3,474 |
| Aerospace Medicine - no surgery<br>Cardiovascular Disease - no surgery<br>Diabetes - no surgery<br>Endocrinology - no surgery<br>Family Practice - no surgery<br>Gastroenterology - no surgery<br>General Preventive Medicine - no surgery<br>Geriatrics - no surgery<br>Gynecology - no surgery<br>Hematology - no surgery<br>Infectious Disease - no surgery<br>Internal Medicine - no surgery<br>Laryngology - no surgery<br>Nephrology - no sugery<br>Neurology - no surgery<br>Nuclear Medicine - no surgery | $3,218 | $6,058 | $4,155 | $5,653 | $3,474<br>[$4,631]<br>[$4,631] |

*A 33 1/3% surcharge (not shown) is added to each year's premium for the stabilization reserve fund.

| Area of Medicine | Premium | | | | |
|---|---|---|---|---|---|
| | Med. Prot. | St. Paul | TVIR | JUA* | PHICO |
| (CONT'D.)<br>Occupational Medicine - no surgery<br>Ophthalmology - no surgery<br>Otology - no surgery<br>Otorhinolaryngology - no surgery<br>Pediatrics - no surgery<br>Physical Medicine & Rehab. - no surgery<br>Radiology - no surgery<br>Rheumatology - no surgery<br>Rhinology - no surgery | $3,218<br>[$5,535] | $6,058 | $4,155 | $5,653 | $3,474<br>[$4,631] |
| Cardiovascular Disease - minor surgery<br>Endocrinology - minor surgery<br>Family Practice - minor surgery<br>Gastroenterology - minor surgery<br>Geriatrics - minor surgery<br>Gynecology - minor surgery<br>Hematology - minor surgery<br>Infectious Disease - minor surgery<br>Internal Medicine - minor surgery<br>Laryngology - minor surgery<br>Nephrology - minor surgery<br>Neurology - minor surgery<br>Ophthalmology - minor surgery<br>Otorhinolaryngology - minor surgery<br>Pathology - minor surgery<br>Pediatrics - minor surgery<br>Radiology - minor surgery<br>Rhinology - minor surgery | $5,535 | $8,843 | $7,029 | $8,284 | $7,411 |

*A 33 1/3% surcharge (not shown) is added to each year's premium for the stabilization reserve fund.

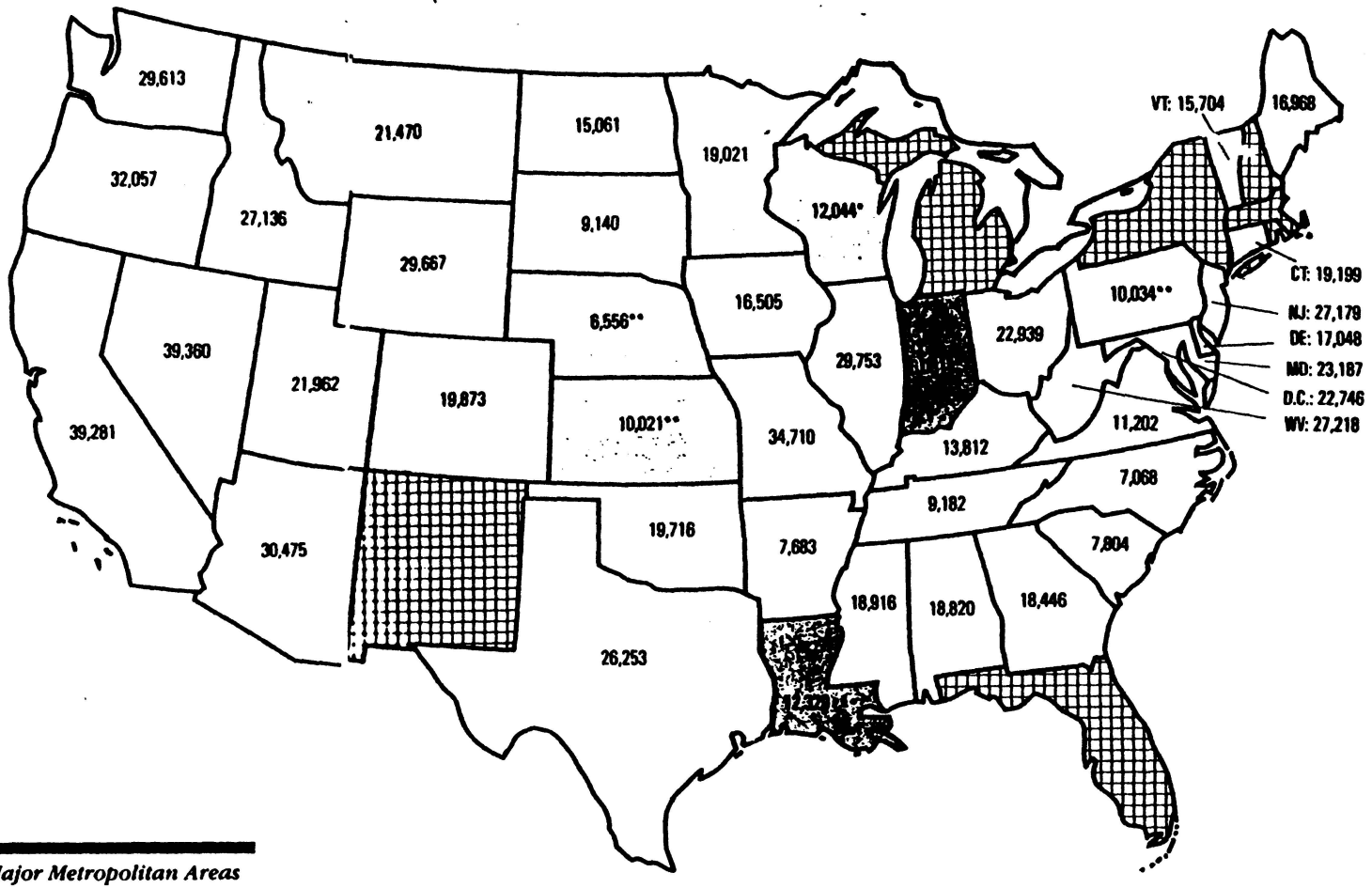
| Area of Medicine | Premium | | | | |
|---|---|---|---|---|---|
| | Med. Prot. | St. Paul | TVIR | JUA* | PHICO |
| | $7,402 | $11,634 | $9,317 | $10,918 | $13,895 |
| Colon & Rectal Surgery | | | | | [$24,237] |
| Endocrinology - major surgery | | | | | |
| Family Practice - including obstetrics | [$9,976] | | | | |
| Gastroenterology - major surgery | | | | | |
| Geriatrics - major surgery | | | | | |
| Nephrology - major surgery | | | | | |
| Ophthalmology - major surgery | | | | | [$7,411] |
| Urological Surgery | | | | | [$16,211] |
| | $9,976 | $14,417 | $12,518 | $14,602 | $13,895 |
| Emergency Medicine | | | | | |
| | $18,554 | $22,974 | $20,904 | $24,413 | $24,237 |
| Anesthesiology | | | | | |
| | | $26,206 | $23,517 | $27,410 | |
| Emergency Medicine - major surgery | [$9,976] | | | | [$24,237] |
| General Surgery | [$18,554] | | | | [$24,237] |
| Otorhinolaryngology - major surgery | [$18,554] | | | | [$16,211] |
| Plastic Surgery | [$24,009] | | | | [$29,084] |
| | $29,831 | $35,818 | $29,904 | $36,399 | $29,084 |
| Cardiac Surgery | | | | | |
| Cardiovascular Disease Surgery | | | | | |
| Orthopedic Surgery | | | | | [$38,779] |
| Thoracic Surgery | | | | | |

*A 33 1/3% surcharge (not shown) is added to each year's premium for the stabilization reserve fund.

| Area of Medicine | Premium | | | | |
|---|---|---|---|---|---|
| | Med. Prot. | St. Paul | TVIR | JUA* | PHICO |
| Surgery - Obstetrics & Gynecology | $39,653 | $44,796 | $38,938 | $45,390 | $38,779 |
| Neurological Surgery | $39,653 | $56,388 | $49,643 | $57,376 | $48,472 |

*A 33 1/3% surcharge (not shown) is added to each year's premium for the stabilization reserve fund.

# St. Paul Fire and Marine Insurance Company
## *Proposed* Physician & Surgeon Average Rates
## On An Annual Basis After July 1, 1988
***(Class 4 doctor/mature claims-made rates primarily at $1 million/$3 million limits)***




***Major Metropolitan Areas***

| | |
|---|---|
| Chicago | $51,439 |
| Houston | $39,323 |
| Los Angeles | $47,959 |
| New Orleans | $15,380*** |
| Philadelphia | $20,370** |
| St. Louis | $41,666 |
| San Francisco | $43,578 |
| Washington, D.C. | $22,746 |

***Limits Table***

$1 million/$3 million
*$400,000/$1,000,000
**$200,000/$600,000
***$100,000/$300,000

The St. Paul does not offer physician and surgeon medical liability insurance in these states.

APPENDIX H

**Section 38.2-2228. Certain medical malpractice claims to be reported to Commissioner; duty of Commissioner; annual report; statistical summary.** -- All medical malpractice claims opened, settled, or adjudicated to final judgment against a person, corporation, firm, or entity providing health care and any such claim closed without payment during each calendar year shall be reported annually to the Commissioner by the insurer of the health care provider or, if there is no insurer, by the health care provider. The reports shall not identify the parties.

The report to the Commissioner shall state the following data, to the extent applicable, in a format prescribed by him:

1. Nature of the claim and damages asserted;
2. Principal medical and legal issues;
3. Attorney's fees and expenses ~~incurred~~ paid in connection with the claim or defense to the extent these amounts are known;
4. Attorney's fees and expenses reserved in connection with the claim or defense;
45. The amount of the settlement or judgment awarded to the claimant to the extent this amount is known;
56. The specialty of each health care provider; ~~and~~
7. The date the claim was reported to the company;
8. The date the loss occurred;
9. The date the claim was closed;
10. The date and the amount of the initial reserve;
11. The reserve valued at the end of the current calendar year;
12. The amount of loss paid by the insurer if different from the amount of settlement or judgment awarded to the claimant; and
613. Any other pertinent and relevant information which the Commissioner may require as is consistent with the provisions of this section.

The report shall include a statistical summary of the information collected in addition to an individual report on each claim. ~~Each annual report~~ Statistical summaries and individual closed claim reports shall be a matter of public record. Individual open claim reports shall not be a matter of public record.